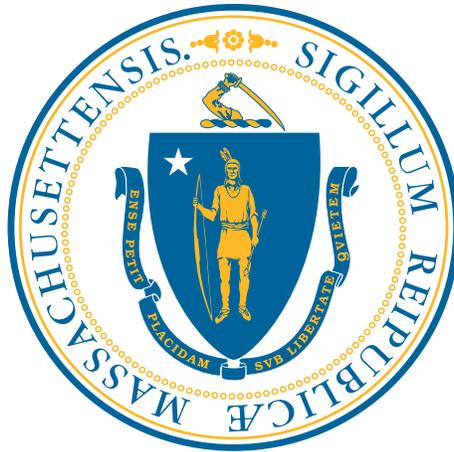


**COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID**

**PROPOSAL IN RESPONSE TO THE
CENTER FOR MEDICARE AND MEDICAID INNOVATION:**

***STATE DEMONSTRATIONS TO INTEGRATE CARE FOR
DUAL ELIGIBLE INDIVIDUALS
(RFP-CMS-2011-0009)***



January 28, 2011

1. High Level Description of Massachusetts' Proposed Approach to Integrating Care

Pursuant to new authority available through the Patient Protection and Affordable Care Act (ACA), MassHealth (Massachusetts' Medicaid program) is submitting this proposal in response to solicitation #RFP-CMS-2011-0009, State Demonstrations to Integrate Care for Dual Eligible Individuals, to test and evaluate a model of care delivery for dual eligible adults ages 21-64 that fully integrates the delivery and financing of all Medicare and Medicaid services for this population.¹ Under the proposed model, MassHealth will assume complete operational responsibility for the care of this population—comparable to its responsibility for its MassHealth-only membership—including the administration, management and oversight of all Medicare-funded and Medicaid-funded services. MassHealth believes this unprecedented level of integration is necessary to achieve better health outcomes for this population and to provide higher quality, more cost effective, person-centered care.

Massachusetts' initiative to integrate care and financing for dual eligible adults ages 21-64 is a fundamental component of a broader effort in Massachusetts to transform its health care system by restructuring how care is delivered and how providers are reimbursed. Massachusetts' reform efforts include initiatives to develop patient-centered medical homes, bundled payments, accountable care organizations, and state legislation to require a transition from fee-for-service provider payments to global payment methodologies. Most of these initiatives are supported by opportunities in the ACA. Through these initiatives, Massachusetts seeks to ensure access to appropriate services, integrate comprehensive services at the person level, improve care coordination, and create payment systems that hold providers accountable for the care they deliver. Massachusetts aims to reward quality care, improve health outcomes, and more effectively spend health care dollars.

A. Problems with the Current Coverage and Payment Policy for Dual Eligibles Ages 21-64

Currently, care for dual eligible adults ages 21-64 is fragmented, unmanaged and uncoordinated at the program level, and based on an inefficient fee-for-service (FFS) provider payment system. Different eligibility and coverage rules in MassHealth and Medicare contribute to these problems. The current system lacks sufficient care coordination for the comprehensive services this population needs, which inhibits access to critical services, particularly community-based behavioral health services, and encourages cost-shifting between providers and payers. All of these factors adversely impact this population's quality of care and health outcomes and contributes to MassHealth and Medicare spending problems.

State and federal spending is inefficient and unsustainable: Massachusetts projects that combined spending on its dual eligible adults ages 21-64 will reach \$3.85 billion in 2011; \$1.27 billion in Medicare expenditures and \$2.58 billion in MassHealth expenditures.² For dual eligible adults ages 21-64 in FFS, few of these expenditures are used for care management. As this group uses a wide array of services, the lack of care management may increase the incidence of duplicative services, contraindicated therapies and drugs, and inefficiencies in care.

Insufficient care coordination: Most MassHealth dual eligible adults ages 21-64 have complex care needs (approximately 76% have a chronic medical condition in addition to a disability), but most lack access to integrated care systems that approach care delivery from a holistic, person-centered perspective and promote care management and care coordination. Dual eligible adults ages 21-64 do not receive managed care under current MassHealth program rules, and are limited to receiving their services in the uncoordinated FFS environment. Dual eligible adults tend to use a variety of acute and primary care services, behavioral health services, and long term services and supports (LTSS), but these areas of a person's care often are disconnected in the current delivery system. Individuals may experience limited pockets of case management for certain sets of services (e.g., case management for Home and Community Based Waiver (HCBW) services or Medicare Advantage plan management of acute Medicare services). However, case management focused on only one area of a person's care is less effective than comprehensive care management that addresses all aspects of care.

