

# ADDP Presents Dual Eligibles Testimony

## ADDP ANNUAL MEETING

January 17, 2012  
Great Hall  
Massachusetts State  
House  
10:00 A.M.

Agenda  
Annual Report  
Election of Officers  
Treasurer's Report  
Dual Eligible Panel  
Discussion  
FY 13 Budget Priorities

## ADDP Legislative Box Luncheon

11:30 A.M. to 1:00 P.M.  
Have lunch with ADPP  
and your  
Representative and

## ADDP Details Areas of Concern

### Eligibility, Appeals, Authority, Funding In Need of Clarity

ADDP has outlined a series of concerns that members believe must be addressed by the Commonwealth, as the State continues working on a proposal to place individuals dually eligible for both Medicare and Medicaid into managed care programs.

On behalf of ADPP's 128 member organizations, President & CEO Gary Blumenthal, submitted public testimony to Mass Health leaders today that requests clarity on five key issues including:

- **Protection of existing** Long Term Supports and Services (LTSS) **fiscal resources** remaining within the LTSS sector
- Administrative or other cost **savings** achieved from system redesign being **retained and invested into the LTSS sector**
- **LTSS Case Management, independent of ICO** with clear regulatory authority over ISP decisions & implementation retained by the Department of Developmental Services, or their designee
- **Rate Setting authority maintained** under present statutes and regulations, including Chapter 257, prohibiting ICOs from negotiating discount rates to service providers
- **Adherence to current CMS and maintenance of effort regulations** that will assure that access to services and supports, including specialty services maintained as an entitlement, based upon need.

ADDP indicated the Association would recommend the Commonwealth "carve out" LTSS-HCBS-DD services **unless** Mass Health can provide

Senator  
Great hall  
Massachusetts State  
House

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assurances addressing the above concerns.

# Duals Demonstration Proposal Public Comment

**Gary Blumenthal, President & CEO  
January 10, 2012**

On behalf of the 128 member organizations of the Association of Developmental Disabilities Providers, I wish to share our general concerns about the Commonwealth's efforts to integrate care for Medicare/Medicaid enrollees.

As an element of the Affordable Care Act of 2009, we support efforts of the Obama and Patrick Administrations to increase the efficiency, cost effectiveness and outcomes of the health care system as embodied by the ACA. Massachusetts has been a visionary leader in promoting expanded coverage and health expenditure reform at both the national and state level for many years.

We understand that the rationale for the movement to support individuals dually eligible for Medicare and Medicaid in a managed care model is in response to data which suggest that poorly coordinated health care and unnecessary acute medical care is producing poor quality care and excessive costs to the public.

We believe that efficiencies achieved through integrated health care may increase resources, and support setting fair rates to community service providers and fair wages to community based direct support workers while expanding the number of people to be served by the health care system and allowing for the use of innovative supports and services.

**We endorse the substance of the assessment and recommendations of *The Arc of Massachusetts*** in their public testimony on this issue. We concur that there is a great need to separately track health care costs and the cost of Long Term Supports and Services, regardless of whether there is one capitated rate or any other rate model utilized in the demonstration project. We wish to seek to see assurances built into the demonstration project that verifies:

- Protection of existing LTSS fiscal resources remaining within the

LTSS sector

- Administrative or other cost savings achieved from system redesign will be retained and invested into the LTSS sector
- LTSS Case Management, independent of ICO with clear regulatory authority over ISP decisions & implementation retained by the Department of Developmental Services, or their designee
- Rate Setting authority maintained under present statutes and regulations, including Chapter 257, prohibiting ICOs from negotiating discount rates to service providers
- Adherence to current CMS and maintenance of effort regulations that will assure that access to services and supports, including specialty services maintained as an entitlement, based upon need.

While we hope that a movement towards managed care administered by third party Integrated Care Organizations will produce positive health care expenditure reforms, prior to the Commonwealth seeking to include Long Term Supports and Services (LTSS) and specifically Home and Community Based Waiver Services for individuals with Developmental Disabilities, we request that that the state clarify the following:

1. How will eligibility and individual ISP service plan decisions be executed to respect the clinical judgment and expertise of consumers, families, and developmental disabilities professionals?
2. What appeals processes would exist to protect the professional judgment of developmental disabilities providers and community experts?
3. What will be the authority of the Department of Developmental Services and Mass Health with regard to monitoring and appealing ICO service decisions?
4. What professional standards, including knowledge, training and experience working with people with developmental disabilities will exist for service decision personnel within ICOs?
5. Noting that 40% of all DD consumers are Dually Eligible for Medicare and Medicaid, regardless of whether they are served in POS, State Operated Programs or State Developmental Centers, would the funding levels and/or cost basis of each of these programs be subject to a similar funding range, subject to managed care company discretion?

6. If POS, State Operated Programs and State Developmental Centers are dependent upon funding determined by ICOs, will specific decisions regarding amounts & length of service, eligibility for service, or continuation of service, be determined by the ICOs?

7. In establishing blended rates to cover all program participants, how will regulations be established to ensure that ICOs protect consumer access to care, and that reimbursements for LTSS be adequate (and compliant with Chapter 257 in order to sustain the fragile community Medicaid services which will be necessary for Medicare savings? If there are losses in direct health care costs, what protections will be established to ensure that LTSS costs will not be be constricted to help cover plan losses?

8. If LTSS HCBS DD WAIVER Services are included in the demonstration project, is the State going to include all related federal funds, including case management dollars in the pool of available system dollars? If that is the case, will the State cease to perform service coordination?

9. If DD services and supports are included in the Demonstration Project, how will ICOs be expected or required to adhere to the provisions of Chapter 257 regarding rates and the evolution of Direct Support Worker salaries?

10. If LTSS HCBS DD Waiver programs are included what administrative structures would be in place to assist provider agencies who would be reporting to multiple funders including ICOs, and the State?

11. Can the State assure the developmental disabilities community that administrative savings generated from a reshaping of the developmental disabilities system is re-invested into developmental disabilities service and supports?

If the State is unable to clarify these questions, then we would request the Commonwealth be explicit in its demonstration proposal request to ask for a carve out or exclusion of HCBS DD supports and services from the proposal.

**ADDP would be in support of re-examining our position pending substantive clarifications and formal commitments by EOHHS regarding these issues of concern.**

We look forward to hearing such clarification from the state, and would be happy to continue discussions regarding these issues.

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This email was sent to corrinne.altmanmoore@state.ma.us by [garyblumenthal@addp.org](mailto:garyblumenthal@addp.org) | [Update Profile/Email Address](#) | Instant removal with [SafeUnsubscribe™](#) | [Privacy Policy](#).  
ADDP | 1671 Worcester Road | Suite 201 | Framingham | MA | 01701

**From:** Kim Shellenberger [kshellenberger@commonwealthcare.org]  
**Sent:** Tuesday, January 03, 2012 10:58 AM  
**To:** Duals (EHS)  
**Cc:** Susan Kaufman  
**Subject:** Questions on Duals Demonstration from Commonwealth Care Alliance

Dear EOHHS:

I am writing on behalf of Commonwealth Care Alliance with specific questions on the Duals Demonstration Design. We plan to submit more comprehensive written and oral testimony in the coming days. In the meantime, we are submitting the below questions in hopes that EOHHS might respond more quickly to these specific questions.

1. We believe that the methods for developing risk adjustment and rating categories should take into account appropriate approaches for the sub-population of duals utilizing high levels of long term supports and services (LTSS). What will be the process for the development of risk adjustment methodologies, rating categories, financing approaches and capitation rates? What is the process for providing input into the development of these methods?
2. Given that the duals demonstration is a program to integrate and coordinate clinical care for this population including comprehensive individual assessments, individualized care plans and the development of unique clinical relationships, we believe it imperative to have monthly rather than daily enrollment in order to build and maintain these clinical programs and relationships. The duals demonstration draft does not state whether enrollment will be daily or monthly but it does refer to "no lock in". Has EOHHS made a decision as to whether enrollment will occur daily or monthly? If not, how will EOHHS make its decision?
3. When we read the covered services we weren't clear whether the services currently under the rehab option were included in the services that ICOs will be expected to provide. Can you clarify?
4. The draft design document states that the roll-out will be phased beginning with Greater Boston. What is the anticipated timeframe for the phased roll-out to achieve statewide status?
5. When will the duals data set be available? When are the population-based profiles that include utilization going to be available for planning purposes?
6. Will there be licensure requirements and/or regulatory reserve requirements for ICOs?

Yours truly,

Kim Shellenberger, MBA  
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TESTIMONY ON A DRAFT DEMONSTRATION PROPOSAL TO  
CMS FOR A STATE DEMONSTRATION TO INTEGRATE CARE  
FOR DUAL ELIGIBLES  
BY MARVA SEROTKIN, CEO, THE BOSTON HOME  
JANUARY 4, 2012

Good Morning, my name is Marva Serotkin and I am the CEO of The Boston Home (TBH) representing our 96 residents, members of our outpatient wellness program B.Fit! and hundreds of family members and friends of our residents. In sum, all people with progressive neurological diseases that are in need of our specialized services and support wherever they live. Margaret Marie and Isely Lamour will also be joining me in testifying this morning.

Founded in 1881, TBH is a residence and center of excellence for adults with advanced progressive neurological diseases, primarily MS. Always an innovator, TBH has extended its mission to include individuals living in the community through B.Fit!, our day program of wellness and socialization and specialized outpatient rehabilitation services. We serve as a source of expert advice on best practices to care for this population through our formal annual training Institute for health professionals across the country and through a variety of other internship and fellowship opportunities. The only facility of its kind in New England and only one of a handful nationwide, TBH touches the lives of thousands of people.

Our residents and outpatients are typically;

1. 57 years of age with onset of the disease between 20-40 years of age *70% 21-64 year of age*
2. Significantly physically disabled with most functionally quadriplegic
3. Intellectually curious with cognitive deficits addressed by resident centered care team

Margaret Marie, a resident of TBH, and Isely Lamour, a B.fit! participant, represent their fellow residents and outpatients.

TBH has led the way in implementing an innovative medical home model of resident-centered, integrated, comprehensive care based in our residential facility. Our internists working with our nurses coordinate primary care, preventive health services, wellness and specialty care. The progressive nature of these diseases requires timely response to acute conditions as well as adjustments to seating and wheelchair accessibility. The majority of these services are provided on site. Assistive technology, 24 hour monitoring and assistance with ADLs promote independence and socialization.

I encourage the authors of the proposal to consider the following:

1. **Risk adjustment** must reflect the needs of the population to be served and cannot be based solely on current utilization of services. How will functional status be incorporated, for example? Will participants be able to choose The Boston Home as they do today? Current Medicaid methodology for determining nursing home rates does not capture the true cost of caring for a very disabled population. How will the capitation rate reflect the true cost of nursing home care for this population? For example, our residents require two staff members to transfer them. Staff perform 140,000 each year! Medicaid payment for Itss should be based on meaningful groupings, developed in consultation with clinicians and human service providers to ensure that high Itss users are not grouped with those who are not.
2. **EHR** is a critical tool for coordinating care. There are few if any entities that have an EHR that combines data across the continuum. Targeted funding must be considered for the implementation of a meaningful EHR.
3. **Assistive technology** is costly and there is much waste due to lack of expertise and maintenance. Preferred vendors should be considered with a specialist coordinating this aspect of service.
4. **Training** is a key component for developing expertise to care for the population. A training coordinator should be considered.

5. The **care coordinator** and community health worker have some overlapping roles. A careful review of these roles should be undertaken.
6. The ICO must be well **capitalized** to absorb the inevitable cash flow fluctuations. There is no reference to the amount of capital required of the ICOs. Requirements should be flexible to encourage participation by non-profits and other provider groups.

The Boston Home is prepared to work with the State to accomplish the goals of the proposal while preserving the right of individuals to choose TBH. TBH and the residents and outpatients join together to achieve independence and socialization. Innovative use of assistive technology, staff training, network of specialists who have a track record caring for adults with disabilities (dental and eye are two examples), and care coordination are well developed and will serve as a pioneering partner with an ICO. ICOs should be paid in such a way that they include TBH in their network. Not only should participants have the right to choose TBH but also no ICO should be penalized because of that choice.

Respectfully submitted by:

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**Marva Serotkin, MPH - President & CEO, The Boston Home**

Marva received top honors from the Massachusetts Health Council for her “outstanding contribution” in promoting the health of residents of the Commonwealth.

Under Marva’s leadership, TBH was designated a “Center for the Promotion of Excellence in Long-Care” by the National Multiple Sclerosis Society. TBH has received national attention for its innovative programs in assistive technology, wellness and spirituality, creative arts and clinical practice.

Active in many leadership activities, Marva serves as President of the Mass Senior Care Foundation and is past president of the Codman Square Health Center Board of Directors where she is a member of the board of trustees. She has presented at numerous national and international healthcare conferences, including conferences held in the Netherlands and Portugal. She also presented at the International Association of Homes and Services for the Ageing in Norway.

Marva is a past President of the Massachusetts Public Health Association and Mass Senior Care Association and a member of the American Health Care Association. She also holds an appointment as an Assistant Clinical Professor at Tufts University School of Medicine. She is a Licensed Nursing Home Administrator. She is an appointed member of the City of Newton Health and Human Services Advisory Committee.

Prior to The Boston Home, Marva was the Chief Executive Officer of the Shattuck Hospital in Boston and President of Cura Visiting Nurse Association in Plymouth. She has served as a key member of the executive management teams at Carney Hospital, Children’s Hospital in Boston, and the Boston Department of Health and Hospitals.

She received a Master of Public Health from Yale University and an A.B. in Biology/Liberal Arts from Boston University.

## Medicaid/Medicare Dual Eligibles Testimony

DDS Chapter President Stu Dickson

Local 509, SEIU

January 4, 2012

Massachusetts must explicitly modify its initial Proposal to CMS to exempt CMS Waivers in DDS (including Targeted Case Mgt, (TCM) for DDS Service Coordination) and Title XIX for state operated programs in community and facility settings. This must be further extended to other public/private human services within DDS, DMH, MRC and services for blind/deaf individuals reimbursed through Medicaid/Medicare dollars. Local 509 agrees with the need to address needless costs of **medical** procedures, tests abuse, billing and administrative redundancies, etc. This is profoundly different than the care of human beings. Cost effective case management for human beings requires far more of a skill set than being ensconced in an office wearing head phones and gauging what is billable within the bottom line and what isn't. Including DDS CMS waivers, TCM, other human services in the Dual Eligibles Proposal to CMS would result in many thousands of public/private layoffs for "cost efficiencies" and profits to managed care organizations (ICO's). Massachusetts has not properly studied the impact of including DDS CMS Waivers, TCM, and public/private human services into this Proposal.

- Has the legislature been consulted and fully aware of the severely limiting effect this Proposal would have with their flexibility regarding hundreds of millions of Medicaid dollars that previously went into the General Fund?
- Does Massachusetts have sufficient information regarding the experience and performance of ICO programs providing case management and supports to human service populations and services supporting them? Without an experienced, existing infrastructure to address human services, we would be adopting a "pay us and we'll figure out a way to build it" approach. Society's most vulnerable citizens deserve much better planning and thought regarding considered changes of this magnitude.
- Why would Massachusetts want to further risk unemployment (which in turn affects other jobs, mortgages, pension obligations, bond ratings) by possibly eliminating current human service jobs with the Dual Eligibles process?
- The **HUMAN** side of this equation has already seen devastating budget cuts and layoffs since 2007. Human services jobs in Massachusetts have never fully recovered from budget cuts as far back as 2003. Budget cuts have **ALREADY** achieved whatever savings are intended with the Dual Eligibles Proposal. This makes the Dual Eligibles Proposal **unnecessary for human services**. Unlike medical administration, billing and tests, cost savings in human services directly result in layoffs and putting society's most vulnerable at risk.

- There is concern that the financial incentives will result in a decrease in the quality of services and care. Case management within ICO's present an inherent conflict of interest as they work for the bottom line of ICO organizations, not the needs of individuals. A capitated service system will end up "decapitating" people whose needs have changed.
- People who develop medical, aging or behavioral issues will be told "too bad, this is all you get" with no other recourse within state or federal government. Without a Service Coordination model, there is a total lack of oversight and monitoring of ICO companies serving the public.
- This proposal seems to limit consumer choices and the lack of continuity of care in regards to service providers. Consumer choices must be protected.
- The Service Coordination model would be eliminated as a result of this proposal. In order to promote independent living for consumers, there must be an independent long term supports coordinator.
- Massachusetts **must** take a more careful approach instead of blindly leaping into this breach. Preliminary findings in Illinois, which put their state Medicaid/Medicare services out to bid, has worsened quality of care and affected unemployment statistics significantly in that state. Tennessee has requested to exempt their DDS CMS Waivers in Dual Eligibles process and Massachusetts should do the same instead of disrupting services and laying off thousands of workers.
- The introduction of for-profit management in the mental health system has led to a reduction of outpatient services, as noted by the many closures of outpatient clinics across the state.

Massachusetts used to be a national leader regarding the diversity and quality of it's human services systems. We should not be competing with other states to "race to the bottom" and abdicate government's most important duty: to safeguard and preserve a decent quality of life for it's most vulnerable citizens. Please act to explicitly correct this Proposal soon!



**To:** Dr. JudyAnn Bigby, Secretary  
Executive Office of Health and Human Services

**From:** Michael Weekes, President/CEO  
Providers' Council

**Re:** Testimony on the State Demonstration to Integrate Care for Dual Eligible Individuals

**Date:** January 9, 2011

Thank you for the opportunity to submit comments on the Proposal to the Center for Medicare and Medicaid Innovation regarding the State Demonstration to Integrate Care for Dual Eligible Individuals. The Providers' Council is a statewide association of home- and community-based caregivers that contract with state purchasing agencies to deliver a wide array of human and social services.

We have carefully reviewed this document and discussed it with a broad spectrum of advocates, providers and individuals who currently receive Medicaid and Medicare. We were pleased to solicit thoughts from our collective membership and present them to the Executive Office of Health and Human Services them in our testimony.

#### **Positive aspects of the plan**

This proposal is broad in scope and makes every effort to explain the new system that will serve “dual eligibles,” as well as the various changes that will need to accompany the implementation. In particular, the Providers' Council and its membership were pleased to see the following assurances:

1. The Demonstration will provide comprehensive services that address the enrollee's full range of needs, beyond that which is currently covered by standard Medicare and Medicaid benefits. It will ensure effective services by delivering them in a setting of integrated care management and coordination based on a person-centered medical home model.
2. Integrated Care Organizations (ICOs) will be accountable for the delivery and management of all covered medical and long-term services. They will arrange for the availability of care and services by specialists, hospitals and providers of long-term services and supports, in addition to other community supports. Eligible members will have a wide choice of ICOs, the opportunity to preserve relationships with current providers/caregivers and the ability to change plans or opt out of the Demonstration at any time.
3. ICOs will be required to develop a meaningful consumer input process in their ongoing operations, and that process will measure and monitor the quality of service and care. ICOs will be required to have the internal capacity or must make contractual arrangements to ensure availability of all services in a member's care plan.

## **Providers' Council**

### **Testimony on Demonstration Proposal – page 2**

**January 9, 2012**

4. The current misalignment of funding of care for dual eligibles causes an overreliance on less appropriate and most costly hospital-based care and institutional long-term supports and services. This plan seeks to remediate this situation and other fragmentations in service delivery, which drives up needless spending.
5. MassHealth will further require ICOs to continually enroll those interested providers that meet network requirements.

Throughout the proposal, the Commonwealth shows its intent to build a program that fully serves the state's most vulnerable residents. We do, however, have the concerns that are listed below.

#### **Concerns with the plan**

In reading the Demonstration Proposal, we believe it will be incredibly complex and undoubtedly complicated to implement. While the proposal is certainly clear on its goals and objectives, we need financial data in order to fully balance the equation created by the demands of this program and resources that are available. For instance, on page 32 you indicate that your analysis compared historical fee for service utilization and cost data for the target population to benchmarks for comparable populations, including Medicaid-only members with disabilities with access to these services, and data from Medicaid managed behavioral health programs in other states. Actuarial analysis supports the prospects for this model with expanded benefits to produce both short term and longer term savings, offsetting the cost of providing the additional behavioral health diversionary services. It would be extremely helpful to have access to this and similar data.

Behind every good program is a sound financial plan, and we would like assurances that this program is both fiscally sustainable and one which will not destabilize the current system. We want to ensure the program is fair to all stakeholders, including people served, the ICOs and the community providers.

The Appendix G that contains the financial plan was not available with the initial release of the document. The Council made multiple requests to review Appendix G that contained the financial information, but this document was not provided to us. This makes it difficult, we feel, to do a full and comprehensive review of the plan until we can see the numbers behind it.

After our second request, we were told the "detailed budget request is not part of the document we have released for public comment, but it will be included in the final document we submit to CMS." We would ask that this appendix be made publicly available now and the Executive Office of Health and Human Services also solicit comments and thoughts on this important section of the plan.

## Providers' Council

### Testimony on Demonstration Proposal – page 3

January 9, 2012

#### Other, more specific concerns of the Providers' Council include:

- As we review Section II, *Benefit Design*, there are numerous program needs stated that will come at considerable cost, and this will likely add expenses to budgets that are already significantly strained. For example, starting on page 11, the proposal outlines specialists, care teams and clinicians who will work for successful “planned encounters,” rather than episodic, reactive care. The activities to be performed by care coordinators and clinical care management teams are extensive and will likely be expensive. A budget would be helpful.
- The Demonstration will replace the distinction between Medicare and Medicaid services with a single, robust benefit package that integrates currently covered Medicare and Medicaid services with additional behavior health diversionary and community support services. ICOs will be required to use a range of services as substitutions to avoid high-cost traditional services. While we understand this in the narrative, these statements lack the clarity that a simple budget or business plan would provide.
- Page 26 states that Medicare will not pay solely for Medicare services and Medicaid will not pay solely for Medicaid services. This ultimately infers that these funds are all fungible and raises a question regarding the criteria for the ultimate fiscal triage that could take place should funding and savings assumptions not materialize. There appears to be no fiscal program modeling that calculates the many fiscal challenges that will undoubtedly occur throughout this Demonstration, which could result in service cuts. It would be useful to know what the core services are that will be preserved at any cost.
- The proposal also states that policy goals and key principals outlined in this proposal will drive the payment methodologies. Developing a global payment approach will be an iterative, data-driven process influenced by program design decisions, such as the covered benefit package or enrollment policies. This statement seems to edge away from the comprehensive program that is outlined in the proposal. Again, we would welcome the opportunity to review any financial models which attempt to predict how this program will be staged and funded and where any cost or funding shifts may occur.
- Recent budget exercises over the past few years have indicated that Medicaid and Medicare funding is not able to meet the demand for service. With that, we have additional questions and concerns.
  - What is the projected financial savings target? Will the savings you anticipate cover the increased costs from CMOs, PCMHs and their advanced staffing?
  - Will there be waiting lists? If so, how will it be handled to increase services?
  - Would a budget show us how these expenses will be integrated into the current overhead of state government and any additional expenses expected to be incurred?

## **Providers' Council**

### **Testimony on Demonstration Proposal - page 4**

**January 9, 2012**

- Will current funding be able to accommodate some CMOs, which will likely come with higher overhead structures than others – plus an added margin for profit?
- Will ICOs be required to comply with rates for specific service codes set by Chapter 257?
- What consumer protections will be in place to ensure that individuals with disabilities do not experience reduced amounts of service and incur adverse outcomes as a result of policies or practices implemented by ICOs?
- Will CMOs be required to comply with the state's Surplus Revenue Retention policy?

### **Conclusion**

We thank you for your attention to our comments. We are interested to hear responses to our questions so we might share them with our members and other stakeholders. Additionally, we hope to see a line item budget with current, known revenues and service outcomes matched against a proposed line item budget that highlights new expenses and anticipated service outcomes. We think this is a critical piece of information, and it must be distributed to all stakeholders if we are to do a full evaluation and discussion of the Demonstration Proposal.

Again, we thank you for your time, and we look forward to the opportunity to continue working with the state as this project moves forward. We appreciate your efforts to date to make this process inclusive and transparent.



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January 9, 2012

Executive Office of Health and Human Services  
Attn: Lisa Wong  
One Ashburton Place, Room 1109  
Boston, MA 02108

Delivered electronically via: [duals@state.ma.us](mailto:duals@state.ma.us)

RE: State Demonstration to Integrate Care for Dual Eligible Individuals Draft for Public Comment

Dear Ms. Wong:

We appreciate the opportunity to review and provide our thoughts on the above mentioned proposal. As a Senior Care Options (SCO) provider, we are keenly aware of the benefits of integrating care for individuals who are eligible for both Medicare and Medicaid. As an innovator in creating SCO, Massachusetts has been one of three states used as the foundation for the opportunities now being created by the Medicare Medicaid Coordination Office (Coordination Office) to create integrated solutions throughout the country.