Challenges for providers: In the current FFS system, particularly when multiple payers are involved, providers face challenges communicating and collaborating with one another about a person's care. Providers may not be aware of the different types and sources of care provided or available to the dual eligible individuals they serve. Further, neither Medicare nor Medicaid programs have the right incentives to offer providers reimbursement for a full range of services to meet those needs. Many FFS providers lack the information systems, reimbursement incentives, and financial and staff resources necessary to coordinate the comprehensive care needs of dual eligible individuals and to help ensure these individuals receive the highest quality, most cost effective services in the right settings. Further, providers have the administrative burden of billing and navigating

¹ Dual eligible elders in Massachusetts already can access programs that integrate Medicare and Medicaid services and, to some extent, integrate financing, including the voluntary Senior Care Options (SCO) program and the Program of All-Inclusive Care for the Elderly (PACE).

² Projections derived from per capita estimates for dual eligibles from: MedPAC Report to the Congress: Aligning Incentives in Medicare. "Chapter 5: Coordinating the care of dual-eligible beneficiaries." June 2010, page 135.

different sets of policies, procedures and reimbursement rules for two different government programs as they attempt to provide comprehensive care.

Challenges for beneficiaries: Dual eligible individuals with complex care needs interact frequently with various parts of the health care system; many simultaneously use acute care services, Medicaid or state-funded LTSS, behavioral health services, prescription drugs, and other supports. In a FFS system, many of these individuals, who already struggle with the daily challenges of their conditions or disabilities, must arrange their own care. This may entail communicating with multiple providers, coordinating numerous doctor appointments and arranging for transportation needs. These activities may be even more difficult and complex for individuals with cognitive impairments.

Inadequate access to coordinated behavioral health services: A subgroup of particular concern is individuals with behavioral health needs. These beneficiaries represent a substantial portion of dual eligible adults ages 21-64, and face particular challenges with accessing appropriate care. The integration of behavioral health and medical care is an important challenge in any health care system, but it is especially problematic for dual eligible individuals who need to navigate across different payers. In 2008, 64% of MassHealth dual eligible adults ages 21-64 experienced chronic mental illness and/or substance abuse. However, MassHealth FFS and Medicare services together constitute an incomplete continuum of behavioral health services. Behavioral health services provided by the two programs are generally limited to only acute inpatient psychiatric care, acute substance abuse services, psychiatric day treatment, and traditional behavioral health ambulatory care. Medicare and MassHealth's FFS systems also lack the infrastructure to coordinate behavioral health care services for dual eligible beneficiaries. Massachusetts proposes to offer, through this model, both care coordination and expanded behavioral health services, including a broad array of diversionary services, all of which will support more effective care and avoidance of inpatient psychiatric treatment.

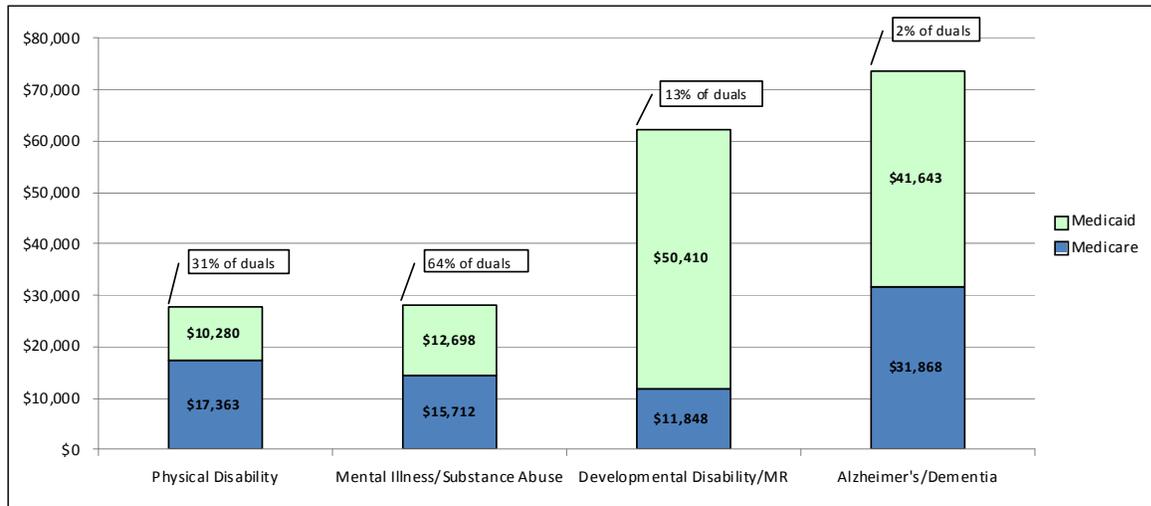
Lack of integration fosters cost-shifting and underinvestment: Medicare and MassHealth coverage rules create unintended incentives for cost-shifting among providers and between payers. With two parallel but unaligned systems of care, providers and payers can avoid costs by transferring beneficiaries from one service or setting to another that is the responsibility of a different provider or payer. This practice unnecessarily increases state and federal spending, may not be in the best interest of the beneficiary, and could adversely affect the beneficiary's health. MassHealth could, in the existing framework, pursue bringing diversionary behavioral health and LTSS into the service mix for dual eligible individuals that could substantially impact acute care spending and health outcomes. However, there is no current mechanism by which resulting acute care savings accrued by the Medicare program can be redirected to the Medicaid program to help finance the increased non-acute spending. The net effect is an underinvestment in appropriate, cost-effective care for dual eligible adults.