The population that has historically not qualified for SCO – those 21 to 64 years old – have had limited options to date to benefit from the coordination of their services, development of person-centered approaches to accessing benefits and services, and solutions to increase the likelihood that these individuals can remain in the community rather than face less attractive institutional care. We have been pleased to see an appreciation in Massachusetts for the importance of developing a model for individuals who have not been eligible for SCO based upon their age and are supportive of the Commonwealth's interest in working with the Coordination Office to leverage the Financial Models to Support Integrated Care. To that end, we have provided the following feedback and insight based upon our experience to support a highly effective program for Medicare Medicaid Enrollees in Massachusetts.

Changing the delivery model for populations is often a difficult endeavor. Protecting beneficiaries as they are transitioned into a managed model is critical to minimize disruptions and ensure improved quality for beneficiaries and overall success for the

program. We recommend that the Commonwealth adopt beneficiary protections summarized below:

- Medicare Medicaid Enrollees should be provided with sufficient choice among ICOs and ICOs should be required to demonstrate sufficient networks of providers to enable individuals to have the ability to choose among providers.
- ICOs should be required to create networks of providers with clinical competency and cultural sensitivities to the populations to be served. Individuals should have access to providers that have a demonstrated understanding of the unique needs of individuals who are eligible for both Medicare and Medicaid and are under the age of 65.
- ICOs and their network of providers should have demonstrated ability to support Medicare Medicaid Enrollees through appropriately structured health education materials and programs.
- ICOs should be allowed to develop networks of high quality providers and not be required to contract with any willing provider. While the ability to create a network of providers is fundamental to managed care, ICOs must meet network standards set forth by the Commonwealth and CMS and must have mechanisms to regularly assess network capacity.
- A single, robust appeals and grievance system ought to be established that should be easy for Medicare Medicaid Enrollees to access.
- Reasonable transition of care requirements should be established to ensure continuity of care during the transition to the integrated program. ICOs must demonstrate an effective process to assess needs and transition care appropriately.
- A population and program specific quality framework should be created that addresses the unique needs of the population to be served in the integrated program. Quality criteria should include such things as person-centered care plan development, maintaining individuals in a community setting, and repatriating individuals from an institutional environment.

UnitedHealthcare serves more than 125,000 individuals in programs designed to increase the use of community services through Medicaid long-term care programs in six states in addition to Massachusetts. In these other states we serve populations under 65 and have significant understanding of the unique needs of this population and clearly understand how their needs differ from aged individuals.

The predominance of behavioral health needs is often more significant and certainly different from the behavioral health needs of individuals over 65. We understand the challenges associated with substance abuse issues as well as severe and persistent mental health concerns. In addition, our more than 20 years of experience serving populations under 65 have provided us with the knowledge that many non-aged Medicare Medicaid Enrollees often have more social and functional issues than those who are more clinically complex due to age and proliferation of chronic conditions and co-morbidities.

UnitedHealthcare is working nationally to support primary care practices that desire to become more active providing comprehensive care management for their patients. We have numerous relationships nationally serving commercial, Medicare, and Medicaid members in a broad spectrum of practice centered models. Our organization has worked with physicians to support both the technological needs of practices as well as the care management needs. We have worked to increase care management capacity in practices as well as placed our own care managers in targeted practices to support their desire to become more responsible for care management. In addition, we have developed payment approaches to support and incentivize improved quality and coordination for our members served in these models.

We are enthusiastic about the increased interest by physicians and their practices to become more engaged and take a more significant leadership role in improving quality and coordinating services for our members. Based upon this commitment, we understand the goals of the Commonwealth to leverage person-centered medical homes as the basis for care delivery for the Medicare Medicaid Enrollee population under 65. We do, however, have concerns about the approach laid forth by the draft proposal.

Our experience in SCO as well as serving similar populations nationally has provided us with a deep understanding of the breadth of needs of these individuals. Their needs are far more extensive than just clinically and behaviorally based and we believe, based on our experience, that very few practices understand the scope of needs and are fully prepared to comprehensively manage them.

As an example, many of these individuals will likely need personal care attendant services. Coordinating personal care attendants is a very burdensome responsibility and requires immediate resources to identify gaps in services and align caregivers with very short turn around. Another example of the complexities of caring for this population includes the arrangement of contractors and other professionals to support home modification. These types of services typically fall well beyond the comfort of practices and well outside the scope of resources available in a person-centered medical home. In addition, these long-term care supports and services are as important to maintaining independence and quality of life as arranging for behavioral or physician interventions.

The strength of programs like SCO has been the ability to truly treat our members from a holistic perspective and develop a comprehensive, integrated approach to assessing individual member needs and aligning services – regardless of type – through a single care plan and with a central care coordination function. The proposed direction set forth in the draft proposal, we believe, may dilute the strengths and proven capabilities of programs like SCO. We appreciate the goal of increasing the prevalence of person-centered medical homes, but believe that this approach may not meet the comprehensive and complex needs of individuals to be served in the program.

We are also concerned about the need to transition all of the primary care practices into person-centered medical homes. While certain large, multi-specialty practices are well

positioned to adopt the characteristics of medical homes, many single practitioners or smaller practices would not be well positioned. Our experience with these practices in Massachusetts and in other states demonstrates that many of these practitioners are highly effective primary care providers, but are not well positioned for the financial, technological, and personnel issues related to transitioning into person-centered medical homes. Creating a system that essentially pushes these providers from the position of providing care for Medicare Medicaid Enrollees will likely have an adverse impact on access and quality for the entire Medicaid system. Furthermore, creating a program which may cause providers to not participate due to the requirement to transition to a person-centered medical home may be contrary to the Commonwealth's goal of maintaining long-standing patient-provider relationships.

We recommend the Commonwealth consider an approach that encourages the transition to person-centered medical homes for practices that are capable and willing to make that transition, but maintain the overall responsibility of the ICOs to support the needs and capabilities of each practice along a continuum of medical home capabilities. This would allow for the development of true person-centered medical homes for large practices that have the resources and interest in managing the whole individual – including functional, social, behavioral, and clinical needs – through individual practices that do not have the resources or interest in providing this broad scope of care. The ICOs should be responsible for assessing the practices in their network and providing the care coordination capabilities and resources based upon the needs of each individual practice. This approach would minimize access issues as discussed above and would support a spectrum of primary care practices. Furthermore, the ICOs should be responsible for assisting practices to increase care coordination responsibilities over time and based, again, upon individual practice capabilities, resources, and desires.

Funding person-centered medical homes should also be based upon the continuum of capabilities. For large practices that are taking on the full responsibility of holistic care coordination, sub-capitation payments are likely an effective payment vehicle. This type of relationship ensures shared risk between the ICOs and the practices and demonstrates a desire of all parties to comprehensively address the needs of individuals in an integrated approach. This payment vehicle, however, is not appropriate for practices that are unable

to take on the coordination of the full spectrum of services needed by many of these Medicare Medicaid Enrollees. ICOs should be given discretion to develop payment mechanisms that encourage a strong role for primary care providers and practices in line with the capabilities of the individual practice. These payment mechanisms should include such things as payments to encourage care management and coordination by the practice as well as the potential for incentive payments to recognize practices and practitioners that provide high quality care.

In addition to the difficulties of requiring the transition to person-centered medical homes noted above, we recommend Massachusetts consider the implications of over-emphasizing a medical model to serve Medicare Medicaid Enrollees. As previously

mentioned, our experience nationally has demonstrated that many individuals that will be served in this model have needs that are primarily social and functional. By creating a

structure that is, by its very nature, medically focused, the primary needs of an individual – those that may be driving the most significant cost and complexity – may go underserved. Linking to community resources – including treatment and peer supports – providing appropriate personal care attendant services, accessing affordable housing, and supporting complex family dynamics may be the most effective mechanism to improving the quality of life for an individual and ensuring long-term placement in the community. These supports are equally important, in many cases, to ensuring effective physical and behavioral health coordination. SCO offers an example of the importance of linking to community-based services through the effective relationships between the SCOs and the Aging Service Access Points (ASAPs). These relationships allow for an effective approach to holistic care coordination that leverages clinical, behavioral, social, and functional expertise.

While we appreciate the goal of the Commonwealth to create a model that enables primary care practitioners to serve in the role of coordinating care, we believe that it may not be wholly reflective of the needs of individuals to be served in this program. Furthermore, we believe the Commonwealth has a high-quality proven model of care in SCO that has decreased the use of nursing homes, hospitals, and emergency rooms through the foundation of holistic, comprehensive care coordination. This proven model should be looked to not only as a basis for understanding the comprehensive nature of the needs of Medicare Medicaid Enrollees but also as a successful delivery model. We encourage the Commonwealth to consider an approach that leverages the strengths of the proven model within SCO while supporting the desire of the state to move more practices to person-centered medical homes. We believe this approach will better support the needs of the individuals to be served as well as create a realistic approach to achieving the goals of Massachusetts in ultimately improving the care and quality of Medicare Medicaid Enrollees while reducing the costs associated with the highly fragmented care to which they are subjected to in a non-integrated model.

Migrating from an unmanaged, fragmented system to a coordinated, integrated system will improve quality and decrease the cost of services for both the Medicare and Medicaid programs. This transition, however, requires specific structure to ensure a sustainable program. Entities that are chosen to serve as ICOs should be sufficiently capitalized to ensure financial viability. Both SCOs and MassHealth plans have sufficient financial resources to bear the risk associated with an integrated, capitated approach. Authorizing entities without similar financial resources and reserves to participate as ICOs can undermine the program integrity. Managing the risk associated with Medicare Medicaid Enrollees requires sufficient capital in order to minimize provider payment issues or continuity of services to enrollees. In addition to sufficient capital, ICOs should have demonstrated capabilities and experience in caring for a Medicare Medicaid enrolled population, demonstrated ability to build networks and create access to services, and sufficient experience improving quality to ensure program success.

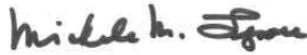
In order to support the spectrum of primary care delivery previously mentioned, ICOs should have the primary responsibility to meeting the requirements of the program. ICOs

may determine, as mentioned above, to sub-capitate risk to qualified person-centered medical homes, but must retain overall responsibility to ensure high quality care and overall program success.

Finally, funding for the integrated model should be sufficient to ensure program viability. Inclusion of any additional benefits and administrative requirements set forth in the contract should be directly funded by CMS and the Commonwealth. In addition, any administrative costs or incentives conceived by the Commonwealth to support the development and maintenance of person-centered medical homes should be included in the capitations paid to ICOs.

Thank you for the opportunity to review the draft proposal and for the ability to provide feedback based upon our experience in Massachusetts and nationally. We look forward to an ongoing dialogue as the Commonwealth moves to procuring and implementing this program. Should you have any questions of us in the meantime, I can be reached at (781)472-8512 or [michele\\_m\\_lepore@uhc.com](mailto:michele_m_lepore@uhc.com).

Sincerely,



Michele M. Lepore  
Plan President  
UnitedHealthcare Community Plan



January 9, 2012

Executive Office of Health and Human Services  
Attn: Lisa Wong  
One Ashburton Place, Room 1109  
Boston, MA 02108

Re: Comments on the Draft Demonstration Proposal on Integrating Medicare and Medicaid for Dual Eligible Individuals

To Whom It May Concern:

Network Health appreciates the opportunity to provide comments to the draft demonstration proposal by the Executive Office of Health and Human Services (EOHHS) to the Centers for Medicare & Medicaid Services (CMS) on Integrating Medicare and Medicaid for dual eligible individuals (the Demonstration). As a Medicaid managed care organization serving Massachusetts Medicaid beneficiaries for almost 15 years, including over 11,700 members who are currently enrolled under MassHealth RC 2 rating class due to their disability status – many of whom are in the two-year waiting period for Medicare eligibility, we are very interested in expanding our skills and expertise to serve this population.

We recognize the importance of the Demonstration to the lives of over 115,000 individuals between the ages of 21 and 64 who are enrolled in both Medicaid and Medicare programs. These individuals, who as a group bear some of the most complex and serious mental health and physical health challenges, today face significant barriers to health and well-being due to a fragmented care system exacerbated by two separate and complex care financing systems. Yet, despite these barriers, and to the credit of the committed efforts of the Commonwealth's policymakers and the disability advocacy community, a very substantial number of consumers have access to life-saving supports and programs that are national models for consumer choice and patient-centric care. It is equally imperative that the Demonstration does not jeopardize access to such supports, particularly around community based long-term care services, recovery programs, peer supports and other proven programs that enable individuals to live successfully in the community and to meet their own personal goals for independence and well-being.

Network Health strongly supports a new Medicaid/Medicare integrated care program that maintains what currently works well for the disabled community while addressing the barriers and fragmentation that impede individual health and well-being. We strongly support the goals of the community and service providers to “first, do no harm” and we see the Demonstration program as the opportunity of a lifetime to address the long-standing structural impediments to quality care and well-being that have particularly plagued this population. It is with this perspective that we offer our comments to the State's draft proposal of December 7, 2011.

**I. Care Model :**

The most serious concern we have with the proposal as written is that it fails to adequately recognize the role that the Integrated Care Organization (ICO) plays in the person-centered coordinated care model. In the draft proposal, the reliance is placed entirely on the Primary Care practice or Patient-centered medical home (PCMH). As stated,

*“The care of every ICO enrollee will be anchored in a PCMH. PCMHs can be seen as the hub of the integrated care system and will coordinate care for ICO enrollees by providing leadership of care teams ..... the ICO will be required to contract with practices that operate as PCMHs, providing care and services with the following key features: Integrated primary and behavioral health care services, multi-disciplinary, team-based approach to care delivery, planned care, easy and flexible access, person-centeredness, care coordination, clinical care management.”*



The PCMH is required to achieve NCQA recognition within the three-year demonstration period as well as maintain electronic health records and progress toward meaningful use. In addition, the proposal states that the PCMH

*“will provide integrated primary and behavioral health care services, accomplished through 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 practice, ....”*

The ICO is expected to provide enhanced payments to support the necessary investments in practices to build medical home capabilities “to the extent there is insufficient capacity of practices in the Commonwealth.”

In the proposed model, the ICO is obligated to accept risk for the costs and quality of the patients’ care and benefits, with ultimate accountability to CMS and EOHHS, yet the ICO serves in an administrative capacity only, with at most a limited part in the provision of clinical integration and care coordination services.

**To rely so completely on the PCMH model is overly aspirational in terms of the current and expected capacity of primary care practices to take on the full care model responsibilities that are appropriate to ensure quality care. The proposed model fails to leverage the already existing resources and proven capabilities of organizations such as Network Health.**

We believe the proposed care model is seriously flawed for the following reasons:

- 1) There is demonstrable evidence of the value that the ICO can and should serve in the clinical care model. Network Health’s clinical care model is based upon key components and principles that are consistent with the goals of the proposal and are designed to support and expand on the relationships between the consumer and his or her provider(s), and is particularly designed to support the primary care relationship for the coordination of medical services. Network Health’s integrated care management model is first and foremost patient-centric and based upon the whole needs of the consumer- not the person’s condition or medical diagnosis. Network Health fully integrates social, medical, behavioral health, wellness and illness prevention care coordination and care management services for its enrollees. Network Health’s holistic approach to care and wellness has improved member health outcomes and satisfaction, and is consistent with the elements of the integrated care model as defined in the proposal. Though some important modification of the model will be required to recognize and serve the needs of consumers with Long-term Support Services (LTSS) needs, such as the inclusion of new partners to the care team when appropriate, Network Health’s care model provides support to strengthen coordination of care throughout the continuum, filling in gaps as needed. Moreover, the model supplements but does not duplicate care management services when existing services are working to meet the consumer’s needs.
- 2) The tools available to an organization such as Network Health should be leveraged under this Demonstration. Network Health has the ability to tailor its clinical programs to the particular needs of the population and can serve all levels of needs of the community. This includes the deployment of nurse-practitioner or physician led community based care teams that would be responsible to provide, as appropriate, a coordinated, urgent community/home based response to higher risk members with complex physical or behavioral health needs. Through social care management and clinical community outreach services, Network Health reaches individuals who are not currently engaged with a PCMH or otherwise are not receiving needed services to maintain health and wellness or to avoid emergency room and hospitalization services. The Network Health care model is particularly effective for meeting this population’s diverse needs.



- 3) While Network Health certainly supports the expansion of the patient-centered medical home model, particularly for patients with more complex physical health needs, the proposal's care model design does not recognize the reality of the Massachusetts physician market which includes a relatively limited number of practices that have all the desired care integration capabilities or can realistically be expected to have such capabilities in the next three years. This is particularly problematic and inconsistent with the desire to provide broad patient choice of network providers – in both primary and specialty care – and to preserve relationships (including non-medical independent living supports) that are working well today from a consumer's perspective. The proposal recognizes that a significant investment may be required for the sufficient development of PCMH capacity, but it doesn't speak to the source of these investment resources. Will this be directly factored into the capitation dollars that will be available under this program? It is unlikely that there will be sufficient dollars under this program to meet this goal of PCMH development over a multi-year time period. Any required payments would need to be directly funded in the rate calculation and should be only mandated under this Demonstration for practices where there is clear evidence of value received for such payments in the near term.
- 4) Even in a mature environment of PCMH development, primary care practices will not likely have the same access to all areas of supports that may reside in or be under direct contract with an ICO entity. Depending on the volume of patients with complex or special needs, it may not be practical for a practice to make such direct investments in care supports. For example, most primary care practices in varying stages of PCMH development do not expect to have both behavioral health and physical health capabilities and/or may not have sufficient volume of patients with social needs to support the types of social services that would be part of a care team led by the ICO. This is even more the case for coordination of long term support services in the community. Moreover, as the ultimately accountable entity, the ICO will have the full access to claims data and other information concerning all services delivered to its enrollees, not just the data available through a practice's own electronic medical record system. ICOs have the ability to integrate data from multiple sources - pharmacy, inpatient, outpatient, and all other services -that can directly feed into the care management process, including needs assessments, and support the delivery of care wherever it is received.

In summary, we support and encourage a care model that favors the use of PCMHs wherever possible, **AND** recognizes the role of the ICO as **the accountable organization in the care team**, utilizing an integrated, consumer-centric approach, whereby the consumer is the ultimate lead in his or her own care choices. Moreover, the care model must be flexible enough to leverage specialty providers (e.g. where the primary disability is mental health) as "health homes" and allow for different levels of ICO support based upon the level of infrastructure capabilities at the practice level. Finally, where LTSS are identified as potentially appropriate, the team should include an objective coordinator of LTSS to be provided under a contract with the ICO and such agencies that currently have expertise in supporting the use of these services in Massachusetts today.

## **II. Long-term Community Support Services:**

We applaud the inclusion of LTSS in the Demonstration as this allows for truly integrated care across the continuum and recognizes the consumer-focused holistic approach to health and well-being. We also recognize the existence of well-established networks of providers and programs currently serving the disabled community and believe that these should not be reduced or needlessly duplicated. For that reason, we support including specific language in the proposal that recognizes the value of these current programs in maintaining consumer independence within the individual's local community and that ensures that these services and supports will not be jeopardized or compromised by the new structure. We recognize the benefits of contracting with the network of providers that are utilized today and would want to leverage the expertise of Independent Living Centers, Aging Services Access Points (ASAPs) and Recovery Learning Centers. We support inclusion of such groups' participation on the care



team when a potential need is identified. We welcome consistent criteria as to when such inclusion is mandated under this program and a unified objective appeal process to provide sufficient safeguards to ensure that there are no inappropriate reductions of services. We recognize the benefits of the large number of programs that are currently in existence to provide different types of community supports depending on the needs of the consumer, including such programs as peer supports and the Personal Care Attendant (PCA) program as it exists today which allows consumers to directly manage their PCAs. We would support language in the proposal that mandates preservation of these programs through contracted arrangements with the ICO.

### **III. Provider Networks:**

The draft proposal recognizes the need for broad provider networks through contracts with ICOs. We believe this is an important element of the program design, with the preference for services to be delivered through PCMH primary care practices when consistent with consumer choice, but with a broader primary care and specialty network available to consumers as well. Broad provider networks can be successfully mandated as part of the ICO's contract with CMS and EOHHS, with terms and conditions similar to that required today by MassHealth under its MMCO contracts. We would not object to additional requirements upon the ICO to ensure that it affirmatively seeks contracts with providers who have established relationships with enrollees. We also would be supportive of a requirement similar to an "any willing provider" provision that requires an ICO to contract with providers identified as currently serving members who meet the ICOs terms and conditions for participation, including credentialing, unless there is a demonstrated compelling reason not to do so.

In order to ensure adequate accountability and to encourage providers to accept the obligations that come with being a contracted provider, "single-case" agreements should be the exception and not the rule. If providers are permitted to selectively serve enrollees on a case-by-case basis without being subject to contractual requirements around quality, patient choice and access, ICOs will have lost their leverage in influencing and improving the services of the direct providers of care and the result will be less accountability and more fragmented services. As importantly, without a contractual relationship, the ICO is limited in its ability to truly partner with providers around data sharing, quality improvement efforts, and care coordination services. Assuming that the final global payments support reimbursement at no less an amount than is currently paid by Medicare and Medicaid today, ICOs should have no significant barriers to obtaining a comprehensive network of providers. We would therefore strongly recommend that the final Demonstration design include provisions to ensure network access and continuity of care, with sufficient oversight and appeals to protect consumers, but that the model relies on a comprehensive contracted network as the basis for the provision of services.

Network Health strongly believes that this Demonstration must not reduce the level of reimbursement currently paid to providers, i.e. Medicare rates for Medicare-covered services and Medicaid rates for Medicaid covered services. Any anticipated cost savings must not be predicated upon unit cost reduction but rather should result from improved quality and health outcomes and concomitant reduction of unnecessary and inappropriate services.

### **IV. Enrollment**

Network Health believes that it is critical to the success of this program to have an adequate number of enrollees – both at the aggregate level and at the ICO level - and that the proposal's inclusion of a passive voluntary opt-out enrollment process is critical to this goal. From the ICO's perspective, this program will require a significant start-up investment in new contracted arrangements, systems modifications and processes, and additional clinical team resources, which are dependent on sufficient scale to make business sense. Moreover, in order to effectively improve the way care is delivered at the primary care level through practice redesign, there needs to be a minimum volume of enrollees included in a practice panel. While we recognize the unpopularity of an opt-out model for many in the advocacy community, we believe that with adequate information, sufficient safeguards for outreach and education, and a transparent and streamlined process for enrollment and disenrollment, these concerns can and should be appropriately addressed. From the perspective of the ICO, a passive enrollment process is a crucial program design to ensure sufficient enrollment of not just the most engaged and active members of the community but also those individuals and their families who are not currently engaged with a primary care provider or who are not able to



successfully navigate the system today and therefore fall between the cracks in the current fragmented system. It appears, based upon past experience both with the SCO program in Massachusetts and with other similar programs nationally, that a passive opt-out enrollment process is needed to have sufficient enrollment of all dually eligible individuals who can benefit from this Demonstration.

A few concrete suggestions to improve the initial enrollment process:

- 1) All efforts should be made to share with the ICOs information on enrollees' providers, including prior claims data.
- 2) There should be coordination between CMS and EOHHS on all communication materials with one unified review process for all communication materials for new enrollees.
- 3) To the extent possible, the initial enrollment period should coincide with Medicare Part C and Part D open enrollment period timeline to minimize beneficiary confusion. In addition, one benefit of this program will be to ensure that effective dates of enrollment with both Medicare and Medicaid are always synchronized.
- 4) The initial passive enrollment process can be phased in by enrollee birth month (as is being done in California for a new Medicaid Managed care program) as opposed to phase-in by region, in order to allow for sufficient ramp-up time. We would recommend this approach, rather than phase in by region, so that at the start of the program every eligible individual that seeks to actively "opt in" would have a vehicle for doing so, even if the automatic enrollment process did not yet apply to him or her.
- 5) Finally, there should be a limited number of general enrollment (i.e. not special population) ICOs to choose from in any region so that there is a proper balance of choice and scale,

## V. Covered Services

Network Health supports the breadth and depth of services included in the Demonstration. Again, we wish to emphasize that the ICO needs to be ultimately accountable for the care management model—which should include a comprehensive assessment of member's medical, behavioral, environmental and functional needs and the development of an individual care plan based upon those needs, care coordination, monitoring and follow up. We believe to be accountable, the ICO must determine when and to what level the care management is delegated to a PCMH or other entity. In any case, it would operate under a care team model with the consumer at the center of the decision-making process. A broad and robust benefit package is fundamental to the success of an integrated program.

For this program to be viable, the expansion of State Plan services must be appropriately funded and factored into the actuarial rate setting process. Without prior data of such expanded services, it will be incumbent upon CMS and EOHHS to ensure that reasonable assumptions are made about pent-up demand and increased volume due to increased outreach that may not translate into hoped for cost savings in the same premium period.

Finally, we recognize the particular issues associated with the current Home and Community-Based Services (HCBS) waivers may argue for a different treatment of those individuals currently eligible under those waivers, or a "carve-out" for those populations who are currently included in such waivers.

If the Demonstration ultimately allows for specialized ICOs, who serve only a sub-population of the eligible enrollees, it will be particularly important that such special populations be clearly segmented (corresponding to different rating classes) and that the enrollment process not be compromised.



**VI. Financial and other Considerations:**

Network Health strongly supports the key financial principles included in the proposal and highlights the following as critical elements for a financially viable Demonstration:

- 1) A three-way capitated contract with **actuarially sound**, risk adjusted blended capitation rates for the full continuum of benefits provided to an enrollee is essential. The underlying financial model needs to align with and support State and CMS' goals and objectives.
- 2) Where historic data for expanded services (e.g. behavioral health diversionary services) comes from Medicaid only population, data needs to be adjusted as appropriate to take into account differences in the dual eligibility population.
- 3) ICOs should be given full access to State and CMS data related to base-rate development with full transparency in the rating process in order to assess costs and ensure financial viability.
- 4) Unit cost assumptions should take into account the fact that Medicare reimbursement must be maintained for Medicare covered services and that Medicaid reimbursement has been artificially low due to budget cuts for the last several years, jeopardizing the viability of many human service providers.
- 5) To the extent ICOs will be expected to invest in the development and expansion of services at the PCMH level, such investment must be adequately funded up front and included in the capitation rates to the ICO.
- 6) Rating classes should be utilized to distinguish cost differences among segments of the eligible population to the extent possible to ensure appropriate reimbursement and to avoid adverse selection or perverse enrollment incentives.
- 7) Sophisticated risk adjustment across ICOs will be important element of the program design.
- 8) Risk mitigation (reinsurance and narrow risk-corridors) will be critical particularly in the early years of the Demonstration.
- 9) Quality metrics should be integrated into the financial terms to achieve alignment of quality and cost goals. Quality metrics should meet the needs of the consumer and consumer advisory councils should be integral to the development of standard quality measurements.
- 10) To the extent the State allows provider-based organizations to bid as ICOs, there needs to be additional financial solvency and accreditation requirements to ensure adequate beneficiary and provider protections and to ensure a level playing field with organizations licensed to do business by the Division of Insurance.
- 11) All efforts to achieve administrative simplification should be made to optimize the benefits of the Demonstration for the consumers and providers, in addition to limiting administrative expenses.



## NETWORK HEALTH

Network Health appreciates the opportunity to comment on this important proposal. We seek to be a highly valued partner to MassHealth and CMS by serving the health and wellness needs of the dually eligible consumers in a manner that enables everyone to achieve optimal health and well-being.

We look forward to our continued participation in this process.

Very truly yours,

Leanne Berge, Esq.  
Chief Legal Counsel and Vice President  
of Strategic and Governmental Affairs  
Network Health



## Fresenius Medical Care North America

January 9, 2012

Executive Office of Health and Human Services  
Judy Ann Bigby, MD  
Secretary, Executive Office of Health and Human Services  
Attn: Lisa Wong  
One Ashburton Place, Rm. 1109  
Boston, MA 02108

Dear Secretary Bigby:

Fresenius Medical Care North America (“FMCNA”) is pleased to provide comment to the Commonwealth’s proposal to the Center for Medicare and Medicaid Innovation (“CMMI”) on a state demonstration to integrate care for dual eligible individuals. We applaud the Commonwealth for its thoughtful proposal on how to best achieve a comprehensive health delivery system and payment reform in both MassHealth and the broader health care system. The focus of this letter is to address the specific needs of individuals with end stage renal disease (“ESRD”) and how this patient group should be treated in the context of the dual eligible integrated care demonstration.

FMCNA is the largest provider of dialysis products and services in the U.S. and is headquartered in Waltham, MA. There are 74 dialysis facilities in the Commonwealth, and FMCNA is the market leader in this state, providing renal dialysis services to approximately 45 percent of 4,200 Massachusetts residents at our 31 dialysis facilities, with planned expansion at seven locations throughout Massachusetts.

### **Overview of Renal Failure**

Individuals with renal disease are among the most complex, vulnerable and costly of all patient groups. Chronic kidney disease (“CKD”) is a progressive illness and is defined as CKD Stages I through V, with CKD Stage V equating to ESRD. Once an individual reaches ESRD, their options are limited to:

- 1) Organ transplant – primarily kidney but also kidney/pancreas for diabetics;
- 2) Renal Replacement Therapy – most frequently this is in the form of (A) in-center hemodialysis, which is done generally three to four times each week for four hours per session; (B) home hemodialysis or (C) home based peritoneal dialysis;
- 3) Death – If a patient with ESRD chooses not to be on dialysis or cannot obtain an organ transplant, death will likely occur within a few weeks.

In addition to suffering the complications that accompany loss of renal function, these patients typically have multiple chronic conditions such as hypertension, cardiovascular disease or diabetes (over 50 percent of individuals with ESRD are diabetic) that lead to renal failure.

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### **Fresenius Medical Care North America**

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The incidence of CKD is increasing in the general population due to hypertension and diabetes, and goes largely undetected. These patients are typically socio-economically disadvantaged, with approximately 50 percent being dual-eligible, kidney disease has a disproportionately high impact in minority and underserved populations. Due to the medically complex and chronic nature of this disease, the late stage CKD and ESRD population accounts for nearly 10 percent of total Medicare spending. The Centers for Medicare and Medicaid (“CMS”) has long recognized the specialized needs of this costly patient group and has tested a variety of models to address the clinical needs of this population and has engaged the kidney care industry in multiple demonstration projects and renal-specific initiatives.

### **ESRD Disease Management Demonstration**

Fresenius Health Partners (“FHP”), a division of FMCNA, has recently concluded a five year demonstration program with CMS in which we applied an Integrated Care Management (“ICM”) Health Home model in a Medicare Advantage Chronic Special Needs Plan for people with ESRD. While the Demonstration was national in scope, Fresenius chose to launch its first sites for the Demonstration here in the Commonwealth with over 350 Massachusetts patients. The demonstration was found to be successful by Arbor Research Collaborative for Health (“Arbor”), Medicare’s contracted independent evaluator of the ESRD Disease Management Demonstration. Among their findings, Arbor noted that the rate of dialysis patient mortality for patients enrolled in the Fresenius program was significantly reduced, the rate of cardiovascular and all cause hospitalizations were reduced and the cost of care was 5.1 percent below the Medicare fee-for-service rate for beneficiaries with ESRD. Relevant excerpts from Arbor’s report include:

*“This ESRD Disease Management Demonstration represents a unique opportunity to identify improvement in clinical outcomes in a population that is ideally suited for disease management.”*<sup>1</sup>

*FMC’s demonstration project demonstrated “improved time to first all-cause and cardiovascular hospitalization, and hospital admission rate over time. In addition, utilization of other costly services including SNF stays and outpatient physician visits were consistently reduced ... as compared to FFS. These findings translated to cost savings which was considerable...”*<sup>2</sup>

*“[P]atients and providers expressed satisfaction with their experiences with the Disease Management Demonstration.”*<sup>3</sup>

*“The medical home model is also based on principles of coordinated care delivery. These models would allow for further testing of Disease Management and care coordination concepts for the ESRD population in a FFS setting.”*<sup>4</sup>

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<sup>1</sup> Arbor Research : ESRD Demonstration - Disease Management Demonstration Evaluation from 2006-2008, the First Three Years of a Five-Year Demonstration, December 8, 2010, pp. 111-17

<sup>2</sup> Id (emphasis added)

<sup>3</sup> Id

<sup>4</sup> Id

In addition to the provision of renal dialysis services, the scope of services furnished in the ESRD Disease Management Demonstration and which FHP continues to furnish to patients is listed in the attached document.

### **Dialysis Provider Participation in Dual Eligible Demonstration**

The provision of services to treat CKD and ESRD and their comorbid conditions is somewhat of a hybrid between services furnished in the physician's office and during hospitalization. Nephrologists often act as the primary care physician for patients with CKD and ESRD, coordinating care with specialists and engaging with other care providers. Given the frequent and persistent contact with patients, nephrologists and dialysis providers are at the center-point of ESRD patients' care. In fact, dialysis providers and nephrologists work together to operate a delivery system that is well positioned to deliver integrated care. Working together, they have developed the tools to address the numerous needs of ESRD patients, including placement and maintenance of improved vascular access to limit interruption of dialysis treatments, management and provision of intravenous and oral medications (ESRD patients are prescribed an average of 14 medications), immunization, co-morbidity management and provision of numerous monthly laboratory tests.

However, despite being well-positioned to deliver the promise of integrated care to this needy population, we are concerned that ESRD beneficiaries may not necessarily fit neatly within the parameters defined by the Commonwealth's dual eligible demonstration proposal. For example, the 74 dialysis facilities in the Commonwealth are owned or operated by a dozen or more entities or companies. A dialysis provider may have facilities in one geographic area of the state, but not in another. The proposed requirement under the demonstration that the geographic service area be statewide may not be workable for a disease-specific integrated care plan due to geographic limitations which may be logistically cumbersome. Additionally, there are a number of different providers of renal dialysis in the Commonwealth, and not all providers have the resources sufficient to participate in an integrated care model for dual eligible beneficiaries with ESRD.

We request clarification on some details of the Commonwealth's proposed dual eligible demonstration. For example:

1. If a dialysis provider submits an application to participate in the dual eligible demonstration as an integrated care organization ("ICO") is it a requirement that they be a licensed insurance entity?
2. If a dialysis provider subcontracts to an ICO as a person-centered medical home ("PCMH") is the dialysis provider required to furnish or coordinate the provision of the full range of covered health care services or can the contracted services be disease-specific and limited to ESRD and associated medical conditions?

In order to ensure that ESRD beneficiaries are able to participate in the dual eligible demonstration, we recommend that the Commonwealth consider other options to address the specific needs of this patient group. One suggestion might be that dialysis providers and nephrology practices jointly subcontract to an ICO to furnish renal dialysis services and other

related health care in a limited geographic area. For example, we could subcontract to furnish such services for dual eligible beneficiaries who receive dialysis services at seven Fresenius dialysis clinics in those three counties. Similar arrangements could be developed in other parts of the Commonwealth as well. To ensure an adequate volume of participants and to generate meaningful data, beneficiaries in a given geographic area would be required to participate unless they choose to opt-out. Renal-related services would mirror those provided in the Fresenius ESRD Disease Management Demonstration. The dialysis organization and associated nephrology practice(s) would not be required to furnish any health care services other than those specified renal-related health care services.

We believe there is a compelling policy rationale for the Commonwealth to consider alternative care models for beneficiaries with ESRD. Failure to consider other options would effectively exclude this chronic, complex and costly patient group from participation in this important demonstration that is intended to integrate the care and payment structure of dual eligible beneficiaries. FMCNA has a proven track record of coordinating and integrating the care of this patient group with demonstrated cost savings to the Medicare program and improved clinical outcomes. In 2011, FMCNA submitted a proposal to MassHealth to furnish similar renal-related services to Medicaid beneficiaries with earlier stages of CKD with the goal of early identification of CKD and a managed, healthier and more cost effective transition into ESRD. While the inclusion of both late stage CKD and ESRD renal services may be beyond the scope of the Commonwealth's dual eligible demonstration to integrated care, the actual services furnished for both patient groups would be the same, with the exception of dialysis services for patients with ESRD.

We would appreciate the opportunity to meet with your office to discuss in greater detail how the dual eligible ESRD patient population can best be served in the context of the Commonwealth's dual eligible integrated care demonstration.

Thank you for your consideration of our comments,

Sincerely yours



Peter F. Sauer  
President  
Fresenius Health Partners, Inc.

cc: Julian Harris, M.D. – Director of MassHealth

David Polakoff, M.D., M.Sc. - CMO – Commonwealth Medicine  
Director, Center for Health Policy and Research



Thomas L. Kelly  
President and Chief Executive Officer  
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January 9, 2012

Executive Office of Health and Human Services  
Attn: Lisa Wong  
One Ashburton Place, Room 1109  
Boston, MA 02108

Re: State Demonstration to Integrate Care for Dual Eligible Individuals

We continue to believe that the proposed non-elderly dual eligible program proposed by the Commonwealth of Massachusetts is well-designed and reflects a sophisticated appreciation of the medical, social and residential challenges of physically and developmentally disabled populations.

Outlined below are our thoughts on how the proposed program might be strengthened:

***Segmentation of population***

The challenges of the non-elderly dual eligible population, and the talents needed to address those challenges are dramatically different from other segments of the dual eligible population. We believe the state should consider a further segmentation --separately contracting for those non-elderly dual eligibles who are eligible for long-term services and support (LTSS). The LTSS segment requires a broad array of residential and social support services that require special skills and capabilities. Similar to the state's Senior Care Options program, it would be highly beneficial for the state to endorse the development of Integrated Care Organizations specific to this group. Further, it may prove desirable to limit the number of ICOs serving the LTSS segment in some or all regions to ensure sufficient numbers for robust programming and support.

### ***Risk Rating***

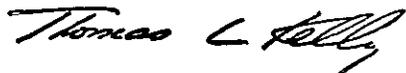
Another important reason to segment the non-elderly population eligible for LTSS is to anticipate and neutralize the difficulty of effectively risk-rating the LTSS and non-LTSS populations in a single pool. While available risk-rating methodologies have improved dramatically, there are no highly effective methods that account for dramatic differences in residential and social needs. By setting rates separately for the LTSS population, you are likely to avoid penalizing ICOs that serve members with the most complex and challenging needs.

### ***Quality Incentives***

We fully endorse the creation of a challenging and comprehensive set of quality measures, and meaningful ICO compensation based upon quality performance. Critical to the effective use of quality incentives is the early and effective measurement of baseline performance in the current (fee for service system).

Thank you for the opportunity to comment. We fully endorse the thoughtful and comprehensive way in which you have developed and tested this innovation proposal. In addition, we believe the proposed integration of Medicare and Medicaid benefits will yield a simpler, less confusing and more responsive support system for members.

Very truly yours,  
Schaller Anderson an Aetna Company



Thomas L Kelly, President & CEO



January 9, 2012

Ms. Lisa Wong  
Executive Office of Health and Human Services  
One Ashburton Place, Room 1109  
Boston, MA 02108

Dear Ms. Wong:

The Association for Behavioral Healthcare appreciates the opportunity to provide feedback on the draft *Demonstration Proposal to the Center for Medicare and Medicaid (CMS) Innovation for a State Demonstration to Integrate Care for Dual Eligible Individuals*. As you may know, the Association for Behavioral Healthcare is a statewide association representing over eighty (80) community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately eighty-one thousand (81,000) Massachusetts residents daily and over three-quarters of a million (750,000) residents annually, while employing thirty-seven thousand and five hundred (37,500) people.

- **Limit the Financial Risk of the Integrated Care Organizations (ICOs)**

ABH strongly urges EOHHS to limit the financial risk placed upon the ICOs in this Demonstration project. We fear that placing risk entirely on the ICOs to achieve significant cost savings will almost certainly lead to their adopting excessively stringent utilization measures, thereby reducing access to services and driving down reimbursement rates to providers. In light of the additional uncertainties inherent in this Demonstration model and the potential for unintended consequences to a healthcare delivery system developed over decades to serve the State's most vulnerable citizens, it is imperative that the ICOs be given the flexibility and fiscal latitude to permit them to develop management systems, learn their roles, and manage their contracted networks without the added undue threat of complete financial loss. Much as EOHHS-MassHealth developed its initial behavioral health carve-out contract for the Primary Care Clinician Program vendor with risk corridors that were reasonable yet combined with close contract monitoring and oversight, the Dual Eligible Demonstration should be similarly initiated. ABH also questions what financial reserves EOHHS will require of its ICOs and how it will determine the viability of those reserves.

- **Exclude Community-Based Flexible Supports**

ABH strongly urges EOHHS to exclude Community-Based Flexible Supports for Department of Mental Health (DMH) clients from the covered services of the Dual Eligible Demonstration. ABH has worked closely with DMH for over 3 years to develop and establish this unique service which currently serves 12,000 DMH-eligible individuals, only 50% of which are dually-eligible. CBFS services are the sole component of the proposed Dual Eligible Demonstration for which a portion is currently billed by DMH to CMS through the Medicaid Rehabilitation Services Option. CBFS services, which are rehabilitative and supportive in nature, are not known or well understood by hospital or primary care providers or third party payers. The services, which incorporate congregate living for individuals with severe and persistent mental illness requiring the greatest intensity of service, allow providers to move individuals in and out of varying types and intensities of service/settings in order to support a person's most effective

and safe recovery in the community. The CBFS services and the populations that utilize them are among the Commonwealth's most vulnerable individuals who are uniquely sensitive to external reorganization or disruption. The potential de-stabilization of this service and population through redesign and revision would be significant. CBFS services remain one of several core resources within the DMH service system for all DMH-eligible individuals, who are often susceptible to episodes of relapse and recovery. The combination of the bundled nature of the services within a single contract, the lack of knowledge and expertise of CBFS services by other healthcare entities, the unique nature of the contracts and funding, and the accompanying specialized contract management all combine to weigh heavily in favor of excluding this service from the Dual Eligible Demonstration.

- **Behavioral Healthcare as a Core Service**

As acknowledged in EOHHS's draft Demonstration proposal to the Center for Medicare and Medicaid (CMS) Innovation, behavioral healthcare is a core service; 2/3 of the dual eligible adults considered for this Demonstration had been diagnosed with a behavioral health condition. ABH member behavioral healthcare providers have been caring for individuals in their communities with both acute and chronic illness for many years – including those with mental illness and substance use disorders. Behavioral health disorders are historically under-diagnosed and undertreated, and adults and children with behavioral health needs require specialized services and dedicated staffing to prevent and treat behavioral health problems. Behavioral healthcare providers often serve as the interface linking those with mental illness and substance use disorders to primary and specialty medical care. Once these linkages have been established, behavioral healthcare providers frequently provide the support and care coordination necessary to sustain these relationships and effectively manage care. ABH strongly supports the improved integration between primary and behavioral health for individuals with mental illness and addiction.

- **Identification and Assessment of Individuals with Behavioral Health Disorders**

The Demonstration must ensure that ICOs are incentivized to identify individuals who are at risk for behavioral health disorders or who are showing symptoms of mental illness and/or addiction. It is important that the ICOs in turn ensure that primary care providers are conducting appropriate screening for behavioral health disorders, using standardized tools. There should also be guidelines in place for follow-up interventions and/or referrals for specialized behavioral health assessment as well as treatment for patients whose screening indicates a behavioral health need.

- **Access to Behavioral Health Services**

EOHHS must ensure that vulnerable populations, including adults and children with behavioral health disorders, are protected. Networks must be robust and ICOs must have adequate and appropriate provisions for behavioral healthcare with individuals having adequate access to choice among providers. ICOs should be required to contract with existing comprehensive (both child and adult) behavioral health providers to ensure a continuum of care. Inclusion of community-based behavioral healthcare providers in the design of the demonstration delivery system is necessary to ensure that the depth of expertise and range of services will be accessible for individuals along the continuum of behavioral healthcare needs.

- **Behavioral Health Homes**

ABH strongly urges EOHHS to adopt the concept of Person-Centered Behavioral Health

Homes which was included at the federal level in the Affordable Care Act. ABH believes that individuals with significant behavioral health needs require either specialized health homes or specialized models of integrated care. It is important to have both options available. For example, ICOs should be mandated to contract with specialty Person-Centered Behavioral Health Homes in addition to primary care medical homes. Behavioral health providers are often the principle healthcare providers for individuals with serious mental illness and addictive disorders. These consumers are less likely to see an external, primary care provider due to their own fears, prevailing sense of stigma attached to behavioral health disorders, and experiences with discomfort or rejection on the part of primary care providers in treating them. In the primary health home, behavioral health providers should be easily accessible, and readily available to provide consultation, brief interventions, and a close interface with primary care visits. In the behavioral health homes, primary care providers should be available to deliver services through contract, close affiliation, or internal employment in order to address the many co-morbid medical illnesses impacting the population for whom significant, unaddressed medical needs exist.

ABH would like to point out that both Missouri and Rhode Island have sought and obtained approval from CMS to implement health homes for individuals with serious and persistent mental illness including those who are dually-eligible. Missouri was the first state to receive such approval. ABH urges EOHHS to review the examples of these states with regard to establishing Person-Centered Behavioral Health Homes.

- **Investment and Transparency**

EOHHS should consider for its contracted ICOs a “maintenance of effort” requirement regarding existing covered services and/or populations for a transition period in order to protect against underutilization. ABH recommends that EOHHS include in the Demonstration proposal a provision similar to Section 14 of the Governor’s payment reform legislation which directs the Division of Health Care Finance and Policy to:

*(f) Establish safeguards against underutilization of services and protections against inappropriate denials of services or treatment in connection with utilization of any alternative payment method or transition to a global payment system; (g) Establish safeguards against and penalties for inappropriate selection of low-cost patients and avoidance of high-cost patients by ACOs and ACO network providers, including but not limited to requiring that ACOs accept as ACO patients all individuals regardless of payer source or clinical profile.*

At the very least, EOHHS should set minimum expectations for utilization and expenditure levels relative to behavioral health. EOHHS should also ensure that financial incentives for ACOs and providers align between behavioral health and other health care services. For example, EOHHS should consider requiring ICOs to report on money spent on their own administration, direct medical costs, behavioral health costs, including inpatient, outpatient, emergency services, etc. In order for the state to create a transparent system and ensure that funding is not diverted from behavioral health services, the state must have access to recent trends in behavioral health spending.

Cost savings from behavioral health services in the Demonstration project should result from individuals receiving behavioral healthcare that is more timely, better coordinated, and delivered in the least restrictive setting rather than simply through ICOs driving down the rates of their behavioral health providers, a potential scenario in the proposed Demonstration. Specific protections must exist to prevent such trends when ICOs contract with behavioral health providers. The Demonstration proposal states: “*ICOs will be required to enroll providers with whom an enrollee wishes to continue a relationship and who are able and willing to meet network requirements and **accept network rates.***” Will behavioral health providers (for whom services have traditionally been historically underfunded for the MassHealth Fee-For-Service Program) be forced to accept even more inadequate rates dictated by the ICOs who are financially at-risk through their own capitation payments? ABH urges MassHealth to require the ICOs to establish single-case, out-of-network agreements with providers for individuals to continue ongoing care under certain circumstances when the provider is not an in-network contracted provider.

Behavioral Health providers have extensive experience with managed care and behavioral health carve-out companies controlling costs through micro-managed pre-authorization and concurrent review utilization management processes. EOHHS’ Demonstration proposal has the potential to result in micro-management and excessively tight utilization management for behavioral health services. EOHHS should include in its proposal protections against such unintended consequences.

Currently, four out of the Commonwealth’s five MMCOs carve out management of behavioral health benefits to privately-held, for-profit companies. MassHealth does not require the MMCOs to disclose the financial details of their arrangements with these for-profit companies. As a result, there is no information available to the EOHHS, the Legislature, or the public on how much tax-payer money is being paid to the carve-out companies. If ICOs carve-out the management of behavioral health benefits to similar entities, the financial terms of those arrangements should be available to the Commonwealth and the public.

- **Quality and Outcomes**

ABH recommends that EOHHS incorporate both performance outcome measures and process outcome measures relative to behavioral health. Some examples of performance or functional outcomes may include decreased use of emergency rooms, ability of consumers to obtain and maintain employment, increased school attendance, quality of life, etc. Examples of process outcomes may include depression screening, number of appeals and grievances, the amount of money spent on behavioral healthcare, the time required to process authorization requests, the time required to pay claims, etc.

In addition to some of the traditional Healthcare Effectiveness Data and Information Set (HEDIS) measures, it would be important to also include performance and quality measures which assess functional measures, recovery, and quality of life. For individuals with behavioral health conditions, important measures include changes in housing and employment status, stage of recovery, satisfaction with services, engagement with the community and social relationships, along with the more traditional measures of length of tenure in the community, number of hospitalizations and time between readmissions, post-discharge follow-up, engagement in alcohol and drug treatment services following admission, etc.

It is also important that measures selected as indicators of Access to behavioral health services or behavioral health Provider Capacity be analyzed against benchmarks for the population in order to truly determine success of the initiative. ABH questions what data/benchmarks will be used by EOHHS for behavioral health services? The number of behavioral health diversionary services provided, for example, is meaningful only if analyzed in comparison to the same data prior to the Demonstration or to commonly-accepted data for the population, model of delivery system, and Massachusetts environment.

ABH would happy to collaborate with EOHHS to provide/develop additional examples and details on possible outcome and quality measures.

- **Access to Health Technology**

Electronic health records and portability of integrated/behavioral health medical records will greatly enhance communication and collaboration. However, financial constraints, especially for behavioral health providers who are not eligible for the federal financial incentives in place for achieving “meaningful use” of electronic records, remain a barrier that the state must address.