B. Massachusetts' Proposed Demonstration Model

Target population: Massachusetts will target for enrollment in the new integrated care model the 115,000 MassHealth beneficiaries ages 21-64 who receive full MassHealth benefits and who are also eligible for Medicare. MassHealth is focusing on dual eligible individuals in this age group because they do not currently have access to an integrated care model. MassHealth has performed preliminary analyses using a linked Massachusetts Medicare/Medicaid FFS dataset for this target population.

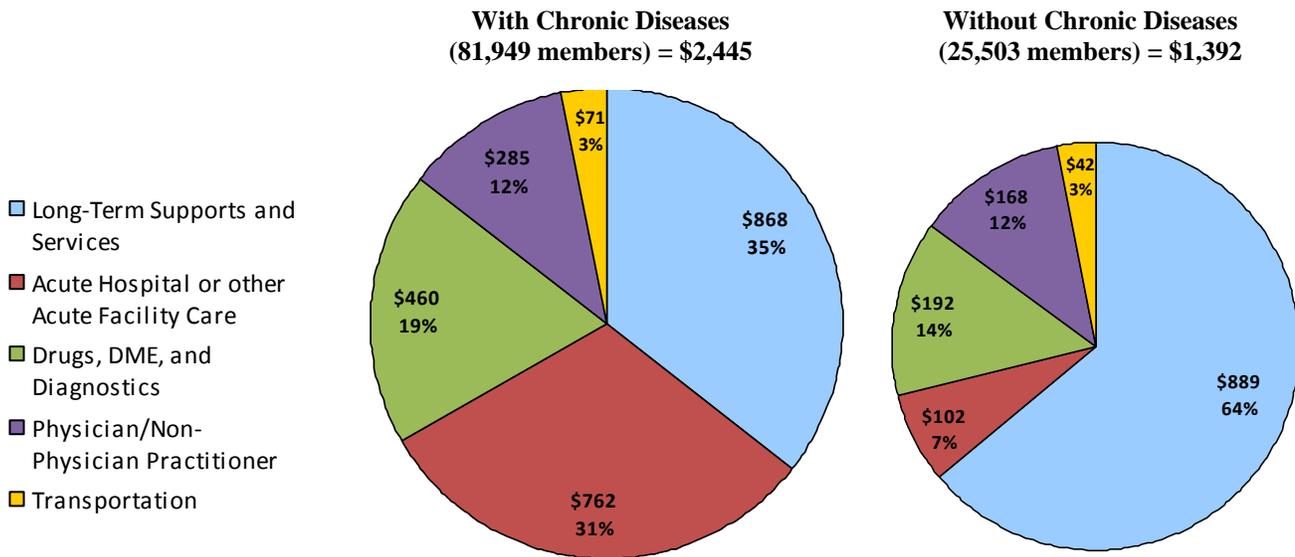
Within the target population are distinct groups of beneficiaries with a wide array of care needs, health conditions, and spending profiles (see Table 1).

Table 1: 2008 Dual Eligible Adults (ages 21-64) in FFS: Per Capita Annual Spending by Payer and Type of Disability³



The service mix and spending profiles of the target population will be further evaluated in the ongoing model design phase. The data also show that individuals with chronic diseases spend significantly more on acute hospital care, prescription drugs, durable medical equipment and diagnostics than those individuals without chronic diseases (see Table 2).