EOHHS must also carefully review all federal and state laws and regulations pertaining to confidentiality of health information, especially pertaining to individuals with behavioral health disorders. Laws and regulations which protect the privacy of individuals may, in some cases, make it more difficult to share information to integrate care.

ABH cautions against creating additional reporting requirements for providers. Rather, EOHHS should look at data and reporting requirements that are already in place in order to avoid adding unnecessary administrative burdens. ABH strongly advocates for data collection systems that are based on providers reporting from their own IT systems.

- **Guarding Against Unintended Consequences for the Broader Delivery System**

Moving a significant portion of the MassHealth Fee-For-Service Program recipients to a new, integrated, demonstration delivery system will undoubtedly create ripples and some unintended consequences across the broader, existing, delivery system. EOHHS perhaps should consider a phased implementation by sequentially including subsets of the dual eligible population, which would ease any larger, unintended consequences from an all-encompassing move to a new integrated delivery system.

- **Shore-Up Fragile Outpatient Services**

ABH has been advocating for years for increased support for the now-fragile outpatient behavioral health delivery system and strongly recommends that EOHHS shore-up this system. Driven in part by significant increases in the cost of psychiatry and medication management, increased rates are greatly needed in order to continue to make available outpatient services for non-dually eligible individuals and going forward, to ensure their availability for the dual-enrolled populations in the new integrated delivery system. As the foundation of the entire behavioral health delivery system, outpatient services remain the most cost-effective means to prevent utilization of higher-intensity and higher-cost services. If the system truly seeks to make quality, cost-effective care accessible at the least intensive level in local communities, outpatient services must receive greater support.

**SUMMARY**

The transition to a new delivery and payment system for dually eligible individuals will undoubtedly be a challenging one. However, the state can and should take steps to avoid many of the potential pitfalls by ensuring careful and thoughtful planning, adequate financing – including funding for behavioral healthcare – and the ongoing inclusion of stakeholders in key decisions. In addition, both incentives and the overall payment system must be transparent to all parties. A comprehensive and prudent transition plan must serve as the cornerstone for this next phase of health care reform.

Thank you again for the opportunity to comment on this important initiative.

Sincerely,

A handwritten signature in black ink that reads "Vicker V. DiGravio III". The signature is written in a cursive, slightly stylized font.

Vicker V. DiGravio III  
President/CEO



January 10, 2012

Lisa Wong  
Executive Office of Health and Human Services  
One Ashburton Place, Room 1109  
Boston, MA 02108

Re: Request for Comments on State Demonstration to Integrate Care for Dual Eligible Individuals: Draft Proposal for Public Comment, DOCUMENT #: 12CBEHSDUALELIGIBLEDRAFTPROPOSAL  
Response Submitted by: Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139

Dear Ms. Wong:

Cambridge Health Alliance (CHA) is pleased to provide the Executive Office of Health and Human Services (EOHHS) Office of Medicaid (MassHealth) with comments on their Request for Comments on the Draft Proposal to the Center for Medicare and Medicaid Innovation "State Demonstration to Integrate Care for Dual Eligible Individuals" (Demonstration).

As a major safety net health care provider system with a commitment to new Accountable Care Organization models and an advancing Patient-Centered Medical Home (PCMH), CHA supports the promise of better patient outcomes through coordinated, integrated care, especially for patient populations with complex chronic conditions. It is important to note that the Commonwealth's Demonstration proposal is the first state accountable care initiative being promulgated, and it is commencing with the most complex population while provider-sponsored accountable care organization models remain in planning and development stages required to organize and build capacity toward new delivery and payment models. As a consequence, it appears that the Commonwealth's proposal therefore builds on an insurance-based model for its proposal for Integrated Care Organizations (ICO) rather than provider-based models. It is suggested that greater flexibility be incorporated into the Demonstration proposal to allow provider-based ICOs to participate, as outlined in the comments below.

The dual eligible population of adults ages 21-64 presents unique considerations with the number of social, economic, functional challenges they face in addition to their complex and co-morbid medical and behavioral health diagnoses that have qualified them for federal disability. CHA is committed to improving the patient care for this complex population and to exploring options for participating in new integrated care models.

We look forward to continued engagement in the working process with MassHealth and other stakeholders to explore a number of considerations that are raised in designing this Demonstration Proposal.

1. ICO Definition (Section C.i.a.)

- a. The proposal defines ICOs as either an insurance-based or provider-based health organization. Because of the similarity of the proposed ICO framework and administrative requirements to those governing current Medicaid managed care and insurance carriers in general, such as

**State Demonstration to Integrate Care for Dual Eligible Individuals  
Cambridge Health Alliance Comments**

acceptance of full capitation and ability to adjudicate claims, it appears that insurance-based organizations can most readily meet the specifications versus many interested provider-based organizations. Some of the proposal's day-one ICO functions include full capitation (both insurance and service risk), claims adjudication, operations of an enrollee customer service department, an internal grievance and appeals process, and comprehensive reporting requirements on quality and cost performance measures that include many new metrics, data sources and required information systems. Claims adjudication would not be possible unless an ICO either has an existing claims adjudication capability, or an established relationship with a Third Party Administrator. The state might consider offering more flexibility in the first year(s), for example allowing the State and CMS to continue paying claims for some ICOs along the lines of a global budget arrangement, to facilitate broad participation in the Demonstration.

- b. The proposal states that "the care of every ICO enrollee will be anchored in a Patient Centered Medical Home (PCMH)". CHA supports the goal of integrating care within a PCMH and designating the PCMH as the hub for the coordination of care. However, the insurance-based orientation of the proposed Demonstration seems to continue many aspects of today's payment system where insurers make the decisions about the coordination of care versus the PCMH provider team being responsible for the care plan in concert with the enrollee. Centering care decisions within an insurance-based ICO is not consistent with the current Massachusetts policy direction for delivery system reform and payment reform goals. Modifications to the Demonstration will be needed to make sure that the PCMH model is supported in terms of care coordination implementation and to more specifically define the contours or ranges for per member per month (PMPM) funding to PCMHs to support care management for this complex population as well as initial infrastructure needed. Consideration could be given in the Demonstration for PCMHs to share in savings that result.
- c. The proposal lacks clarity in the possible scope of an ICO. The proposal states both that ICOs will be required to "demonstrate core competencies across disability types" and later references "smaller or specialized ICOs" (Section E.ii.d). Given how disparate the dual eligible sub-populations are, it is not clear whether one ICO and its participating providers could be a center of excellence for all these sub-populations, or whether a subset of the sub-populations would be more appropriate to a specialized ICO's core competencies. To ensure the widest participation in the Demonstration, the state should clarify that specialized ICOs will be allowed to participate, and provide guidance around the definition of a specialized ICO, such as delimited by population served, geography, or scope of services. A suggestion to help promote continuity of care for enrollees with existing providers is to create a system that permits providers to assist with their patients' enrollment.

**2. Financing & Payment (Section E)**

- a. CHA supports the call by the Massachusetts Hospital Association and the Massachusetts Association of Behavioral Health Systems for a provision that requires ICOs to reimburse providers (both in-network and out-of-network) at reimbursement rates not less than Medicare fee-for-service rates for Medicare covered services. This is critically important to maintain access to patient care services, especially those services like behavioral health services that are at risk due to inadequate reimbursement. Primary care services will need improved reimbursement over current Medicare and Medicaid rates given the PCMH direction and set of responsibilities.

**State Demonstration to Integrate Care for Dual Eligible Individuals  
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- b. Given the risk and complexity of the Demonstration for a new Dual Eligibles population, it is critically important that limited risk be placed on ICOs especially in the initial years of the Demonstration. We believe the application of integrated care models to the dual eligible population holds great promise, but also that the especially complex social as well as medical and mental health concerns and the program implementation requirements point to the need to address financial risk in a phased manner in recognition of the initiative's maturity.
- At the outset, providers will require a limitation on downside risk, with appropriate risk mitigation arrangements in place. Annual risk settlements may be a consideration at the outset of the program with risk corridors considered after the first year or years of experience due to uncertainty around services utilization for these populations and the size of the risk pool at an ICO. Downside risk should be restricted until interventions and outcomes are better understood.
  - In addition, each sub-population will require specialized risk adjustment at the individual member level that reflects the underlying disability and diagnoses of the individuals within that population. Specifically, it would be appropriate to limit risk – using year-end settlement or other arrangements such as risk corridors – for rating categories covering high-risk sub-populations as was done in the introduction of Medicaid Essential. The appropriate limit of financial exposure would encourage participation from a wider range of organizations as initial experience is garnered.
  - In the development of capitation rates, consideration should be given to appropriate and improved adjustments to risk/case mix for sub-populations. The current risk adjustment methodologies available have limitations as they typically given low risk or case mix intensity for mental health and substance abuse utilization even though the resource intensity is high, and increasingly patients present with multiple diagnoses, including mental illness and substance abuse together, and concomitant medical conditions.
  - CHA vigorously supports the inclusion of adjustments for socio-economic status to the list of appropriate adjustments in the parameters. Research consistently confirms that low socio-economic status affects a patient's risk profile, compounding difficulties in accessing health care, understanding and complying with medical instructions (impacting a patient's ability to adhere to recommended treatment regimes), and even is correlated with co-morbidities and chronic conditions. Patient population mix accounts for needed infrastructure investments and utilization costs. These patients need a greater intensity of social, financial, linguistic, and culturally competent support to achieve and maintain health, and global payment adjustments should reflect the costs of these provider services.

3. ICO Infrastructure and Systems to Support Care Coordination (Section E.ii)

We encourage the Demonstration to include financial support for the infrastructure required for ICOs to develop capacity for the Dual Eligibles population. It is critical to identify a source of funding for infrastructure investments and explicit guidance on how they will be disseminated to ICOs and their participating providers.

- Tying together different clinical and community-supportive services, inclusive of community-supportive services and state agency services, will be complex, and coordination of a multi-disciplinary team comprised of a wide and disparate array of individuals, agencies, government departments, and community services, none of which are co-located, will require additional effort, administrative support, and staffing.

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- An ICO will need to create a data repository, communication protocols, and data and reporting conventions shared among disparate providers. On the financial side, financial relationships, and shared financial reporting will need to be established, as well as the capacity to analyze and manage actuarial risk, and to manage health care utilization and outcomes.
- The implementation timeline should reflect the developmental path to create this inter-relational infrastructure and the anticipated ramp up time for reporting and data exchange. These considerable infrastructure demands will require upfront funding and such funding should be included in the capitation rate.

**4. Service Areas (Section C.i.a)**

The proposal defines five service areas “congruent with the areas defined for MassHealth Managed Care Organizations: Central, Greater Boston, Northern, Southern, and Western”. To encourage the broadest range of providers, and to alignment service areas with existing provider system footprints, MassHealth should consider allowing ICO participation in some, but not all towns, in a service area. A precedent can be found in the PACE program, where different PACE organizations have unique defined service areas specific to their patient population.

**5. Provider Network (Section C.i.b)**

CHA, along with MHA, supports the proposal’s strong “any willing provider” provision, which affords continuity of care to patients and their providers. The language that “any willing provider” must meet network requirements and accept network rates limits financial exposure to the ICO as well. One additional area for consideration in the Commonwealth’s proposal are the contours on any out-of-network rates. Out-of-network rates should align with the rates afforded to “any willing provider” based on Medicare reimbursement rates for Medicare covered services to align incentives toward the development of integrated care networks to optimally serve the population.

**6. Covered Services (Section C.ii.b)**

We are pleased that the covered services include additional behavioral health diversionary services and additional community support services that are required for the dual eligible population. Planning work in assessing the statewide and local capacity and gaps in this behavioral health and community support services continuum of care is warranted, due to the extremely fragile nature of those services and current gaps that exist today. The proposal leaves network development and workforce development within the purview of the ICOs. Provider network adequacy is a significant challenge to the success of the Demonstration, especially considering the needs of the population and expansion of covered services. State leadership is needed in providing a statewide gap analysis and in filling the gaps in the continuum of care for selected community and supportive services.

We would like to add that some additional supportive services beyond those listed in the proposal will be essential to the health and well-being of the populations, including supported housing, group home environments, and independent living settings, as well as transportation services. These types of supported housing are not typically reimbursed with health care dollars, but by separate government-supported programs that frequently have lengthy waiting lists and are subject to funding constraints. Consideration should be given to how the Demonstration can assist at a macro-level in forging linkages at the state level and programmatic alignment with supportive housing services that are critical to successful outcomes for this population.

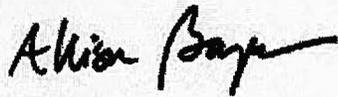
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**7. Medicare Program Integrity**

CHA supports the request by MHA and MABHS that EOHHS and CMS take into consideration unique issues in the Medicare program that affect hospitals, including different regulatory requirements, bad debt provisions and the determination of inpatient days for purposes of Medicare DSH calculations. It is extremely important that the utilization data for Dual Eligibles, which is an integral component of Medicare Disproportionate Share Hospital adjustments made specific to each hospital, be maintained for Medicare DSH reimbursement purposes. [For example, Medicare Advantage data is no longer included in the calculations for Medicare DSH inpatient days, which has resulted in adverse reimbursement impacts to hospitals]. Both the relationship to Medicare add-on payments and Medicare base payment levels must be preserved as a reimbursement floor. Medicare is a well understood, widely used and accepted methodology. Specifically, the inpatient formula includes many critical adjustments to reflect diagnosis, co-morbidity, length of stay, wage area, and geographic location that must be preserved.

Thank you for the opportunity to provide comments. Please let us know of any questions. We look forward to learning how to participate in future steps in program design and implementation for this initiative.

Sincerely,



Allison Bayer  
Acting Chief Executive Officer  
Cambridge Health Alliance

**Massachusetts  
Association of  
Behavioral  
Health Systems**

115 Mill Street  
Belmont, MA 02478

**Nasir Khan, MD**  
President  
**David Matteodo**  
Executive Director

**Members:**

AdCare Hospital  
Arbour Hospital  
Arbour-Fuller Hospital  
Arbour-HRI Hospital  
Boumewood Hospital  
McLean Hospital  
Pembroke Hospital  
Westwood Lodge

**Associate Members:**

Anna Jaques Hospital  
Austen Riggs Center  
Bayridge Hospital  
Baystate Health  
Berkshire Health Systems  
Beth Israel Deaconess  
Brigham/Faulkner Hospitals  
Brockton Hospital  
Cambridge Health Alliance  
Cape Cod Hospital  
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Metro West Medical Center  
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Mount Auburn Hospital  
Newton Wellesley Hospital  
Noble Hospital  
North Adams Regional Hospital  
North Shore Medical Center  
Quincy Medical Center  
Providence Behavioral Health  
St. Luke's Hospital  
St. Vincent Hospital  
Steward Carney Hospital  
Steward Good Samaritan  
Steward Holy Family Hospital  
Steward Norwood Hospital  
Steward St. Elizabeth's  
Tufts Medical Center  
U Mass Memorial Health Care  
Walden Behavioral Care  
Whittier Pavilion

Lisa Wong  
Executive Office of Health and Human Services  
One Ashburton Place, Room 1109  
Boston, Ma 02108

January 10, 2012

Re: Draft Demonstration Proposal for Integrating Medicare and Medicaid for Dual Eligible  
Individuals

These comments are offered on behalf of the Massachusetts Association of Behavioral Health Systems (MABHS), a statewide Trade Association representing 50 inpatient psychiatric and substance abuse facilities in Massachusetts.

**Highlights:**

- We appreciate the opportunity to provide these thoughts to the MassHealth regarding the Dual Eligible Draft Proposal. The Draft Proposal is thoughtful and well-written. We believe it is beneficial that there is a 30 day Public Comment Period.
- MABHS is offering these comments on behalf of 50 inpatient Behavioral Health facilities in Massachusetts. We represent over 90% of the inpatient Behavioral Health beds; 2,300 total and admit over 60,000 patients per year. **The majority of those patients are either Medicare or Medicaid, (on average 67% Public: 38% Medicare; 29% MassHealth).**
- The mix of our patients is one of the reasons why we are acutely interested in this proposal and that it be carefully planned. Also, the Dual Eligible patients who are Medicare eligible based on Disability tend to be among our patients with the most **significant care needs** as their disability must be of two year's duration.
- **We support the idea of a better Integrated Care** and a broader menu of benefits for those patients who have both Medicare and MassHealth. Better integrated and coordinated care will lead to a reduction in medical illnesses and co-morbidity that our patients experience. Conditions such as diabetes, heart disease, and obesity are more common for this population, and studies have shown that the severely mentally ill experience up to 20 years shorter life expectancy than the general US population.
- A broader array of benefits will lead to more opportunities to provide **the right care in the right settings** for these consumers. And we are hopeful that should this Proposal be adopted that CMS will provide for Parity, not only in terms of the scope of the benefits; but also elimination of the 190 Day Psychiatric Hospital Lifetime Limit.
- **Savings from the Dual Proposal** should come from consumers getting better coordinated, timelier care in the least expensive settings; **the savings from this initiative should be able to be achieved through Case Management and Integrated Care as this population should greatly benefit from better coordination and follow up care.**

### **Access/Cost Concerns:**

- However, **we must not jeopardize Access** as a result of this program. We must take the best of both Medicare and Medicaid. Access to Inpatient services for this population is critical, as we see even now at times access can be very tight as Emergency Rooms get inundated with Behavioral Health patients. We must proceed carefully so as not to exacerbate access problems.
- Access is tied to reimbursement as hospitals must be financially viable in order to survive. **Currently our system in Massachusetts is very fragile as Behavioral Health struggles to survive with low payments; any loss of beds would be severely damaging to access.**

**The Medicare payment level must be preserved. The Medicare Prospective Payment System is a national methodology used for hundreds of hospitals; it is widely used and accepted. For Massachusetts, in some cases it can be up to 30% higher than the MassHealth rate for certain facilities.**

- This Proposal **must protect the Medicare payment level** as any reductions would be untenable for our system. Reductions in reimbursement could force beds to close; with Emergency Rooms becoming backlogged with patients waiting for inpatient care, making it impossible for the Dual Proposal to succeed.
- The Draft document does not describe how provider rates will be established. **We ask that MassHealth include in its Proposal that it will not allow the Integrated Care Organizations to reduce Medicare rates.** There must be specific protections for providers because once MassHealth/CMS provides funding to the ICOs, providers will be at their mercy if they decide to drive down rates. The ICOs could have a great deal of market power in the Behavioral Health sector, and it could be very difficult to establish balanced negotiations with providers: the ICOs could have all the power. Providers will be very vulnerable to the ICO market clout unless MassHealth/CMS are explicit that Medicare levels must be maintained.

### **Management/Quality:**

- This Dual Proposal has the potential to lead to **an unintended consequence of micro-management and rigid utilization controls for the Behavioral Health sector.** We have vast experience with entities (i.e Carve-Outs) controlling access through difficult approval and concurrent review processes. Care should not be ratcheted down by Third-Party reviewers as a result of this Proposal. Again, we ask that MassHealth insert protections in this Proposal so that unreasonable utilization management by the ICO would not be allowed. There should be guidance from MassHealth that the ICO will be expected to provide Parity for Behavioral Health with Med/Surg in compliance with Federal Parity Law. There should be specific consumer Appeal Rights including the ability for consumers and providers to appeal to the Office of Patient Protection. Finally, when services are denied, the burden of proving that the service is not medically necessary should be on the entity denying the care rather than the attending clinician.

- As the Final Proposal is detailed, MassHealth should continue its requirement that in developing the Networks, **those providers who are able and willing to continue to serve the Dual Eligibles should** have the ability to be included in the Network.
- Regarding Quality measures, it is important to note that for certain services, providers must meet the **Medicare Conditions of Participation**. These Conditions should be reviewed and included as minimal Network criteria as appropriate as they help ensure certain quality measures are in place.

In summary, MassHealth should **strive to make this program attractive to consumers**. It should do that by protecting that which is necessary and successful (such as inpatient care) in the current system and enhance the services that are not coordinated or available currently. **Take the best of Medicare and MassHealth; provide incentives for the right care at the right time; and protect access to needed services**. MassHealth should give serious consideration to starting on a small scale (pilot programs) and learn and build off of the success of those models. Active consumer and provider participation is essential on an ongoing basis as this proposal proceeds; MassHealth has been excellent in that regard to date and we trust that involvement will continue going forward.

This Proposal is one that we are happy to support if properly implemented; and we look forward to further dialogue on this important matter.

Thank you for the opportunity to offer these comments. Please do not hesitate to contact me should you have any questions.

Sincerely,



David Matteodo, Executive Director  
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January 10, 2012

Executive Office of Health and Human Services

One Ashburton Place  
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Secretary Bigby,

Thank you for the opportunity to submit comments on the State Demonstration to Integrate Care for Dual Eligible Individuals. Harbor Health Services Inc. is a nonprofit community health agency that administers four federally qualified community health centers as well as a PACE program (Program of All Inclusive Care for the Elderly), a capitated program for frail elders. We have also been certified as a level three Patient Centered Medical Home by the National Committee for Quality Assurance (NCQA).

For your consideration today we would like to offer principles that we believe are critical to the success of this demonstration program.

### Principles

- Community health centers and PACE programs have experience and a track record of providing high quality, cost effective care to complex, low income, high risk patients. Consideration should be given to these entities to work alongside the five designated Integrated Care Organizations (ICO's) as specialized provider networks.
- ICO's should be patient driven and focused on wellness, prevention and services across the lifespan. This means that consideration must be given to dental, vision and behavioral health services if the system is going to be truly integrated.
- Constructing an effective system of risk adjustment for the duals initiative will be imperative to the future success and viability of the program.
- The duals proposal should strive to distinguish further between the roles of the Care Coordinator and the Case Manager. A strong team approach is essential to the management and coordination of this population. A stronger emphasis on the creation of teams, the team's role in care coordination and the requirement for team care planning would strengthen the proposal.
- Comprehensive home care services (including, at a minimum, nursing and personal care services) will play a vital role in the success of the program. Ideally, allowing for payment which would support creative care management to include home visiting by many of the other health care team members would provide for closer and more comprehensive

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oversight of care, identifying and treating issues before they become serious medical complications.

- Consideration should be given to the creation of a more comprehensive model for the most complex patients who will require a higher level of care and care coordination and will probably represent the highest cost patients. The proposed plan would split the payment and risk between the ICO and the PCMH. Consideration should be given to create a model for these patients more like that of PACE, where the payment and risk are combined within one program.

### Programs of All Inclusive Care for the Elderly (PACE)

The six PACE programs in Massachusetts, four of whom are administered by or affiliated with community health centers, have a track record of successfully assuming risk and coordinating care for frail elders. One measure of the success of PACE is demonstrated by the fact that only 12% of PACE participants from Massachusetts are in nursing homes, while 100% of participants are certified by the State as needing nursing home level of care.

PACE programs function as the proposed Integrated Care Organizations (ICO) and receive monthly capitation payments from Medicaid and Medicare designed to cover all services. The payment methodology for PACE programs has been developed by the Centers for Medicaid and Medicare (CMS), and should be reviewed by the state when evaluating effective forms or risk adjustment. Medicare payments are based on the participant's age, sex, diagnoses, and an organizational-level frailty adjuster, intended to account for Medicare expenditures for a community-based, functionally impaired population that are not explained by the CMS-HCC risk adjustment model.

While the comprehensive payment model and risk adjustment strategies of the PACE program have been proven to be cost effective, there is increasing research documenting the quality outcomes of PACE programs. In the November 3, 2010 issue of the **Journal of the American Medical Association**, PACE was identified as a model of long term care that is effective, efficient and less expensive than traditional long term care. The research identified four processes that are present in most successful models of primary care for these patients:

- Development of a comprehensive patient assessment that includes a complete review of all medical, psychosocial, lifestyle and values issues.
- Creation and implementation of an evidenced-based plan of care that addresses all of the patient's health needs.

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- Communication and coordination with all who provide care for the patient.
- Promotion of the patient's (and their family caregiver's) engagement in their own health care.

This leads to our final point regarding PACE programs and community health centers. Few programs have taken on the challenge of offering integrated care for low income families or frail elders, where the risks associated with providing care and obstacles to success are greater. The Commonwealth should insist on prior experience in caring for low income and high risk patients when selecting ICO's to provide care for dual eligible individuals.

We at Harbor we believe as you do, that cost containment in our health care system is needed and that the fee for service methodology of payment must be reformed. This demonstration strives to address issues of cost while also improving the quality care for over 100,000 residents of the Commonwealth. We urge your favorable consideration of the points set forth in these comments and thank you for allowing Harbor Health Services, Inc. the opportunity to provide you with our feedback.

Please do not hesitate to contact Kate Audette at 671.533.2358 or [kaudette@hhsi.us](mailto:kaudette@hhsi.us) if you have any questions.

Sincerely,

Daniel Driscoll  
President and CEO  
Harbor Health Services, Inc.

“Your Guiding Light to Health Care”



January 10, 2012

Lisa Wong  
Executive Office of Health and Human Services  
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Re: Request for Comments on State Demonstration to Integrate Care for Dual Eligible Individuals: Draft Proposal for Public Comment, DOCUMENT #: 12CBEHSDUALELIGIBLEDRAFTPROPOSAL  
Response Submitted by: Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139

Dear Ms. Wong:

Cambridge Health Alliance (CHA) is pleased to provide the Executive Office of Health and Human Services (EOHHS) Office of Medicaid (MassHealth) with comments on their Request for Comments on the Draft Proposal to the Center for Medicare and Medicaid Innovation "State Demonstration to Integrate Care for Dual Eligible Individuals" (Demonstration).

As a major safety net health care provider system with a commitment to new Accountable Care Organization models and an advancing Patient-Centered Medical Home (PCMH), CHA supports the promise of better patient outcomes through coordinated, integrated care, especially for patient populations with complex chronic conditions. It is important to note that the Commonwealth's Demonstration proposal is the first state accountable care initiative being promulgated, and it is commencing with the most complex population while provider-sponsored accountable care organization models remain in planning and development stages required to organize and build capacity toward new delivery and payment models. As a consequence, it appears that the Commonwealth's proposal therefore builds on an insurance-based model for its proposal for Integrated Care Organizations (ICO) rather than provider-based models. It is suggested that greater flexibility be incorporated into the Demonstration proposal to allow provider-based ICOs to participate, as outlined in the comments below.

The dual eligible population of adults ages 21-64 presents unique considerations with the number of social, economic, functional challenges they face in addition to their complex and co-morbid medical and behavioral health diagnoses that have qualified them for federal disability. CHA is committed to improving the patient care for this complex population and to exploring options for participating in new integrated care models.

We look forward to continued engagement in the working process with MassHealth and other stakeholders to explore a number of considerations that are raised in designing this Demonstration Proposal.

1. ICO Definition (Section C.i.a.)

- a. The proposal defines ICOs as either an insurance-based or provider-based health organization. Because of the similarity of the proposed ICO framework and administrative requirements to those governing current Medicaid managed care and insurance carriers in general, such as

**State Demonstration to Integrate Care for Dual Eligible Individuals  
Cambridge Health Alliance Comments**

acceptance of full capitation and ability to adjudicate claims, it appears that insurance-based organizations can most readily meet the specifications versus many interested provider-based organizations. Some of the proposal's day-one ICO functions include full capitation (both insurance and service risk), claims adjudication, operations of an enrollee customer service department, an internal grievance and appeals process, and comprehensive reporting requirements on quality and cost performance measures that include many new metrics, data sources and required information systems. Claims adjudication would not be possible unless an ICO either has an existing claims adjudication capability, or an established relationship with a Third Party Administrator. The state might consider offering more flexibility in the first year(s), for example allowing the State and CMS to continue paying claims for some ICOs along the lines of a global budget arrangement, to facilitate broad participation in the Demonstration.

- b. The proposal states that "the care of every ICO enrollee will be anchored in a Patient Centered Medical Home (PCMH)". CHA supports the goal of integrating care within a PCMH and designating the PCMH as the hub for the coordination of care. However, the insurance-based orientation of the proposed Demonstration seems to continue many aspects of today's payment system where insurers make the decisions about the coordination of care versus the PCMH provider team being responsible for the care plan in concert with the enrollee. Centering care decisions within an insurance-based ICO is not consistent with the current Massachusetts policy direction for delivery system reform and payment reform goals. Modifications to the Demonstration will be needed to make sure that the PCMH model is supported in terms of care coordination implementation and to more specifically define the contours or ranges for per member per month (PMPM) funding to PCMHs to support care management for this complex population as well as initial infrastructure needed. Consideration could be given in the Demonstration for PCMHs to share in savings that result.
- c. The proposal lacks clarity in the possible scope of an ICO. The proposal states both that ICOs will be required to "demonstrate core competencies across disability types" and later references "smaller or specialized ICOs" (Section E.ii.d). Given how disparate the dual eligible sub-populations are, it is not clear whether one ICO and its participating providers could be a center of excellence for all these sub-populations, or whether a subset of the sub-populations would be more appropriate to a specialized ICO's core competencies. To ensure the widest participation in the Demonstration, the state should clarify that specialized ICOs will be allowed to participate, and provide guidance around the definition of a specialized ICO, such as delimited by population served, geography, or scope of services. A suggestion to help promote continuity of care for enrollees with existing providers is to create a system that permits providers to assist with their patients' enrollment.

**2. Financing & Payment (Section E)**

- a. CHA supports the call by the Massachusetts Hospital Association and the Massachusetts Association of Behavioral Health Systems for a provision that requires ICOs to reimburse providers (both in-network and out-of-network) at reimbursement rates not less than Medicare fee-for-service rates for Medicare covered services. This is critically important to maintain access to patient care services, especially those services like behavioral health services that are at risk due to inadequate reimbursement. Primary care services will need improved reimbursement over current Medicare and Medicaid rates given the PCMH direction and set of responsibilities.

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- b. Given the risk and complexity of the Demonstration for a new Dual Eligibles population, it is critically important that limited risk be placed on ICOs especially in the initial years of the Demonstration. We believe the application of integrated care models to the dual eligible population holds great promise, but also that the especially complex social as well as medical and mental health concerns and the program implementation requirements point to the need to address financial risk in a phased manner in recognition of the initiative's maturity.
- At the outset, providers will require a limitation on downside risk, with appropriate risk mitigation arrangements in place. Annual risk settlements may be a consideration at the outset of the program with risk corridors considered after the first year or years of experience due to uncertainty around services utilization for these populations and the size of the risk pool at an ICO. Downside risk should be restricted until interventions and outcomes are better understood.
  - In addition, each sub-population will require specialized risk adjustment at the individual member level that reflects the underlying disability and diagnoses of the individuals within that population. Specifically, it would be appropriate to limit risk – using year-end settlement or other arrangements such as risk corridors – for rating categories covering high-risk sub-populations as was done in the introduction of Medicaid Essential. The appropriate limit of financial exposure would encourage participation from a wider range of organizations as initial experience is garnered.
  - In the development of capitation rates, consideration should be given to appropriate and improved adjustments to risk/case mix for sub-populations. The current risk adjustment methodologies available have limitations as they typically given low risk or case mix intensity for mental health and substance abuse utilization even though the resource intensity is high, and increasingly patients present with multiple diagnoses, including mental illness and substance abuse together, and concomitant medical conditions.
  - CHA vigorously supports the inclusion of adjustments for socio-economic status to the list of appropriate adjustments in the parameters. Research consistently confirms that low socio-economic status affects a patient's risk profile, compounding difficulties in accessing health care, understanding and complying with medical instructions (impacting a patient's ability to adhere to recommended treatment regimes), and even is correlated with co-morbidities and chronic conditions. Patient population mix accounts for needed infrastructure investments and utilization costs. These patients need a greater intensity of social, financial, linguistic, and culturally competent support to achieve and maintain health, and global payment adjustments should reflect the costs of these provider services.

3. ICO Infrastructure and Systems to Support Care Coordination (Section E.ii)

We encourage the Demonstration to include financial support for the infrastructure required for ICOs to develop capacity for the Dual Eligibles population. It is critical to identify a source of funding for infrastructure investments and explicit guidance on how they will be disseminated to ICOs and their participating providers.

- Tying together different clinical and community-supportive services, inclusive of community-supportive services and state agency services, will be complex, and coordination of a multi-disciplinary team comprised of a wide and disparate array of individuals, agencies, government departments, and community services, none of which are co-located, will require additional effort, administrative support, and staffing.

**State Demonstration to Integrate Care for Dual Eligible Individuals  
Cambridge Health Alliance Comments**

- An ICO will need to create a data repository, communication protocols, and data and reporting conventions shared among disparate providers. On the financial side, financial relationships, and shared financial reporting will need to be established, as well as the capacity to analyze and manage actuarial risk, and to manage health care utilization and outcomes.
- The implementation timeline should reflect the developmental path to create this inter-relational infrastructure and the anticipated ramp up time for reporting and data exchange. These considerable infrastructure demands will require upfront funding and such funding should be included in the capitation rate.

**4. Service Areas (Section C.i.a)**

The proposal defines five service areas “congruent with the areas defined for MassHealth Managed Care Organizations: Central, Greater Boston, Northern, Southern, and Western”. To encourage the broadest range of providers, and to alignment service areas with existing provider system footprints, MassHealth should consider allowing ICO participation in some, but not all towns, in a service area. A precedent can be found in the PACE program, where different PACE organizations have unique defined service areas specific to their patient population.

**5. Provider Network (Section C.i.b)**

CHA, along with MHA, supports the proposal’s strong “any willing provider” provision, which affords continuity of care to patients and their providers. The language that “any willing provider” must meet network requirements and accept network rates limits financial exposure to the ICO as well. One additional area for consideration in the Commonwealth’s proposal are the contours on any out-of-network rates. Out-of-network rates should align with the rates afforded to “any willing provider” based on Medicare reimbursement rates for Medicare covered services to align incentives toward the development of integrated care networks to optimally serve the population.

**6. Covered Services (Section C.ii.b)**

We are pleased that the covered services include additional behavioral health diversionary services and additional community support services that are required for the dual eligible population. Planning work in assessing the statewide and local capacity and gaps in this behavioral health and community support services continuum of care is warranted, due to the extremely fragile nature of those services and current gaps that exist today. The proposal leaves network development and workforce development within the purview of the ICOs. Provider network adequacy is a significant challenge to the success of the Demonstration, especially considering the needs of the population and expansion of covered services. State leadership is needed in providing a statewide gap analysis and in filling the gaps in the continuum of care for selected community and supportive services.

We would like to add that some additional supportive services beyond those listed in the proposal will be essential to the health and well-being of the populations, including supported housing, group home environments, and independent living settings, as well as transportation services. These types of supported housing are not typically reimbursed with health care dollars, but by separate government-supported programs that frequently have lengthy waiting lists and are subject to funding constraints. Consideration should be given to how the Demonstration can assist at a macro-level in forging linkages at the state level and programmatic alignment with supportive housing services that are critical to successful outcomes for this population.

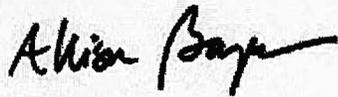
**State Demonstration to Integrate Care for Dual Eligible Individuals  
Cambridge Health Alliance Comments**

**7. Medicare Program Integrity**

CHA supports the request by MHA and MABHS that EOHHS and CMS take into consideration unique issues in the Medicare program that affect hospitals, including different regulatory requirements, bad debt provisions and the determination of inpatient days for purposes of Medicare DSH calculations. It is extremely important that the utilization data for Dual Eligibles, which is an integral component of Medicare Disproportionate Share Hospital adjustments made specific to each hospital, be maintained for Medicare DSH reimbursement purposes. [For example, Medicare Advantage data is no longer included in the calculations for Medicare DSH inpatient days, which has resulted in adverse reimbursement impacts to hospitals]. Both the relationship to Medicare add-on payments and Medicare base payment levels must be preserved as a reimbursement floor. Medicare is a well understood, widely used and accepted methodology. Specifically, the inpatient formula includes many critical adjustments to reflect diagnosis, co-morbidity, length of stay, wage area, and geographic location that must be preserved.

Thank you for the opportunity to provide comments. Please let us know of any questions. We look forward to learning how to participate in future steps in program design and implementation for this initiative.

Sincerely,



Allison Bayer  
Acting Chief Executive Officer  
Cambridge Health Alliance

Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Proposal to the Center for Medicare and Medicaid Innovation  
State Demonstration to Integrate Care for Dual Eligible Individuals Draft for Public Comments

Comments by Neighborhood Health Plan  
Submitted on January 10, 2012

**BACKGROUND**

**Description of Populations, p. 4**

1. Who is currently providing coverage to the 110,000 target population?

**Table B-2 Utilization and Spending Experience, p. 6**

1. In Table B-2, could ranges of expense be provided in addition to the average? For example, it would be helpful to know if 20% of individuals are within 10% of the average cost.

**Appendix C, Tables 2 and 3**

1. What is the anticipated cost impact of additional services in Appendix C, Table 2 and Table 3?

**CARE MODEL OVERVIEW, pp. 7 - 20**

1. We support the overall approach and principles outlined in the proposal. As EOHHS proposes, effective person-centered care requires an engaged provider community supported and empowered through the population-level activities of a health plan.

The data clearly demonstrates a higher level of behavioral health (BH) complexity among the identified target population (i.e. 19-64 y/o duals). The proposal specifies the importance of integrated BH and primary care, and expansion of diversionary services for these members. We concur with both of these positions, and also emphasize that the health profile of the target group necessitates a higher level of BH sophistication at the plan level. It will be important that awarded ICOs have experience with integrated care management (including BH/SA services) for individuals with serious mental illness.

For example, the awarded ICOs have a critical role in supporting continuity of care for individuals that require community-based mental health services. While it is reasonable to require PCMHs to increase screening and identification for BH diagnosis and to coordinate follow-up care, few PCMH sites will have the level of clinical experience with BH to ensure that the appropriate community-based services are being provided, in the appropriate setting, and at the clinically-indicated intensity. In this manner, the plan is integral to supporting recovery by providing the clinical support and guidelines to ensure that patients are being appropriately transitioned to lower acuity services when their condition and presentation warrant such changes in care.

Furthermore, the ICO has an important role in assisting the PCMH in identifying those individuals that could benefit from a coordinated community-based BH intervention, and thus ensure that that the limited supply of community mental health resources are being utilized most efficiently.

The BH competencies of each PCMH will vary, and it should be acknowledged that not all PCMH's are suited to serve complex populations, in particular those with SMI. A core tenet of person-centered care is the concept of meeting an individual where they are. Given the nature of the SMI population, it is unlikely that every PCP-driven practice can effectively engage and provide ongoing care management for this group. Rather, MassHealth should identify PCMHs with the specialized service models and clinical expertise necessary to care for the SMI. This may include CMHC-based PCMHs.

### **Covered Services, pp. 14 - 16**

1. Additional Coordinated BH Diversionary Services: While in full support of the integration of medical and non-medical services, some of the “additional” diversionary services the proposal identifies are not currently offered as part of the MassHealth benefit, i.e., Peer Support, Programs of Assertive Community Treatment (PACT). Historically, these services have been paid for by DMH and not an MCO. There is concern about a potential cost shift to the MCO as we have seen for CBHI services.
2. Dental is not currently a covered service in the Medicaid program. Will capitation rates appropriately reflect preventative, restorative, and emergency oral health benefits?

### **Enrollment Methods, pp. 9 – 11**

1. Will the MCO’s bid impact the enrollment process of MassHealth?
2. Will the enrollment process assign institutionalized individuals evenly amongst the MCOs?
3. Will ICOs be able to bid on individuals with specific conditions only?
4. Will ICOs be able to bid on specific rating regions only?

### **Opt-Out/Lock-In**

5. We support the voluntary opt-out enrollment period, however EOHHS should reconsider whether it is reasonable to provide no lock-in period for members. Many states currently have or are considering lock-in periods. There are real administrative costs to on-board specific types of providers, and the incentives to build these non-traditional provider partnerships are reduced if members may simply switch plans at any time. We recommend that EOHHS consider a lock-in period of, ideally, 1 year, or a minimum of 6 months. MassHealth is making extensive efforts to ensure continuity between enrollees and existing providers, and members would be granted the opportunity to opt-out of a plan before any lock-in would occur.
6. The risk of disruption to BH care along with the privacy restrictions imposed by federal regulations, presents significant obstacles for coordination expectations. Expectations for coordination with state agency/LTSS providers need to be set at the state level to ensure success. Experience with CBHI has demonstrated that protocols alone are not sufficient. Clear standards need to be set to ensure that accountability for coordination will be monitored.
7. There may be risk of adverse deviation associated with voluntary enrollment.
8. There may be risk of adverse deviation associated with the ability to change plans or opt out of the Demonstration at any time.

### **FINANCING AND PAYMENT, p. 25 - 28**

1. As noted in the proposal, risk adjustment is necessary to ensure patient access and reduce financial risk for ICOs serving the sickest members. Commonly-used risk adjustment models often insufficiently recognize the added cost of behaviorally complex or behaviorally co-morbid groups. To address this concern, EOHHS should establish a continuous quality improvement methodology to enhance the precision of risk scores for BH diagnoses. One component of this is a process for collecting and categorizing functional mental health status, and a mechanism to incorporate those indicators into the risk adjustment methodology. MassHealth should utilize a risk-adjustment model that allows for retro-reclassification. Undiagnosed mental health conditions are common due to inadequate screening, stigma, and privacy concerns. However, fulfilling the potential of the integrated care model hinges on diagnostic

accuracy, particularly for BH conditions. As such, the risk adjustment methodology and reimbursement mechanism should allow for rates to be retroactively adjusted where a diagnosis is identified during initial enrollment and/or at some regular interval (e.g. annually).

2. Will there be one global payment for the non-waiver community, institutional, and HCBS Waiver Enrollees summarized in Table B-2 (p. 6) or are there separate and distinct payments?
3. If there is only one global payment, is the risk adjustment factor intended to provide the appropriate revenue adjustment to the MCO for the distribution of individuals in each of the care settings?
4. If the risk factor is based on all 110,000 targeted individuals, will the risk factors used in rate adjustment to the MCOs normalize to 1.000 even if all 110,000 are not enrolled in an MCO?
5. Will the data used to develop base capitation rates be from Massachusetts MCOs?
6. Will the global payment be defined to be actuarially sound?

## **EXPECTED OUTCOMES**

### **Supplemental Risk Mitigation Strategies, p. 27-28**

1. We agree with the use of risk corridors, reinsurance, and stop loss.
2. Withhold has not been demonstrated to drive effective improvement programs. It runs the risk of underinvestment for necessary services.

### **Potential Improvement Targets, p. 30 – 31**

1. We recommend adding comparison to national benchmarks when available.

### **Expected Impact on Medicare and Medicaid Costs, p. 31**

1. What is the projected savings potential to MassHealth from the investment in expanded behavioral health care, LTSS, and community support services?

## **APPENDIX C**

### **Covered Services, Table C. Behavioral Health Services Offered to Adults in MassHealth**

1. PACT is not currently a covered service for the MCO program. There is concern about a potential cost shift to the MCO.

### **Covered Services, Table D. Additional Community Support Services Proposed for the ICO**

2. Clarification needed regarding the “New Benefits” – behavioral health or medical “buckets”.



FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL  
AND MASSACHUSETTS GENERAL HOSPITAL

January 10, 2012

Lisa D. Wong  
Procurement Coordinator  
Legal Unit  
Executive Office of Health and Human Services  
One Ashburton Place, Room 1109  
Boston, MA 02108  
duals@state.ma.us



**Gary L. Gottlieb, M.D., M.B.A.**  
*President and Chief Executive Officer  
Partners HealthCare System, Inc.*  
  
*Professor of Psychiatry  
Harvard Medical School*

Dear Ms. Wong:

Thank you for the opportunity to comment on the state's draft proposal to CMS on integrating care for individuals ages 21-64 who are eligible for both Medicare and Medicaid ("dual-eligibles"). This initiative will be an important step in improving care for the most vulnerable people in our communities. We appreciate the collaborative process that the state has used in developing this proposal, and we look forward to continuing to work with you to ensure its success.

As we have noted previously, we believe that care coordination strategies that create a compassionate, patient-centered partnership among providers, consumers, and their families can make a significant difference in improving both the quality of care and value in the health care system. This care needs to be integrated and coordinated across the health care system, including not only primary and acute care but also behavioral health and long term care services. We are pleased that the state not only shares this vision but is also actively engaged in developing innovative new programs that will help to make it a reality.

We would like to recognize two important changes that the state has made to the proposal since last spring; specifically, that the program will be voluntary, and that it will preserve access to existing health care providers. We thank you for your attention to these important issues.

That being said, we continue to have concerns about the payment system, in particular around what will and what will not be included in the global payments. For example, will payments be adequate to cover the costs of care, and, secondly, will certain services be included as part of the global payments or be paid separately and provided by community-based programs and/or providers (crisis beds, mobile crisis services, etc.)? Clarification of these issues will be important as it will be essential to ensure that adequate resources are available to support the program and the services that will be provided.

Letter to Ms. Wong  
January 10, 2012  
Page 2

Given the number of Pioneer ACOs in the Commonwealth – five out of the 32 selected nationwide – as well as the importance of the Pioneer ACO program to federal policymakers, we recommend that the proposal reflect and affirm the state’s commitment to collaborate with the Pioneer ACOs, since dual-eligible individuals under the age of 65 will be ACO participants. We would like to suggest that the state meet promptly with the Massachusetts ACOs in order to assure an informed discussion of how the two programs will be coordinated. Specifically, we recommend that the state consider a supplemental payment model for the Pioneer ACO dual eligible enrollees, since the ACOs will be receiving a global payment for the Medicare portion of these patients’ services. We would be pleased to work with the state on developing potential options for blending payments for the Pioneer ACOs.

We look forward to working with you on this initiative over the next several months. If you have any questions or would like additional information, please contact Beth LaFortune Gies, Director of Policy and Research, at 617-278-1014. Once again, many thanks for providing this opportunity to comment on this important proposal.

Sincerely,



Gary L. Gottlieb, M.D., M.B.A.  
President & Chief Executive Officer  
Partners HealthCare System, Inc.



## Comments on MassHealth Demonstration to Integrate Care for Dual Eligibles Home Care Alliance

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### A. Background

On behalf of 127 Medicare and Medicaid certified home health agencies, the Home Care Alliance is pleased to offer comments that both support the ambitious direction of the Massachusetts dual eligible initiative, as well as provide specific suggestions as to how to make such a far reaching reform work for those that we care for – the homebound, the vulnerable, and the medically complex.

According to Calendar Year 2008 data made available by MassHealth, home health agencies provided care to 13,687 dual eligible individuals at a total cost (to MassHealth) of \$160 million. Working with these clients has provided Massachusetts home health agencies a unique understanding of their needs and challenges, and agencies have developed trusted relationships in caring for dually eligible individuals. On a daily basis, our clinicians are addressing the full scope of peoples' complex clinical and mental illnesses as they are dealing with multiple medications and teaching and family supports, where appropriate, need to be addressed. For every one of these 13,000-plus patients, home health clinicians have a relationship not only with the client, but with his or her primary care physician. When Medicare is the payor, agencies are required as part of our scope of practice to perform the clinical care management function envisioned in this proposal. In cases where dual eligibles are over 65, home health agencies have historically been the link and the largest referrers to ASAP services.

Although the data do not get into the detail on this, home health agencies working with duals have a good clinical record of managing complex conditions. Those who have home health services are hospitalized less, and only infrequently institutionalized. It is critically important that this skill set not be lost in the movement toward a managed care model.

For home health agencies, the combined Medicare and Medicaid funding model is attractive for two reasons:

It will relieve agencies of the burden of making multiple and ongoing insurance coverage determinations between Medicare and Medicaid. The administrative burden of perpetual billing appeals and case review is costly and time consuming, not to mention it consumes agency resources that could be better spent on direct care.

There is a possibility of an expansion of community based services to better meet client needs. Home health agencies have been as frustrated as the client by the restrictiveness of MassHealth's per-visit reimbursement of only nursing, therapy and aide services. The Home Care Alliance and its member agencies welcome the opportunity to provide Clinical Care Managers, community health workers and health coaches, which we believe belong and, in some cases, already exist in home health agencies.

The more detailed comments below are intended to improve the proposed model by making better use of the talents, skills and experience that we already have in place rather than building a new and potentially costly infrastructure from scratch.

## **B. Care Model/Proposed Delivery Model**

The Alliance is pleased that the ICO's will be made to operate in the patient-centered medical home model and that there is a clear intention to have an expansive provider network "with the capacity to provide enrollees, either directly or by subcontracting, the full continuum of current Medicare and Medicaid services," via open panels. We also recognize and strongly support the requirement that ICOS have a "clear continuity of care process that allows qualified and willing providers, who already serve eligible members wishing to maintain that relationship, the opportunity to join the ICO's provider network." We hope that all Home Care Alliance members that have both the experience and relationships with the dually eligible can continue the great work they have been performing to this point.

With enrollment being a voluntary opt-out process, the Alliance believes that, for many of the 13,000-plus our members serve, the ability to continue with same nurse, aide or agency will be key to their decision to not opt –out. We would therefore recommend much more specificity in how this open panel, and continuity of care process, will be maintained and monitored. Our recommendations are that:

- All in-home direct clinical care and paraprofessional services should be provided by a Medicare/Medicaid certified home care provider.
- Quality measurements for community agencies be a subset of those publicly reported by certified agencies to Mass Department of Public Health for Medicare.
- At least for the initial year, there must be some degree of "downstream" provider payment parameters. At present, the ability of the home health community to provide care depends on the subsidization of the Medicaid rates by Medicare. Without explicit instructions, the clear incentive will be for plans to achieve shared savings not by better patient management, but by provider rate setting.
- Electronic health record integration be a requirement, but that there be a time frame for phase-in.

## **C. Benefit Design/Patient Centered Medical Home**

While it is laudable that the model calls for "regularly scheduled appointments with the care team," that are planned rather than reactive, the population that home health has traditionally served includes a high proportion that are confined to their homes, or leave only with a considerable effort. The Home Care Alliance believes that the alternatives to face-to-face visits, "such as email and telephone," are insufficient to assure links to patients of limited mobility.

We strongly recommend that:

- The benefit design be expanded to allow, if not require, the use of home health remote monitoring technology for certain clients with limited direct access to primary care and a history of instability with heart disease, diabetes, and other chronic conditions. Medicare already allows this and many home health agencies have successful track records with the technology. The state's fiscal year 2011 budget included language in the MassHealth Managed Care Account that opened the door for MassHealth reimbursement as well.
- The benefit design and Care Team model use the in-home clinicians as a primary care extender linked to the PCMH via the electronic record. Recognized as part of the care teams 'eyes and ears on the ground,' these home health clinicians can detect and report changes in condition that warrant intervention, a change to the care plan, or a medication without the need for a scheduled office visit.
- Many practices, especially the smaller physician offices, could benefit from a certified home health agency's requirement to be available 24 hours per day and seven days per week for care, not just Monday through Friday, 9:00 to 5:00.

#### **D. Care Coordination/Clinical Care Management**

The model being proposed would seem to call for a team-based Care Coordinator for every enrollee and a Clinical Manager for those with intensive clinical needs, complex medications or at nursing home risk.

The Home Care Alliance has worked with many managed care entities that provide in-house case management services, some that work well. We would strongly recommend that the model and ICO contracts be much more specific in this area in the following ways:

- **Clarifying that the PCMH/ICOs should directly employ their own care coordinators to work with long term care providers, but in instances where a person is in need of a Clinical Care Manager – that this should be a contracted service, ideally provided by an entity that is: a) directly involved in the client's care, b) who has a clinical background, and c) is accustomed to working for and with primary care clinicians on care planning.**
- **Specify that the level and qualifications of care coordinators may need to be higher for the very high risk behavioral health clients.**
- **Requiring a prescribed assessment, especially for clients who have both extensive behavioral health and medical needs.** The OASIS is evidence-based, used in the Senior Care Options (SCO) model, and may well be required as part of the Medicare ACO model, so the Alliance would recommend it be considered for use with the dually eligible. The fact that federal efforts are underway to map the nursing assessment tool (MDS) to the home health assessment tool (OASIS) is further support to use this established method.

- **Specifying the level and qualifications of care coordinators may need to be higher for the very high risk behavioral health clients**
- **Clinical Care Managers, as outlined in the draft proposal, should serve people with complex medical needs and have an array of abilities. All of these abilities play to the strengths of home health nurses who have experience and many would welcome advanced training. In this case especially, there is an existing workforce that can be tapped rather than recreated.**

#### **E. Modifications to Existing Services/Additional Community Support Services**

The Home Care Alliance sees great potential in the establishment of the Community Health Worker, but for selective patients and circumstances. A trained, but non-clinical or licensed health worker could easily be a home health aide with advanced training, which would serve as a career ladder incentive for the aides themselves. Utilizing a home health aide also means that the workforce is in place and can be more easily trained for deployment as these aides already have 72-hours of training. These should not be set up as substitute services.

With this definition of a community health worker, a viable model could see the community home health provider contracted to provide a Clinical Care Manager who, in that role, can develop a plan with the PCMH to support the client with the right service, at the right time and in the least costly manner to achieve the care plan goals.

#### **F. Other Issues**

The breadth of this change and the potential for disruption in clients lives and claims plans calls for some clear and publicly reported data on the ICOs, such as size of provider networks, patient admission and readmissions rates, degrees of clients assessments for patient safety issues, such as falls risk, and medication compliance.

#### **G. Conclusion**

The Home Care Alliance and its members have the experience and skills that can help make this new integrated model a success. The Alliance hopes that all member agencies that have experience in serving duals also have the opportunity to continue providing that care in a better coordinated system with opportunities for skills training and career advancement. Home care agencies provide an array of services and are flexible enough to ensure an ICO can depend on them in a number of situations, whether it is the ability to provide care 24/7 or provide home health aides training to become community health workers. The role of clinical care managers play to the strengths of home health nurses and experience in caring for dually eligible individuals. The Alliance looks forward to working with MassHealth and ensuring that agencies are properly utilized by ICO's so that people can receive care in the community whenever possible.



January 10, 2012

Executive Office of Health and Human Services  
Attn: Lisa Wong  
One Ashburton Place, Room 1109  
Boston, MA 02108

Sent Via Email to [duals@state.ma.us](mailto:duals@state.ma.us)

**RE: Comments on the Proposal to the Center for Medicare and Medicaid Innovation for the State Demonstration to Integrate Care for Dual Eligible Individuals.**

Dear Ms. Wong:

The following information is being submitted as written comments to the December 7, 2011 Draft Proposal to the Center for Medicare and Medicaid Innovation for the State Demonstration to Integrate Care for Dual Eligible Individuals.

AdCare Hospital is a provider of treatment related to alcohol and drug abuse disorders. AdCare Hospital is licensed by the Department of Public Health Division of Health Care Quality and also holds Certificates of Approval to provide substance abuse services from the Massachusetts Department of Public Health Bureau of Substance Abuse Services. AdCare Hospital is both Medicare and Medicaid certified. AdCare Hospital is accredited by the Joint Commission. AdCare Hospital includes a 114 bed inpatient hospital located in Worcester, MA. AdCare Hospital also provides outpatient treatment at its outpatient locations in Worcester, Boston, Quincy, North Dartmouth, West Springfield and in Warwick, RI. AdCare Hospital admits approximately 2000 inpatients per year that have both Medicare and Medicaid Coverage. Many of these patients continue services in AdCare Hospital's outpatient programs following their inpatient treatment.

AdCare Hospital does believe better coordination of care for dual eligible patients could result in better care and reduced costs for this population by assuring patients are getting the right care, at the right time, and in the right setting. However, AdCare Hospital has some concerns related to the proposal as written.

**Access/Cost**

Access to acute hospital and behavioral services is critical for the dual eligible population. Access is linked to reimbursement as hospitals must be financially viable to continue to provide needed services. AdCare Hospital is very concerned about reimbursement issues for acute behavioral health care providers relative to this population. Dual eligible patients make

up a large percentage of the patient mix for acute behavioral health providers. Dual eligible patients are frequently the most compromised and most costly for behavioral providers to treat. The savings associated with the program being considered should be the result of better coordination of care that results in preventing otherwise unnecessary services. The savings should not be the result of reducing reimbursement rates to providers. As such, the Proposal should prohibit ICOs from reimbursing hospitals less than they receive from Medicare for inpatient treatment services. Any plan that reduced Medicare reimbursement rates for providers could be devastating.

It is important to note that tremendous resources have been utilized to develop the Medicare methodology for payment for inpatient services in hospitals. It is a methodology that is used nationwide. This lends additional support for requiring ICOs to utilize Medicare reimbursement amounts as the minimum contract rates in provider contracts relative to inpatient services.

Additionally, the Medicare program reimburses the physician component of services in the Hospital setting separate from the hospital component. In contrast to that, many insurers and behavioral managed care organizations contract with inpatient providers at a single rate that includes physician services. If it is intended that ICO contracts with inpatient providers are inclusive of reimbursement for the physician component of acute behavioral services, reimbursement rates must be sufficient to support the same.

### **Geographic Limitation**

Section C(i)(a) indicates ICOs will operate in five service areas throughout the state, congruent with the areas defined for MassHealth Managed Care Organizations. Although it does not state ICOs or PCMHs will only contract with providers in their service areas, it is especially important for behavioral health services that patients are not limited to providers within the geographic areas in which they live. Many providers of behavioral health services (including AdCare Hospital) serve patients from all geographic areas of the state.

### **Covered Services**

Section ii(b) provides that the ICO will determine the utilization management tools, including any prior approval requirements....and will have procedures for determining what is a medically necessary service. The dual eligible population will be harmed by unnecessary approval and review procedures for behavioral health services that are currently used by many managed care organizations in the behavioral health field. Utilization management tools that limit access to needed behavioral care only increase overall costs associated with this population as they result in increased ER and acute hospitalizations for both behavioral and medical diagnoses.

### **Expected Impact on Costs**

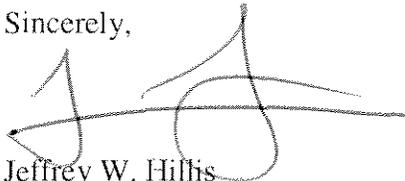
Section iii provides that the initial savings estimates of 1.5-2 percent within the term of the Demonstration appear to be obtainable. AdCare Hospital has concerns that strict and unnecessary utilization management techniques will be used to make up for the significant costs required to develop the infrastructure to support this program. In short, a substantial amount of dollars that currently go to pay providers for services are going to instead be used for administrative costs associated with this program. AdCare questions whether this decision is appropriate considering the significant care needs of this population.

### **Management/Quality**

AdCare Hospital (as well as all Medicare participating hospitals) comply with the Medicare Conditions of Participation for Hospitals. Compliance with the Conditions of Participation are costly, however they assure Medicare participants are receiving treatment in settings that meet certain standards. AdCare Hospital is concerned that Medicare patients that are entitled to treatment in appropriate settings are going to be redirected to less costly alternatives that do not meet the Conditions of Participation and are less safe for Medicare members.

We appreciate the opportunity to comment on the Draft Proposal. If you have any questions regarding these comments, please do not hesitate to contact me at 508-799-9000, Ext. 3123.

Sincerely,



Jeffrey W. Hillis  
Chief Operating Officer



January 10, 2012

Lisa Wong  
Commonwealth of Massachusetts  
Executive Office of Health and Human Services/MassHealth  
One Ashburton Place, Rm. 1109  
Boston, MA 02108

**Re: State Demonstration Proposal to Integrate Care for Dual Eligible Individuals**

Dear Ms. Wong,

Beacon Health Strategies LLC (Beacon) is pleased to provide you with comments on MassHealth's proposal to the Centers for Medicare and Medicaid Services (CMS) regarding a state demonstration to integrate care for dual eligible individuals. We fully support EOHHS's bold approach to applying the principles of person-centered care to serve dually eligible enrollees with chronic care needs.

A behavioral health services company since 1996, Beacon partners with public and private sector managed care plans to treat mental illness and substance use on a fully integrated basis. Our experience is particularly relevant when considering the behavioral health needs of dual eligible enrollees. Today, Beacon works with more than 60 health plans across Medicare, Medicaid, special needs and commercial populations. Partnering with 28 Medicaid plans in 12 states, Beacon administers and coordinates mental health and substance use services to child welfare populations, the seriously and persistently mentally ill, juvenile justice populations, as well as children and adults with special healthcare needs.

Based on 15 years of experience working with the target population, managing both Medicaid and Medicare benefits, Beacon is well qualified to inform the discussion on how best to integrate care for dual eligible enrollees.

We hope that this input will be helpful as EOHHS establishes a new model of integrated care for duals that implements person-centered, coordinated care; improves access to clinically appropriate and cost-effective services; and streamlines administrative processes for members and providers.

Best,

Jim Spink | President

Office: 617-747-1080 | Mobile: 781-710-9545 | jim.spink@beaconhs.com



## Care Model Overview

### *Proposed Delivery System Model – Integrated Care Organizations (ICOs)*

Beacon strongly supports MassHealth's position that person-centered care is best achieved through a partnership between appropriately incentivized providers and health plans capable of supporting population health management. MassHealth's analysis of the target population clearly demonstrates a high level of behavioral health (BH) complexity among the prospective enrollees (i.e., dual eligibles aged 19-64). Given this fact, it is important that the roles of providers and of integrated care organizations (ICO) with regard to mental health and substance use (MH/SU) services are defined clearly.

The draft demonstration appropriately cites the value of both integrating behavioral health into primary care, and also expanding access to diversionary services for the target population. We concur with this position, and emphasize that ICOs are critical to ensuring that these investments generate improved health for members and increased value for the system. Otherwise said, the availability of diversionary services is necessary - but not sufficient - to achieve improved outcomes for the target population.

To promote effective care coordination that supports recovery, ICOs must support Patient-Centered Medical Home (PCMH) sites. Activities should include prospective identification of vulnerable members to ensure that appropriate MH/SU services are being provided to those members who need them, and that the nature and outcomes of the treatment are communicated back to the primary care physician (PCP) for purposes of integrating care. ICOs also have a critical role to ensure that members are appropriately transitioned to less intensive services and less restrictive settings as their condition and situation warrant such changes in care. Because PCMH sites will vary in their sophistication with behavioral health intensive patients and experience with community mental health providers, Beacon views ICOs as educators and network managers. In this capacity, the ICO provides guidance and assistance to PCMHs at the member and system level. For example, ICOs must be able to provide clinical support and clear guidelines for both PCMH and community mental health providers. These standards should establish clear expectations regarding appropriate levels of care, and the criteria and evidence base used to determine when and how to integrate certain MH/SU treatment modalities.

The ICO must provide guidance to the PCMH until such time that the PCMH can operate independently with regard to effective engagement with community mental health providers. In addition, the ICO should work with the PCMH to ensure that a member with complex behavioral health conditions has access to appropriate treatment, or is transitioned to an alternative PCMH that is better equipped to meet the individual's healthcare needs.



To this point, Beacon recommends that MassHealth consider that for certain individuals with serious mental illness, a community mental health center-based PCMH may be the best option to ensure that appropriate, coordinated care is delivered. This idea is consistent with the principles of person-centered planning, which support providing access to high-quality services where the member wishes to receive them.

### *Enrollment*

MassHealth should reconsider lock-in provisions, and determine whether it is reasonable to provide some period of guaranteed enrollment after a member selects a plan. California, for example, is considering whether to allow selected dual-integration sites to lock members into enrollment for six months. There are significant administrative costs to recruit certain provider types, who are critical to ensuring high quality, coordinated care. The incentives to build these non-traditional provider partnerships are reduced when members can simply switch plans at any time.

This suggestion is not intended to limit member choice. Any enrollment lock-in would be implemented in a manner that ensures members are educated on their choices, and affirmatively enroll in a plan. MassHealth is making extensive efforts to ensure continuity between enrollees and existing providers, and members could be granted the opportunity to opt-out of a plan before any lock-in occurs.

Whether MassHealth ultimately allows members to switch plans at any time or permits a lock-in, a careful transition protocol needs to be established to ensure efficient coordination of care. A transition period or authorization needs to be in place, in particular for those with a behavioral health or substance use diagnosis, to allow clinical and treatment information to be exchanged in a manner compliant with 42 CFR. The risks of disruption to behavioral health care, and the privacy restrictions imposed by federal regulations, present significant obstacles for care coordination, thus requiring careful administrative and clinical planning.

Similarly, the state should establish expectations for coordination with long-term support service (LTSS) providers to ensure successful program implementation; protocols alone are not sufficient. Clear standards need to be set to ensure that accountability for coordination is monitored. Providers, state agencies and ICOs must be informed of their roles and responsibilities with regard to coordinating care for demonstration enrollees.

### *Benefit Design*

As the state considers a patient-centered approach to meeting the complex needs of a dual eligible population, the benefit design becomes a critical component to advancing community-based care, case management services and evidence-based mental health and substance use treatment. Focusing specifically on home-based treatment and person-centered modalities is advisable. We strongly encourage the state to avoid broad-based benefit mandates that may not be fiscally sustainable, nor meet the clinical needs of the dually eligible population. Experience in Massachusetts has shown that system-of-care designs based on imposed mandates may actually result in over-utilization, increased cost and diffused outcomes.



The state should consider beginning with a circumspect benefit design, focusing on community-based services and evidence-based treatment predicated on medical necessity and the unique needs of individuals with dual eligibility.

## Financing and Payment

The payment model and rate methodology used for the demonstration have significant implications for member access and financial stability among the provider and ICO communities. MassHealth must use a risk-adjustment model that appropriately reflects the cost of care for the most complex members, thus ensuring patient access to quality services and reducing financial risk for ICOs that serve the sickest members. Commonly used risk-adjustment models, such as Medicare DCG, severely underestimate the cost variance resulting from chronic conditions combined with behavioral health comorbidity.<sup>1</sup> Given the nature of the target population, MassHealth must carefully consider this when selecting a risk-adjustment methodology.

Furthermore, we recommend that the state establish a continuous quality improvement methodology to enhance the precision of risk scores for behavioral health diagnoses. One component of this recommendation is a process for collecting and categorizing functional mental health status, and a mechanism to incorporate those indicators into the risk-adjustment methodology.

Further, MassHealth's selected risk-adjustment methodology should allow for retro-reclassification. Undiagnosed mental health conditions are common due to inadequate screening, stigma and privacy concerns. However, fulfilling the potential of the integrated care model hinges on diagnostic accuracy, particularly for behavioral health conditions. As such, the risk-adjustment methodology and reimbursement mechanism should allow for rates to be retroactively adjusted where a heretofore undiagnosed condition is identified during initial enrollment and/or at some regular interval (e.g., annually).

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<sup>1</sup> Rosen, Amy. Risk Adjustment Models and Applications in the VA. Accessed December, 2011. <http://www.slideserve.com/liam/risk-adjustment-methodologies-and-applications-in-the-va>

Executive Office of Health and Human Services  
Attn: Lisa Wong  
One Ashburton Place, Rm. 1109  
Boston, MA 02108

Thank you for the opportunity to comment on the Demonstration Proposal – Integrating Care for Medicare-Medicaid Dual Eligible Individuals. The physicians and other clinicians at Sturdy Memorial Associates (SMA) look forward to continuing to take care of these individuals, our patients, in a delivery model that encourages improved coordination of care. SMA is a sixty physician group practice that employs the majority of primary care physicians serving the 12 towns comprising the greater Attleboro area.

A reorganization of any health delivery model should be approached carefully, especially one for dual eligible individuals, many of whom have very complex multidisciplinary health issues. We are therefore encouraged to see that the Demonstration Proposal provides flexibility in the care delivery model. This flexible approach will also help ensure that patient relationships with current providers and caregivers is preserved – a critical objective in the Proposal.

Some large, multispecialty practices in urban areas, such as Boston, Worcester, and Springfield, have the resources in one physical location to deliver, through the co-location of the primary care clinician and behavioral health clinician, all of the services described in the Person Centered Medical Home (PCMH). Outside of those situations, the ICO should be given the latitude to assemble the components of the care team not already available in the primary care physician office. This replicates the model that organizations serving the over 65 dual eligible population are utilizing. These organizations reimburse primary care physicians a fee for service payment and employ most if not all of the support team. This would be the most cost effective way to bring this coordinated care approach to the vast majority of the communities in the State.

Finally, the timetable for implementing the new delivery system is aggressive given the complexities this population presents. A phased implementation may result in a better experience for the dual eligible individuals and the providers as we transition this complex population to this new model of care.

Submitted by:  
Joseph Casey, CFO  
Sturdy Memorial Hospital

January 10, 2012

Lisa Wong  
Executive Office of Health and Human Services  
One Ashburton Place, Room 1109  
Boston, MA 02108

Dear Ms. Wong:

I am writing to express my support for the Draft Demonstration Proposal for Integrating Medicare and Medicaid for Dual Eligible Individuals.

For the past 13 years I have been the Durable Medical Equipment Coordinator for Boston's Community Medical Group. We are a primary care practice contracted with Neighborhood Health Plan to manage the care for MassHealth eligible adults with disabilities. Our capitated model gives us the flexibility to prescribe and purchase medical equipment and supplies based on each patient's needs, rather than by a strict ruled-based insurance model.

I have been a wheelchair user for 30 years and have also receiving my primary care from Boston's Community Medical Group since 1988. In my opinion, BCMG provides the best care model in the country for persons with disabilities. We provide patient-centered care that improves quality of life, while at the same time keeping people out of the hospital and reducing health care costs.

I am excited at the prospect of seeing our model of care expanded throughout the Commonwealth and ultimately across the country.

Sincerely,

*Ken MacDonald*  
Durable Medical Equipment Coordinator



that have a focus in evidence based modalities that treat serious mental illnesses? The proposal is vague in this area. Considering how critical these issues are to how the PCMH functions and the quality of care afforded the “dual”, there needs to be further clarification in this area.

1. **Transportation Needs of People with Mental Illness:** Transportation is a huge issue for people with mental illness. Many people rely on public transportation to get to their appointments. While the proposal (p. 13) talks about the Care Coordinator ensuring the referrals result in “timely appointments,” the proposal does not go into detail about transportation and the needs of disabled people who are “dually eligible”.

NAMI was recently reminded of transportation challenge of people with mental illness by one of our chapter affiliates, NAMI Berkshire County which is located in Pittsfield, MA. To get from N. Adams, where the hospital and many clinics are located, to Pittsfield can take up to 50 minutes. Without adequate public transportation people won't be able to get to their appointments in a timely fashion. And currently the Berkshire Rapid Transit Authority is cutting services so travel is especially challenging for people who rely on public transportation.

Isolation is a barrier to recovery and management of chronic illnesses. Transportation needs for people with chronic illnesses have to be addressed to enhance opportunities for and access to wellness programs in the community, create and maintain social supports in the community, and improve overall health and long-term outcomes.

We urge that the Care Coordinator get involved in the individual's transportation needs because the care they receive is so dependent on transportation.

2. **Certified Peer Specialist:** Many studies show that peer support is the most cost effective way to improve outcomes. While peer specialists would be a new covered service under this proposal, we feel it doesn't go far enough. Peer support is a vital component of recovery for all people with mental illness. We believe Peer Support should be used in a number of ways:

- Peer Specialists should work one- on- one with people who are “dually eligible”;
- Peer Specialists should be a member of the Care Coordination Team and the Clinical Management team;
- Peer Specialists should be tasked with helping the individual get involved with Recovery Learning Communities, Independent Living Centers, Clubhouses, and other peer-run services in the community
- Peer Specialists should have a role in the “enrollee customer services,” as discussed on p. 24;
- Peer Specialists should also be part of the governing roles on either Advisory or Governing Board;
- Peer Specialists should be included in any “ombudsperson” role;
- Peer Specialists have been successful “navigators” at Boston Medical Center and should be used as “navigators” in this proposal too – for both people with mental and physical disabilities;
- Peer Specialists should also be involved with any oversight of this initiative.

This proposal should allocate significant funding to facilitate peer support.

3. **Grievance and Appeals:** Currently, the “dually eligible” have two appeal procedures which are very confusing. NAMI Massachusetts supports this initiative to create one appeal and grievance process that should give the utmost protections to ensure that the beneficiary is given all his or her rights.
4. **List of Services that would be covered under this Project, Appendix C:** NAMI Massachusetts supports expanded Behavioral Health Services and Additional Community Support Services as set forth in Appendix C. We particularly want to comment on:

- Expanded oral health benefits. We note that many people with mental illness have “dry mouth” because of the prescription medication they are on. “Dry Mouth” causes unnecessary oral health problems and need for preventive, restorative and emergency oral health care;
  - Community Crisis Stabilization is also a necessary service for people with mental illness and their families;
  - Peer Supports/Counseling/Navigation: This is a vital component of recovery for people with mental illness. See NAMI Massachusetts’s comments in #3 above which spells out these responsibilities in more detail.
5. Additional Coordinated Behavioral Health Diversionary Services: The Care Coordinator needs to be involved with at least two issues that are vital for people with mental illness – housing and employment. We urge that the Care Coordinator should become educated about and develop relationships with Housing Authorities and vocational/employment services in the service area in order to be engaged in these critical areas. In cases where the “dually eligible” are served by a PACT or CBFS team, the Care Coordinator should work with these specialists assigned to the areas of housing and vocation.

Additional Diversionary Services should include post discharge clinics where doctors and other practitioners focus on those vulnerable transition times and try to keep patients from returning to the hospital. Hospital readmissions — the revolving door of discharge, recurrent illness and repeated trips back to a hospital bed — are a huge and costly problem for people with poorly managed chronic illnesses. This revolving door often happens because of a lack of follow-up care and/or follow-up care that is not responsive to people with chronic illnesses such as mental illness.

6. Role of family members: Family members play a critical role in the recovery of many people with mental illness. Family members often feel locked out so this proposal needs to make sure to involve them wherever it would be beneficial to all people involved. There must be clear communication with family members. Although protections by HIPAA make this challenging, here are some ideas:

Care Coordinators and Peer Specialists should be encouraged to refer family members for education and support to organizations like NAMI Massachusetts. Family isolation and stigma are often associated with mental illness and other chronic illnesses and produce strains in a family that can lead to exasperation, a sense of abandonment and demoralization. These effects may interfere with natural caregivers’ capacity to support their mentally ill relatives and to assist in their rehabilitation, especially when the treatment system does not provide to them education, social support, and coping skills training.

Families can have a significant effect on the course of serious mental illnesses, in that their behavior toward their mentally ill relative can often facilitate or impede recovery. Families are critical to a person's social network, the functions of which include: social and instrumental support; access to other people and resources; mediation of information; and the placing of demands and the imposition of constraints. All of these functions are essential to developing skills for coping with a psychiatric disability.

The Care Coordinator should be tasked with making appropriate referrals to family members. For example, NAMI Massachusetts offers free education programs and support groups for family members and other caregivers such as a free Family-to-Family (12-session) education course.

7. **Additional Community Support Services and Community Health Workers:** NAMI recognizes that the people who are “dually eligible” are a diverse group of individuals: culturally, linguistically, ethnically, hearing and non-hearing, and regard to the form of disability or chronic illness. We therefore support the notion that Integrated Care Organizations (ICOs) employ trained non-medical community health workers that meet all the diverse needs of people who are “dually eligible”. This should not only apply to the services that are provided, but to any education and outreach efforts.
8. **Wellness** is briefly mentioned on page 15, but diet, exercise and general wellness are a huge part of recovery and need to have more focus in the proposal. Perhaps a clearer definition of “wellness” should be defined as part of the treatment plan and the proposal should make it clear who should be responsible for overseeing this objective. Wellness can be encouraged and supported by peer run entities such as Recovery Learning Communities and Clubhouses. Transportation to access wellness programs is essential for people living with mental illness because most do not have the means to purchase and/or maintain a car. The Care Coordinator should be given these important tasks as well.
9. **Outcome Measures:** The text and chart on pgs. 28 – 30 are good but we have additional comments. While not every person who is “dually eligible” should be measured in these ways, here are some other metrics that should be considered:
  - Gainful employment or volunteering whether full- or part-time;
  - Reduction of services with providers (a weaning off);
  - Development of self-mastery skills and independence;
  - Financial independence;
  - Support networks: reconnecting with people one may have lost touch with, regular attendance of support group(s) meetings;
  - Improved overall health: sustained weight loss, lowered cholesterol, controlled diabetes and asthma;
  - Regular exercise regime.
10. **Communications from MassHealth, Medicare and the ICO:** Communication from the state and federal governments to people who are “dually eligible” has been problematic for years. Many people, including family members, cannot read and comprehend the frequent gibberish in the notices that are distributed. There needs to be a dramatic improvement in the content and form of communicating with beneficiaries, and this proposal does not give us the assurance that this will happen.

A better form of communication should start with the Voluntary OPT OUT enrollment provision and a clear statement of what the new integrated program for the “dually eligible” will contain and why people should maintain their integrated coverage with Medicare and MassHealth. A couple of highlighted services would be peer specialists and expanded dental benefits -- these services would be very attractive to most people with mental illness.

Communication and education in this area are further examples of how peer run services can serve a vital role at little cost. Peer run entities should be consulted as to how to best facilitate communication and get the word out to all constituencies, including diverse populations.

11. **Reimbursement Rates:** Access is affected by poor reimbursement rates. We know this from seeing how outpatient and inpatient care is delivered. Everyone, including Attorney General Martha Coakley (in the Caritas Christi/Steward transaction) has noted that the reimbursement rates for psychiatric services are woefully inadequate.

NAMI Massachusetts has long been concerned that there is a constant whittling away of psychiatric beds in Massachusetts hospitals and that there is no longer a robust number of inpatient beds in the Commonwealth. We believe this is an abdication of government responsibility that is a true public health issue. Patients and family members from many parts of the Commonwealth have to travel long distances to see their loved ones in psychiatric hospitals.

Adequate reimbursement rates affect access because hospitals would not be so eager to close psychiatric units if the reimbursement rates were better. We are aware that MassHealth reimbursement rates are lower than Medicare reimbursement rates. Because behavioral health in general is so underfunded (at the inpatient, community and outpatient level), we urge that as this proposal is further developed any efforts to combine MassHealth and Medicare payments do not do so at the risk of lowering reimbursement rates which would harm access.

We also note that many mental health clinics have closed or are close to closing because of inadequate rates from MassHealth.

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in blue ink that reads "Laurie Martinelli". The signature is written in a cursive, flowing style.

Laurie Martinelli  
Executive Director



January 9, 2012

Executive Office of Health and Human Services  
Attn: Lisa Wong  
One Ashburton Place, Room 1109  
Boston, MA 02108

Re: Demonstration Proposal on Integrating Medicare and Medicaid for Dual Eligible Individuals

Dear Ms. Wong:

The Massachusetts Behavioral Health Partnership (MBHP) is pleased to provide brief comments on MassHealth's draft proposal to the Center for Medicare and Medicaid Innovations for a State Demonstration to Integrate Care for Dual Eligible Individuals. We have attended the public meetings held by MassHealth and appreciate the openness and transparency associated with the development of this project.

As the Commonwealth's behavioral vendor for the past fifteen years, we have developed and continue to manage, the majority of the behavioral health diversionary services featured in this draft. We serve a population that includes many of the 'pre-duals' referenced in the program design. It is from these experiences we provide the following comments.

**Behavioral health in the new design:**

- **Patient-centered medical homes, integration, co-location.** We applaud the addition of behavioral health to primary care and vice-versa. We respectfully suggest that this is a many-faceted project and that achieving truly integrated care requires much more than co-location. We would like to see stronger mention of training and support for both behavioral health and primary care providers to assure the success of this integration. We also suggest support for development of specialty ICO's and/or patient centered medical homes for persons with severe and persistent mental illness, given their unique needs.
- **Specific requirements regarding maladaptive substance use.** Behavioral health screening for depression in the primary care site is mentioned. We suggest that screening regarding substance use be explicitly mentioned in the draft. There are well-developed evidence-based practices for screening and brief treatment of substance use in primary care sites and we would like to see that referenced, given the needs of the dually eligible population.
- **Specialty behavioral health services.** In the model, behavioral health is mentioned most often as part of the primary care service. This placement of behavioral health is especially appropriate to assure that all members are screened and can easily access brief, evidence-based treatments in the primary care setting. Additionally, the dually eligible population contains a large number of persons with serious and persistent mental illness who require specialty behavioral care and/or monitoring. We suggest that you consider discussing this interface, and how you will require the PCMH or the ICO to assure that these specialty services are readily available.
- **Requirements for adoption of a recovery orientation and use of peer services.** We are very encouraged to see the addition of these services and approaches in the draft proposal. In our experience, they add an extremely positive element and are directly supportive of the PCMH.

**Leveraging the Commonwealth's existing programs:**

- **Behavioral health services and expertise in coordinating care.** MBHP, as the state's current behavioral health vendor, along with the MassHealth-contracted MCO's, have considerable experience in working with populations similar to the dual eligible population. We suggest that MassHealth consider how this experience and expertise can be accessed and used to support the new program. This could reduce some of the program costs and also speed implementation.
- **Networks and credentialing.** Again, we suggest that MassHealth consider how a program design might include some elements of programs already purchased by the state. Requiring providers and ICO's to build, credential and manage networks of sufficient breadth and diversity to serve the population will be costly and duplicative. Some of these costs could be mitigated if existing resources are used, such as the well-established MBHP network of behavioral health diversionary services.

**General concerns about program design and funding:** The proposed program offers a rich array of services to persons with dual eligibility, and reflects input from many sources. It also creates new entities (ICOs) who will incur costs in setting up networks, quality monitoring and support for the PCMHs. Given the additions, the possible initial upward spending associated with getting the right care in place, and the requirements for PCMHs to have on-site care teams for each member, plus care coordination and care management for some, it seems that rate setting, financial arrangements and program support may be difficult. Again, we encourage the Commonwealth to consider the resources they have already purchased and have in place that may provide less costly, easier to implement processes that could be used for this program.

Thank you for the opportunity to comment on the draft proposal. This is an exciting venture, the results of which will greatly benefit persons with dual eligibility and will also provide us all with valuable information of how new care systems can be most successful.

We look forward to your submission to CMS, its favorable review, and to next steps in this important project.

Sincerely,



Nancy Lane, Ph.D.  
Chief Executive Officer  
(617) 790-5609 (office)  
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## **Commonwealth Care Alliance Feedback for EOHHS Dual Eligibles ICO Proposal**

### ***Introduction***

The *MA Demonstration for Dual Eligibles under 65* represents a unique opportunity where both Federal and state policy are aligned to support more effective care delivery and cost outcomes for this very complex population. This critical policy involves integration at many levels: the integration of Medicare and Medicaid financing, integration of physical and behavioral health services and the integration of acute, primary and long term care - all for populations that have experienced fragmentation of care on every level. This is a great opportunity to work together to fundamentally change the health care system – because the fee for service system is broken and it is particularly ineffective when it comes to people with disabilities who are on Medicare and Medicaid. At the same time, because this is a once in a generation opportunity, we have an obligation to “get it right” – particularly for those populations who stand to benefit the most but are the most difficult to serve.

Given its mission of serving the most complex, government funded consumers of health care in an environment of integrated care and financing, Commonwealth Care Alliance is particularly focused on dual eligible beneficiaries with complex care needs and corresponding high costs of care. According to the recent report from the Massachusetts Medicaid Policy Institute on the likely dual eligible population, 22% of dual eligible beneficiaries under 65 are responsible for 57% of total dual costs. These 22% represent the dual eligibles who use a high level of long-term services and supports (LTSS), either in the community (19% of all duals under 65) or in institutions (3% of all duals under 65). The individuals in this group have significant developmental, physical and behavioral disabilities and many have multiple co-occurring disorders.

There is no experience in Massachusetts and almost none nationally with the enrollment of this segment of the dual eligible population (or for that matter, their Medicaid only counterparts) in integrated delivery systems or managed care. As a result, there is no proven model for what a comprehensive care system needs to look like for these high LTSS utilizing populations. Often these individuals are disconnected from or under-served by primary care and are not receiving basic wellness, preventive health and chronic disease management services. Their physical and behavioral health care as well as their LTSS is provided by multiple organizations each with some responsibility for their care, but with

no overarching accountability for the full service or care plan required; this fragmentation, frequently results in unnecessary emergent, acute and long term care facility admissions. At the same time, many of these individuals have deep and ongoing relationships with providers of long term behavioral health, housing, and other community-based long term services and supports.

Improving the health access and outcomes – and reducing excess costs for these populations - will require the creation and evolution of new models of meaningful primary care that are highly coordinated and integrated with supportive services, based on a partnership between primary care and the full range of behavioral health and other LTSS human services providers. CCA is committed and prepared to invest significant financial resources in collaborative development with health and human services providers, consumers, consumer advocates and others in order to get it right. However, to do so and to be successful, CCA need EOHHS as a partner in segmenting and addressing the unique needs of this 22%, as described below.

### ***The Need for a Demonstration within the Demonstration***

Precisely because the subpopulation of beneficiaries with high LTSS utilization is responsible for such a high share of the costs, relies on a complex web of services and supports, and because there is little experience or evidence-based approaches on which to draw, a standard procurement does not make sense for this segment of the dual eligible population. EOHHS' approach for the population with high LTSS use should be to create a "demonstration within the demonstration" with clinical models, risk adjustment, risk sharing, and enrollment strategies tailored to the needs of the subpopulations that make up the high LTSS users. Using a segmented approach for high LTSS users will permit the use of flexible, creative strategies to care for complex populations starting from the strengths of the ICO model- care teams and care coordination. This "demonstration within the demonstration" would allow EOHHS to work collaboratively with disability-competent and interested ICOs and allow ICOs to work with consumers and providers of LTSS to create and test models for team-based care and integration of physical and behavioral health that make sense given the needs of specific subpopulations such as those with intellectual disabilities or severe and persistent mental illness. These models do not exist currently, so it is important not to commit to a model without evidence.

This recommendation for a demonstration within the demonstration does not necessitate a change from EOHHS' expressed timelines for implementation: go live in January 2013 and achieve scale in 2013. Our recommendation that the population of high LTSS users be segmented from a design perspective does not mean the result will be any less robust or financially sustainable than the overall demonstration – or that it will require a separate team of resources for development. But to be successful in achieving all of the initiative's

objectives including the sustained participation of the beneficiaries targeted, prospective ICOs must develop models collaboratively with LTSS providers who house and serve these populations on a daily basis and work in partnership with EOHHS to create a meaningful demonstration of what is possible. This will allow us to design a program that:

- Creates and demonstrates new **primary care team models** that effectively link primary care, behavioral health, and LTSS in a manner that improves health status and reduces inpatient and emergency care utilization and costs;
- Demonstrates **effective risk adjustment** and permits risk sharing during the ramp up, an essential requirement to attract entities as ICOs to work in this new arena of serving these complex populations new to integrated care;
- Identifies those **community-based long term support services that can be effectively integrated** into a capitated plan.

Each of these key aspects is discussed in greater detail below.

### ***Primary Care and Care Coordination***

An effective model of care for the 22% of beneficiaries who are high utilizers of LTSS will require creating and evolving new models based on developing effective primary care networks that operate in true partnerships with human services providers. In the demonstration within the demonstration, there needs to be the flexibility to customize primary care and care coordination. The model and locus of primary care will differ based on the needs of particular subpopulations such as those with developmental disabilities or severe and persistent mental illness. Primary care may need to be provided in different locations, whether it is in supportive housing or community mental health centers, as well as by newly identified providers to ensure that a responsive and well-coordinated care delivery approach is achieved.

Given the challenges as well as the opportunities, the model of patient centered medical home (PCMH) as it is described in the draft submission is too prescriptive. First, we recommend that there be unequivocal clarity that the expectation is that the ICO will serve as a single accountable entity responsible for the totality of each enrolled beneficiary's care. The current discussion of PCMHs in the draft confuses this expectation significantly. Also, among the PCMHs that exist or are being developed across the Commonwealth, there is very little if any focus on the needs of these very vulnerable sub-populations with highly specialized needs. The design of this initiative needs to support models that are more varied and collaborative – and potentially mobile – far beyond a team based approach within the walls of a physician office as envisioned in the NCQA certification model. The key is that each beneficiary has an individualized care plan as a driver of services and

resource allocation and a person-centered interdisciplinary care team with appropriate skills and roles to develop it and carry it out.

In the most complex sub-populations of duals, there is minimally functioning primary care, let alone PCMHs. Effective primary care for these populations, where it exists, tends to be delivered by caring, compassionate and hardworking providers who are not a part of effective networks of care; increasing numbers of duals with extensive LTSS needs are being served by medical residents in tertiary care settings who change often rendering continuity of care for these beneficiaries nonexistent.. New primary care practices may need to be identified, resourced and/or built and ICOs may need to build capacity around good and willing existing PCPs in the community with team members who can provide components of the model such as home based primary care, care coordination, health education, and behavioral health care. The primary care model needs to allow for the involvement of clinicians currently employed by LTSS providers as agents of primary care and care coordination. Finally, for some clients it will be important to have on the team representatives from independent community based agencies such as Centers for Independent Living, Aging and Disability Resource Centers and caseworkers from existing state agencies such as DDS, DMH, and MRC to facilitate access to community based services.

Finally, the development of both primary care and, in particular, specialty care by ICOs serving this segment of dual eligibles requires the flexibility to accommodate strong preferences around consumer choice. ICOs should be able to work with a broad range of PCPs, assuming they are willing to work with the ICOs model of care, in order to honor current primary care relationships and not be bound by requirements that PCPs meet PCMH standards. In addition, consumers often have long-standing and very effective relationships with specialists. For this population, specialty networks need to be built around the consumer not brought to the consumer. In order to do this, ICOs need the flexibility to work with specialists not in the contracted network or to build flexible contracting arrangement with long time specialists associated with their consumers.

### ***Risk Adjustment***

ICOs working with the 22% of the population with highest LTSS use will need to be assured of accurate risk adjustment if they are to participate in this initiative.

For benefits covered by Medicare, **ICOs must receive an individual, risk adjusted payment directly from CMS.** Medicare has developed a risk adjustment methodology utilizing HCCs that is person-centered and takes into account each individual's complex set of clinical diagnoses and disabilities. Albeit imperfect, this methodology is proven, it is transparent and it has been designed to respect beneficiary rights with respect to the Medicare trust fund. This does not mean that the state cannot participate in savings on the

Medicare side either by receiving a share upfront (directly from Medicare) or more appropriately by sharing in the savings that are achieved in this demonstration.

The Medicaid base capitation rate should be based on meaningful groupings developed in consultation with clinicians and human services providers. It is key that specialized rating categories be created for the LTSS high utilizers and that EOHHS not group high LTSS users with those who are not – no ICO will be able to afford to enroll these clients because there will not be sufficient funds to provide care if this mistake is made. Additionally, it will be important to sufficiently account for planned but not currently provided care coordination, behavioral health diversion and other supports that are anticipated to be part of the demonstration plans' obligations.

Finally, because both the models of care and the risk adjustment are fundamentally untested for these populations, the state should share in the risk in the early years of the demonstration. During the first year of the demonstration, ICOs might receive global per member per month payments but the risk remains with the state. During the subsequent years, the state could implement risk corridors or stop loss, which could be phased out as actual program data improves the risk adjustment methodology. No withholds by the state for quality or pay for performance should be instituted during the first years of the program.

### ***Benefits***

CCA is aware of the concern in the health and human services community about the inclusion of LTSS in the ICO benefits package. There is not a unified answer to this question and there is very little evidence base for decisions in this area. Many questions have not been answered by the EOHHS draft plan, such as whether the rehab option is currently included in the ICO package of benefits.

It is most critical that ICOs be responsible for, and the capitation include, those LTSS that are intimately linked to diverting beneficiaries from hospital and nursing home admission (such as PCA services) and that present opportunities for cost effective service substitutions to be made. Including these benefits allows the ICO to make a determination of need based on an individualized care plan, not algorithms employed by Medicaid. Other LTSS may not need to be part of the ICO global budget but can still be part of an individualized care plan and coordinated by the team. For example, waiver services such as residential care and rehab services are not necessarily critical to include initially. Also, a “demonstration within the demonstration” approach could also allow for pilots that test the effectiveness of different benefit models to begin to develop an evidence base.

## ***Enrollment***

CCA is aware of the impetus at both the Federal and state level to bring this program for dual eligibles to scale through passive enrollment. CCA asserts that the objectives of this policy initiative will not be met if this enrollment strategy occurs. We would request that EOHHS consider and explain to potential ICOs how it can be implemented successfully particularly for the 22% of the dual population who are high LTSS users. CCA encourages EOHHS to consider that beneficiaries will choose to opt out if the program is not credible in its design and approach thus rendering the goal of scale unachieved. Building support for the program with consumers will entail a deliberate program development effort that assures consumer voice at the table, and through this process, a high degree of voluntary participation will result.

Because so many beneficiaries in the high LTSS population do not have meaningful primary care relationships with PCPs, any assignment to ICOs risks being completely arbitrary. Also, there are not significant numbers of qualified, disability competent potential ICOs in our current environment who will design programs to effectively handle the complex needs of the high LTSS users. This capacity needs to be developed over time. To expect that consumers will remain “opted in” given that care environment reality is an unlikely assumption.

For high LTSS users, the success of the program for this group depends on two things that cannot be achieved in a passive enrollment environment. First, each individual must have an individualized care plan from Day 1 of enrollment that governs care delivery, assures continuity of care with existing providers, provides care coordination and oversees appropriate resource allocation. An individualized care plan requires a thorough assessment of the individual’s current health and social support needs as well as an inventory of their care providers. New providers and services will need to be recruited and added to the care team. With passive enrollment, the ICO needs to develop plans for all individuals assigned, many of whom will not even be aware of their “choice” of ICO, from Day 1.

Secondly, key to success is consumer engagement and choice. We urge you that for this complex population, in an environment of demonstration within the demonstration, to allow ICOs the opportunity to work with human service providers, consumer advocates, medical and behavioral health providers to enroll and engage individuals to make a choice of participation in an ICO. We are concerned that an absence of true choice and, therefore, a risk of plan development that is insufficiently responsive and responsible, may well result in consumers opting out of the process entirely and remaining in a fee for service environment. If this happens, it will not only affect the opportunities for those individuals

to receive the benefits of better integrated care, it will also affect our ability to finally prove the concept that this kind of care and financial integration is possible – and better.

CCA understands that for this demonstration within the demonstration to be successful the ICOs have an obligation to achieve substantial scale in a reasonable timeframe. We urge that for this population, in an environment of demo within demo, ICOs be allowed the opportunity to work with consumers, human service providers, advocates and providers to design a fundamentally ground breaking new program in which consumers will want to enroll and engage on a voluntary basis. If that plan is not achieved and sufficient enrollment does not occur, EOHHS could then reconsider alternative approaches.

Finally, the draft plan does not specify if enrollment for ICOs will be daily or monthly. CCA strongly recommends that the monthly enrollment format utilized by PACE and SCO, two similarly positioned clinical care delivery programs, be adopted for this new initiative. This approach allows more time for ICOs to conduct comprehensive assessments of each enrollee and create individualized care plans; this, could all be lost if the individual decides to dis-enroll and re-enter the fee for service system the next day. A monthly enrollment approach is complementary to a voluntary opt in framework.

### ***Geography and Provider Networks***

ICOs that are equipped to enroll special subpopulations may be different from ICOs that enroll the majority of dual eligibles. Because of this, EOHHS should consider allowing different procedures for these ICOs, including having different rollout schedules, geographic definitions, and geo-access requirements. It will be important in designing a demonstration within a demonstration to address the following questions:

- What is the timeframe for the regional rollout?
- Will ICOs be able to operate in only specific geographic regions?
- What will the geo-access requirements be?
- Will there be geographic flexibility since the boundaries cited in the design document to date are based on the current Medicaid MCOs, not the boundaries that ICOs might find more meaningful?
- Will ICOs serving specific populations be able to serve partial geographic service areas or other special circumstances related to serving subpopulations appropriately? For example, exclusive relationships may exist with a small number of primary care sites in a region, but not the region at large.

### ***Data for Planning***

In order to design and model clinical interventions targeted to specific populations, ICOs are in need of additional data on the under 65 Dual population. We understand that MassHealth has received data on Medicaid claims and costs from CMS and linked this to MassHealth data on a beneficiary basis. CCA strongly urges the state to make this data available to prospective ICOs. In addition, we would request population-based profiles that include utilization be made available for planning purposes.

### ***Implications for the Current SCO Program***

Finally, CCA is very concerned about the language in the draft plan and action taken to inform CMS of EOHHS's interest in changing the financing and regulatory framework for SCO. This is very worrisome for those organizations, such as CCA, who have served as pioneers in demonstrating the success of a fully integrated model. In particular, we find the policy unacceptable that individuals in ICOs would continue in that ICO with no enrollment process when they turn 65. This is a problem not just for the 22% who are high LTSS utilizers, but for the entire under-65 dual population. All duals in ICOs need to be informed of the full array of programs for which they are eligible, particularly because the SCO programs are far more robust than the programs that ICOs will put together for seniors during their early years. Not to do so is to invite resistance from senior advocates. At the same time, without a stream of new, turning 65 enrollments, the current SCO programs will become unsustainable.

If it is not the intention of EOHHS to disrupt and potentially dismantle a highly successful program for seniors then we request that this language be removed from the draft. At the same time, EOHHS should convene the SCO entities as well as senior advocates to determine how to build a bridge between ICOs and SCOs. CCA will be eager to play a leadership role in such a process.

### ***Conclusion***

In conclusion, CCA strongly advocates the use of this opportunity to truly “demonstrate” what is possible in serving these populations more effectively. It is imperative that public policy makers recognize that we are creating something new here, not simply procuring something as though it already exists. We do have models and experiences that we can build on, in particular SCO as a single accountable entity where full authority is delegated to one organizational entity to determine how best to organize and provide care. This is fundamentally different from the ICO/PCMH framework that presumes a separation between insurance and care delivery in two separate organizations.

CCA is already deeply engaged in collaborative development of clinical models with health and human services providers, consumers and advocates. And, we are committed to

designing a robust program and creating enrollment channels to achieve a scale of several thousand enrollees in the first year.

It is our belief that this ICO demonstration is a unique opportunity to demonstrate that we can achieve sufficient voluntary enrollment and demonstrate new models of primary care, care coordination, and continuity management. Through a thoughtful design for this initiative we believe that it can be demonstrated that care can be improved and costs reduced through decreasing unnecessary hospitalizations & service use, and that other quality of life improvements such as enabling more enrollees to remain in the community. For the high LTSS population, this will not be an easy task. This model will be successful if it allows for the development of new primary care models, forges relationships between different types of essential providers, integrates the silos of the current care delivery system, and shifts the culture to one of integrated care driven by the needs of the individual enrollee. However, in order to do any of this, we need EOHHS as a partner in designing a demonstration with the demonstration for this segment of the population that addresses risk adjustment and risk sharing, model development and enrollment strategy.

As a company that offers specialty health care solutions to public and private payers, Magellan Health Service's attention is focused on supporting the most costly and complex populations and services in health care today. The depth and breadth of our experience in managing behavioral health care, radiology, specialty pharmaceuticals and administering Medicaid pharmacy benefits enables us to provide invaluable insights and deliver innovative solutions that positively impact both the quality and the cost of many of the nation's fastest growing areas of health care.

Magellan does business with health plans, employers, and State Medicaid programs across the country. We serve:

- Approximately 50 million lives in our Behavioral and Radiology Management businesses,
- 5.5 million lives that are under management in our Medical Pharmacy product
- 42 health plans, pharmaceutical manufacturers, and state Medicaid programs in our ICORE business
- 26 States and the District of Columbia in the Medicaid Pharmacy Benefit Administration business segment

Corporately, Magellan:

- Has over 5,000 employees
- Collectively, provides services to approximately 14% of the US population

Maintaining the highest level of integrity and a commitment to clinical and quality excellence, while containing costs have long been Magellan hallmarks. We believe in the power of partnership and the spirit of innovation and approach every opportunity with these philosophies in mind. By working together with health plans, employers, government agencies, consumers, service providers, and other stakeholders, we are able to leverage these partnerships to deliver innovative cost effective solutions.

It is through these partnerships that we work every day to:

- improve the quality of life and well being for the millions of individuals and families we serve;
- deliver on the promise of high-quality services at a manageable cost; and
- pursue new methods, experts and businesses that support this philosophy and strengthen our company.

We appreciate the opportunity to comment on the draft Demonstration Proposal to the Centers for Medicare and Medicaid Services (CMS) for a State Demonstration to Integrate Care for Dual Eligible Individuals today. We fully support the passive enrollment of eligible members into the program with a voluntary opt-out process in order to facilitate the enrollment of as much of the dual eligible population into the program as possible. The passive enrollment process is absolutely essential to allow for the alignment of incentives and the ability to properly manage the economics in order to deliver the highest level of services. As stated in the demonstration proposal, this element of the program is critical to attracting a sufficient number of Integrated Care Organizations (ICOs) into the program. Without enough members enrolled, it will be difficult for any entity providing care and services under this program to succeed and could very well discourage participation as well as create financial instability in the market.

As an entity with extensive experience providing care to the Seriously Mental Ill (SMI) population, we are particularly sensitive to the importance of maintaining existing relationships with current service providers in order to ensure a smooth transition for members into the new program. We understand

the complex care needs and the importance of respecting member choice to enroll into an entity that will provide continuity of care through providers in the ICO network as well as with available benefits and support services. Therefore, we support the use of neutral and impartial enrollment brokers to assist members with selecting the most appropriate ICO to meet their care needs.

Thank you for your consideration.

Sincerely,

Scott Markovich  
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January 10, 2012

Ms. Lisa Wong  
Executive Office of Health and Human Services  
Commonwealth of Massachusetts  
One Ashburton Place, Room 1109  
Boston, MA 02108

***Re: State Demonstration to Integrate Care for Dual Eligible  
Individuals - BMCHP Comments on Draft Proposal dated  
December 7, 2011***

Dear Ms. Wong:

On behalf of Boston Medical Center HealthNet Plan (BMCHP), a Massachusetts managed care organization and contractor in the MassHealth managed care program, I am writing to state our general support for the Executive Office of Health and Human Services (EOHHS) Proposal to the Center for Medicare and Medicaid Innovation (CMMI) for a Massachusetts Demonstration to Integrate Care of Dual Eligible Individuals dated December 7, 2011 (the Proposal). BMCHP believes that the proposed dual eligible initiative presents a promising opportunity to serve the complex health needs of dual eligible individuals, improve coordination and quality of care for this population, and support the Commonwealth's payment reform efforts.

***Integrated Care Organizations (ICOs)***. BMCHP understands that the proposed program would provide Medicare and Medicaid services to dual eligible adults ages 21-64 through "Integrated Care Organizations" (ICOs), utilizing care management and coordination practices and a patient centered medical home (PCMH) model. BMCHP notes that the Proposal defines an ICO as "an insurance-based or provider-based health organization contracted to and accountable for providing integrated care to enrollees." We assume the term "insurance-based" organization refers to an entity licensed and regulated by a state insurance department, and, by extension, subject to the financial and market conduct requirements that ensure the ongoing financial stability and consumer protections in the event of the insolvency.

BMCHP concurs with the National Association of Insurance Commissioners (NAIC) position that agencies involved in risk-bearing activities should be subject to some form of insurance regulation. We recommend that "provider-based health organizations" that operate as ICOs and assume direct financial risk under the Proposal need to be subject to (1) managed care consumer protection requirements (i.e., rules governing disclosures to members, appeal rights, marketing, etc.) and (2) financial oversight similar to insurance requirements including, at a minimum, the following:

- Minimum net worth requirements

- Annual reporting requirements
- Periodic review and examination of the organization's books and records

We believe that such oversight of provider-based health organizations is essential to ensure that EOHHS and dual eligible individuals receiving services from a provider-based health organization are protected in the event of insolvency of such organization. We therefore suggest that the definition of ICOs be modified to reflect that provider-based health organizations must either be or become licensed by the Massachusetts Division of Insurance or, alternatively, enter into an agreement with a properly licensed Massachusetts insurance-based organization to satisfy the managed care and insolvency standards required by the Massachusetts Division of Insurance.

**Financing and Payment.** BMCHP supports the MassHealth payment reform goals and the payment strategies identified in the Proposal. We share EOHHS' interest in creating a payment model that adequately reflects the cost of services required to support the program, includes appropriate risk adjustment to account for different risk experiences among entities, and includes a mechanism for cost sharing when the cost of services is materially over- or under-estimated.

Creating base rates for the proposed dual eligibles program requires the integration of data from Medicaid and Medicare programs and the establishment of cost estimates for new services. The utilization and unit cost assumptions applicable to all services (and new services in particular), need to be clear to the ICO to support program goals. Specifically, we are aware of the disparity in Medicare and Medicaid payment levels in Massachusetts, and concerned about the willingness of providers to participate in the proposed integrate care program if the payment is inadequate.

With respect to risk adjustment, commonly used models often insufficiently recognize the added cost of the most complex cases, particularly among those with behavioral comorbidities. We urge EOHHS to evaluate risk adjustment methodologies specifically for this program and extend their commitment to continuous improvement, demonstrated under the current MassHealth managed care program supporting Rating Categories I, II, V, and VII, to the dual eligible program. Since this is a new program, EOHHS should utilize a retrospective risk adjustment process for at least the adjustment relevant to the settlement within the risk corridors.

**Enrollment of Dual Eligible Members.** BMCHP understands that the proposed demonstration would employ a voluntary opt-out enrollment process. We recognize that dual eligible individuals tend to be passionately committed to "controlling" their own health care and maintaining relationships with established health care providers. We appreciate EOHHS' efforts to embrace these values through a flexible enrollment process that permits program opt-out, is without a lock-in period and allows members to change ICOs whenever they would like. Nonetheless, based on our experience with the MassHealth managed care program, there are significant administrative, cost, and treatment consequences related to such enrollment policies.

Continuity and coordination of care may be improved and cost savings may be achieved under a longer member enrollment period. Consistent with the savings goals of this

initiative, we urge EOHHS to reconsider a lock-in period for members. There are significant administrative costs to on-board specific types of providers, and the incentives to build these non-traditional provider partnerships are reduced if members may switch plans at any time. It is our understanding that the State of California is considering a limited, six-month enrollment lock-in period for selected dual integration sites. Alternatively, a lock-in period of six or 12 months with a "free look period" of 30-90 days during which time members could switch ICOs is another possible design. We believe these options merit further EOHHS consideration.

Similarly, we suggest that EOHHS consider limiting the number of ICO changes that a dual eligible member may make in a year. Allowing members to change ICOs at any time creates the following concerns:

- Frequent changes make it challenging to produce standardized quality metrics such as HEDIS measures requiring periods of continuous enrollment.
- Frequent changes create continuity of care and care coordination challenges unless there is an established process allowing for the exchange of information and data between ICOs.
- It is likely that ICOs will have less Race, Ethnicity and Language data as enrollees are sometimes reticent or irritated that they need to provide information again if they have just given it to a previous ICO.
- Allowing enrollees to change ICOs at any time makes it more difficult to measure long term health outcomes and program success.
- A pattern of frequent enrollment changes could have an adverse effect on anticipated cost savings for this population. If an ICO wishes to enter into a shared savings model contract with a PCMH group for the three year demonstration period, a constant "churn" of members may result in an ICO paying for savings for which they are no longer responsible.

Should EOHHS ultimately allow members to switch plans at any time, a careful transition protocol and plan needs to be established to ensure coordination of care. A transition period/authorization would need to be in place, in particular for those with a behavioral health (BH) or substance abuse (SA) diagnosis, to allow clinical and treatment information to be exchanged in a manner compliant with applicable regulations. The risk of disruption to BH care along with the privacy restrictions imposed by state and federal regulations present significant obstacles for coordination expectations.

**Complaints, Grievances and Appeals Processes.** The Proposal refers to developing a "robust unified internal and external complaints, grievances and appeals processes." Currently, MassHealth, Commonwealth Care, Medicare and commercial products each are subject to different and complex appeal and grievance regulations, and insurance organizations that offer multiple programs or products must comply with different requirements. Multiple processes add to administrative costs and are potentially confusing to members. To the extent feasible and consistent with applicable regulatory requirements for dual eligibles, EEOHS should make every effort to avoid a

Ms. Lisa Wong  
January 10, 2012  
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separate grievance and appeals process necessitating separate processes, policies and procedures. Instead, EOHHS should seek to utilize existing robust processes wherever possible.

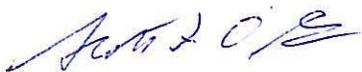
*Patient Centered Medical Homes.* As we move towards establishing patient centered medical homes (PCMHs) for this population, we encourage EOHHS to consider additional and emerging models of PCMH integration, such as use of a Community Support programs, PCP preferred behavioral health providers (not necessarily co-located) or other types of peer navigators to assist with coordination of care and service delivery.

BMCHP urges EOHHS to work collaboratively with NCQA to reach agreement about the “complex care management” delegation requirements as they pertain to PCMH, especially while a provider group is actively working towards obtaining NCQA PCMH certification. Until the group achieves the certification, there would need to be duplication of efforts under NCQA health plan delegation standards, leading to enrollee confusion. We believe that setting adequate PCMH access standards and EOHHS engagement in providing training and other supports for the PCMHs are very important components of further defining the PCMH model.

***Implementation Strategy and Anticipated Timeline.*** BMCHP applauds the comprehensive work to date on this demonstration program. However, we urge EOHHS to carefully assess the timeline outlined in Section G.iv. Specifically, we are concerned that the proposed four-month contract readiness period may be inadequate, and urge EOHHS to remain engaged with potential ICOs to determine an implementation plan and timeline that will support the success of the demonstration program.

BMCHP looks forward to opportunities to collaborate with EOHHS in workgroups and other meaningful forums in the further development of the Massachusetts program for dual eligible individuals. We look forward to sharing our considerable experience in managed care and complex case management with the Commonwealth to meet the quality and cost goals under this demonstration. We thank you for your consideration of these comments and request that you consider the attached questions as you refine the Proposal.

Sincerely,



Scott O’Gorman  
Executive Director  
Boston Medical Center HealthNet Plan

The leading voice for hospitals.

January 10, 2012

Lisa D. Wong, Procurement Coordinator  
Executive Office of Health and Human Services, Legal Unit  
Commonwealth of Massachusetts  
One Ashburton Place, 11th Floor  
Boston, MA 02108

***Re: EOHHS Proposal to CMS for a Demonstration Program to Integrate Care for Medicare and Medicaid Dual Eligible Individuals***

Dear Ms. Wong:

On behalf of our member hospitals and health systems, the Massachusetts Hospital Association (MHA) appreciates this opportunity to provide further comment on the commonwealth's Medicare and Medicaid dual eligible proposal that will soon be submitted to the Center for Medicare and Medicaid Innovation (CMMI). We thank you for including hospitals in the stakeholder process and we look forward to continuing to work with the administration on this initiative.

Massachusetts hospitals are committed to healthcare delivery and payment reform, including efforts to further integrate patient care through care coordination, Accountable Care Organizations (ACOs), and new payment methods such as global payments. The commonwealth's dual eligible proposal embraces these concepts and we believe it has promise to one day improve the healthcare experience for these patients as well as produce cost savings for both the healthcare system and state government. For these reasons, we support the submission of this proposal with the recommendations described below and the understanding that we will address more detailed issues as they arise.

With an undertaking as significant as this, the challenges will be numerous, the amount of change is great, and the concerns of both patients and healthcare providers are many. Collaboration, fairness, and realistic expectations will be needed over the long-term for this program to be successful. We look forward to continuing to work together to ensure that the new program addresses the needs and concerns of patients and health care providers.

***Provider Reimbursement***

Under the existing dual eligible process, hospitals and physicians are paid predominantly by the Medicare program. Hospitals are very concerned that under this new demonstration program, reimbursement rates could be set lower than Medicare currently pays.

MassHealth currently fails to reimburse hospitals adequately, due in large part to the state's continuing fiscal challenges. MHA estimates that hospitals were paid approximately 71 percent of cost on average in fiscal year 2011. We estimate that Medicare covered 93 percent of costs on

average in fiscal year 2011. Adoption of Medicaid payment rates for hospital and physician services for this population would be unacceptable as it would exacerbate the severe Medicaid underpayment problem.

In the proposal, EOHHS envisions a 3-way contract between CMS, MassHealth, and Integrated Care Organizations. MassHealth will propose that CMS and MassHealth will together negotiate with the ICO, but that CMS and MassHealth will contribute separately to the single base capitation rate paid to the ICO. MHA views the change to a 3-way contract as a significant positive development compared to the original proposal which had assumed EOHHS control of Medicare funding.

The proposal states that both Medicare and Medicaid historical payments will be used in developing the base capitation rates paid to ICOs. It is our understanding that in developing the capitation payment, hospital and physician services will be priced primarily based on historical *Medicare* payments as that is the current primary source. This assumption is an important provision for the state in order to ensure adequate funding to cover this program. It is also important to note that historical Medicare payments are constantly changing, so an adjustment to reflect current-year Medicare hospital payment rules should also be consider including adjustments for wages, medical education, and disproportionate share hospitals.

MHA notes, however, that there is no language that describes what the ICO is expected to reimburse hospitals and physicians. MHA believes that for Medicare-covered services, providers should at the minimum be reimbursed at Medicare rates. If an ICO were to reimburse hospitals below Medicare rates, we believe that would negatively affect the ability of providers to care for this population. We also believe it would threaten the success of this new initiative as it would distort the market for Medicare services and could make it financially difficult for providers to participate in the program.

Hospitals are strained already by the Medicare reimbursement cuts from the Affordable Care Act. Additional cuts are now a real possibility given federal budget deficit discussions on Capitol Hill. While Medicare reimbursement rates are less than adequate, MassHealth rates are unfortunately far worse given multi-year Medicaid cuts.

Since this issue extends beyond just financial ramifications for healthcare providers, we believe EOHHS and CMS must require a floor to protect providers currently reimbursed by Medicare. Under this new initiative, more will be expected of providers and it would unfair and unreasonable to expect hospitals and physicians to be paid less than the current Medicare rates.

Out-of-network providers must also be protected. Hospitals are required by law to provide care to Medicare beneficiaries. If a dual-eligible beneficiary receives care at a hospital that is not affiliated or contracted with the ICO, hospitals should, at the least, be reimbursed the Medicare rate.

MHA requests that EOHHS modify its proposal to state specifically that ICOs will be required to reimburse providers (both in-network and out-of-network) at reimbursement rates no less than Medicare fee-for-service rates for Medicare covered services.

### ***Shared Savings***

The proposal references incentive payments for quality measures and achieved savings that seem to relate specifically only to ICOs. While contract arrangements between ICOs and healthcare providers could very well include such provisions, we believe EOHHS should state clearly that it expects the savings generated by this initiative be shared by all that help to achieve positive results, including healthcare providers. Collaboration on this new payment-and-delivery model will extend beyond EOHHS, CMS, and an ICO. Hospitals and other providers will be instrumental to this program's success and their efforts to produce positive results in care management and health outcomes should be recognized.

### ***Provider Networks***

As described in the proposal, the dual-eligible population is one with varying levels of chronic conditions, physical and behavioral health, and cognitive disabilities. Their healthcare needs can be intensive and complex, and therefore their continued relationships and access to their healthcare providers is vital. Given the unique circumstances of these patients, the new program should make maintenance of provider-patient relationships a priority. MHA supports provisions that aim to ensure provider access for dual-eligible patients, including requiring ICOs to permit willing and able providers that currently care for these patients to be included in an ICO's provider network.

### ***Integrated Care Organization***

An Integrated Care Organization is defined in the proposal as an insurance-based or provider-based health organization. MHA believes this term presents confusion given the larger issue of payment and delivery reform underway in Massachusetts and nationally, which is centered on the concept of integrated care. We believe the ICO term is more commonly thought of as relating to healthcare providers, not health insurers, and is sometimes used interchangeably with ACOs. For example, in Governor Patrick's 2011 payment reform legislation, an ACO is defined as "an entity comprised of provider groups which operates as a single integrated organization..." Similarly, ACO models described in the state's Special Commission on Payment Reform are also provider based<sup>1</sup>.

We believe state government's first initiative related to payment and delivery reform should not confuse this important term. We suggest using a different term, such as "Contracted Dual-Eligible Health Entities," which shall be insurance-based or provider-based health organizations.

### ***ICO Risk Assumptions***

Global payments paid to ICOs will involve the assumption of risk by the ICO. MHA is pleased that MassHealth recognizes that precautions will be needed to mitigate risk so that ICOs are not exposed to sizeable shortfalls. Inadequate payments to ICOs will only pressure these organizations to make unpleasant decisions related to provider reimbursement, provider networks, and how services are managed. Financial uncertainty, especially in a new demonstration program involving patients with chronic and multiple medical conditions, should be limited to prevent failure of this initiative.

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<sup>1</sup> "Recommendations of the Special Commission on the Health Care Payment System", Commonwealth of Massachusetts, July 16, 2009, pg. 53 [http://www.mass.gov/Eoohhs2/docs/dhcfp/pc/Final\\_Report/Final\\_Report.pdf](http://www.mass.gov/Eoohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf)

### ***Timeline***

The EOHHS proposal envisions releasing the ICO procurement in the Spring of 2012 and selecting ICOs by mid-2012. Selected ICOs would have four months for contract readiness activities, and enrollment packages would begin to go out to the target population in October 2012. Enrollment is expected to begin in January 2013.

MHA believes this timeline is very aggressive and perhaps not realistic. It will take considerable time to settle the details of blending two different entitlement programs, each with its own set of rules, benefits, and payment assumptions. The ICO RFI process will likely be very complicated. After ICOs are determined, contracting with providers will not be simple. If current Medicaid MCOs are selected, their current contracts with providers will not be applicable given the Medicare reimbursement basis for many healthcare provider groups. New contracts and even payment methodologies will have to be developed, which will take time to negotiate. And providers will need to understand the details of the new program before entering into contract with ICOs.

We understand that any project must have timelines, but establishing a program that meets the needs of providers and patients, and is comprehensible to all stakeholders in every necessary detail, must be the priority.

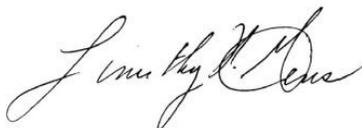
### ***Other Provisions***

MHA recognizes that this EOHHS proposal only begins to touch on the many details involved with developing a new Medicare/Medicaid program for the dual-eligible population. Issues that were not mentioned but are important to hospitals include the following:

- Medicare and Medicaid provider requirements, including discharge planning requirements, notices of services, payment obligations, and adverse incident/SRE reporting obligations to the patient and the program under Medicare and/or MassHealth.
- Medicare reimbursement for bad debt related to these patients. Hospitals currently receive an adjustment of 70% for bad debt expenses related to Medicare-covered services not paid for by the patient or other payers.
- Medicaid cross-over claims, such as Medicare co-insurance paid by Medicaid.
- Medicare and Medicaid inpatient day classification for purposes of determining Medicare Disproportionate Share Hospital (DSH) adjustments.

We thank you for your consideration of our comments. We look forward to working with the Patrick Administration, CMS, and others in the healthcare community on this initiative.

Sincerely,



Timothy F. Gens  
Executive Vice President & General Counsel  
Massachusetts Hospital Association

Lisa Wong

Executive Office of Health and Human Services

One Ashburton Place

Boston, MA 02108

**Comments of the Massachusetts Medical Society Concerning EOHHS's Medicaid-Medicare Dual Eligible Proposal**

The Massachusetts Medical Society wishes to commend the Patrick Administration for the process and the approach it has taken in addressing the needs of dual eligible patients. Meeting the needs of the most complex patients is a daunting task and the proposal put forth includes key elements which the MMS has adopted as essential in any meaningful and effective reform. The MMS House of Delegates adopted these principles for payment reform through our representative meeting system of governance. The full list of principle is included at the end of this testimony. They are consistent with the process and goals outlined in your approach.

**One size will not fit all**

On page 9, the proposal recognizes the importance of continuity of care and of facilitating the maintenance of existing physician patient relationships as new entities are formed. Additionally the proposal supports the concept that out of network providers may be necessary to meet the unique needs of individual patients. The MMS urges that Independent Care Organizations must be required to offer meaningful contracts to all willing physicians who currently treat dual eligible patients and other providers as necessary to meet the needs of these patients.

The MMS strongly supports opt out provisions for this project which will allow patients with complex needs to maintain existing relationships or form new ones when their needs are not met. We have high hopes that this pilot project will create new models of care that are increasingly effective, but the health of individual patients should not be sacrificed in models unsuited for their clinical needs.

**Fee-for-service payments still have a role**

As noted, complex patients may need the services of unique and out of network providers. We are pleased the proposal recognizes this possibility and urge more complete adoption of language to meet access needs of patients.

**Adequacy of Rates**

Central to the effectiveness of the pilot project is the adoption of adequate rates of payment for providers who choose to participate. ICO's must provide meaningful rates to providers both in and out of network to make this pilot work for patients, providers and the Commonwealth. The

MMS strongly suggests that bidders be required to reimburse providers at a least 2011 Medicare rates rather than lower MassHealth levels.

### **Person-centered Medical Home**

The MMS strongly supports physician directed patient centered medical home models. The MMS is concerned that the model outlined in pages 11-14 is permissive rather than restrictive in its requirements that a “PCMH care team may consist of a lead primary care or behavioral health clinician..” Clearly dual eligible patients should have a lead primary care physician or physician supervised nurse practitioner or physician assistant on their team. Patients with behavioral health issues as their basis for eligibility should have qualified physicians or physician supervised behavioral health providers leading their teams. The MMS strongly supports the creation of teams of clinicians and support services for complex patients. It is our strong belief that care must be integrated with the complex co-morbidities of dual eligible patients handled in a comprehensive and coordinated way. Therefore we believe that physicians should be in leadership roles in person centered medical homes.

### **Final Points**

The MMS supports the efforts of the Administration to move forward with health care reform both to improve quality and to reduce the rate of growth in costs. We support the transparency of the process that has created this project. We urge continued transparency in the process as it develops towards a model of comprehensive care. For example, measures of quality in new systems must be carefully monitored to ensure that they result in clinical improvements rather than measurement of a few chosen tests or interventions for all patients. Quality measurements must have value or they become an impediment to patient centered care.

The MMS appreciates the opportunity to comment on this exciting proposal both in this testimony and throughout the process. We stand ready to work with the Administration towards increased effectiveness of patient centered medical care.

## **MMS Principles for Health Care Reform**

- 1. Physician leadership.** Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.
- 2. One size will not fit all.** One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.
- 3. Deliberate and careful.** Efforts must be undertaken to guard against the risk of negative unintended consequences in any introduction of a new payment system.
- 4. Fee-for-service payments still have a role.** While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments will likely should be a component of subset of any global payment system.
- 5. Infrastructure support.** Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.
- 6. Proper risk adjustment.** In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.
- 7. Transparency.** There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.
- 8. Proper measurements and good data.** Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for

both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.

**9. Patient expectations.** Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

**10. Patient incentives.** Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.

**11. Benefit design.** Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.

**12. Professional liability reform.** Defensive medicine is not in the patient's best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.

**13. Antitrust reform.** As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.

**14. Administrative simplification.** Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Physicians should be protected from undue administrative burden, or should be appropriately compensated for it.

**15. The incentives to transition.** In order to transition to a new model, incentives must be predominantly positive.

**16. Planning must be flexible.** Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.

**17. Primary care physician.** All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.

**18. Patient access.** Health care reform must enable patient choice in access to physicians, hospitals and other services, while recognizing economic realities.