Table 2: 2008 Dual Eligible Adults (ages 21-64) in FFS: Combined Medicaid and Medicare PMPM Spending by Service Category, with and without Chronic Diseases³



MassHealth will use planning funds during the design phase to conduct detailed analyses on the target population particularly to determine the expanded long term services and supports that would be most effective in the model, and to develop strategies to more efficiently care for the subset of the population that drives a large portion of spending. Massachusetts' preliminary analysis on the linked data set shows that 23% of duals in the target population account for 76% of total Medicare and Medicaid combined spending. They further account for 84% of Medicare's acute care spending for the target population. Integrating care has the potential to greatly contribute to quality improvements and potential savings which could be reallocated to better meet the needs of the entire target population.

Massachusetts plans to design its integrated care model in a manner that maximizes the target population's participation in the program. Historically, enrollment by dual eligible individuals in managed care nationwide has been low due to the general lack

³ Preliminary analysis on MassHealth's linked Medicare and Medicaid data set for Dual Eligible Adults ages 21-64 – CY2008. Massachusetts' Response to RFP-CMS-2011-0009

of experience by care entities in managing long-term care, costly initial program investments and uncertain financial impacts, separate Medicaid and Medicare administrative rules, and discomfort of beneficiaries and their advocates with managed care. However, sufficient levels of enrollment in this new model will be critical to expand access to services and care coordination, improve quality of care and health outcomes, and effect delivery system and financing system changes. The ability to realize the savings potential of this proposed model is dependent on assuring adequate enrollment in the integrated care entities. As Massachusetts designs the demonstration model, it will work closely with its actuary and with stakeholders, including consumers, advocates, and providers, to determine what features will provide the most value to beneficiaries and how best to encourage maximum participation. Stakeholders already have identified several features that may make an integrated care program attractive to the target population, including continued access to existing providers, expanded access to community-based supports, and assistance with scheduling specialist appointments.

Service delivery system: Massachusetts' integrated care model for dual eligible adults ages 21-64 will be implemented statewide. Through a bidding process, MassHealth will use combined Medicare and Medicaid funding to contract with entities to integrate comprehensive care at the person level, and provide both MassHealth and Medicare services. These integrated care entities will deliver care with a person-centered approach that ensures that all of the health needs of individuals in the target population are met and coordinated across the health care and long term support delivery system. These entities will be evaluated based on a comprehensive set of quality metrics that will be developed to assess their performance. While this model builds off of MassHealth's experience with the SCO program, Massachusetts proposes administering this program at the state level. Massachusetts will significantly improve the alignment of financial incentives and provider accountability by making one global payment for all Medicare and Medicaid services, a broader continuum of behavioral health services, and community support services.

The key design principles of the proposed model are:

1. **Person-Centered Care**: Places the dual eligible individual and, at the individual's discretion, family members and other informal caregivers, client advocates and peers, at the center of the care team to ensure person-centered planning and promote self-direction;
2. **Comprehensive Care Coordination**: Maintains a close relationship between the beneficiary, primary care practitioners, care coordinators, and all other providers of services; relies on a team-based approach to care delivery; performs comprehensive care assessments, care planning, self-management coaching; has a regular process for monitoring and updating care plans; provides particular focus on improving transitions between care settings; and, addresses intensive care management needs of populations with specific challenges (e.g., homelessness, complex medical conditions, substance use disorder);
3. **Accountability for Delivery of Covered Services**: Identifies one entity as accountable for the delivery and management of all covered health and support services for each individual;
4. **Improved Health Information Technology**: Uses mechanisms to collect, store, integrate, analyze and report data in a timely manner, including the measurement of person-level outcomes and identification of high utilizing members for increased attention; and to support comprehensive care coordination across providers and settings of care;
5. **Quality Management**: Measures health outcomes, adheres to evidence-based best practices and promotes continual quality improvements;
6. **Administrative Simplicity**: Unifies policies, procedures, payments and administrative processes;
7. **Financial Integration**: Uses an alternative payment methodology; a single global Medicare/Medicaid payment with incentives for quality outcomes, efficient health care delivery and effective care coordination; and employs mechanisms to ensure appropriate risk adjustments for the population and risk and savings arrangements; and,
8. **Health Disparities**: Increases access to care, provides care and develops care teams with awareness of the cultural perspectives and languages of beneficiaries, and is accountable for quality metrics aimed at reducing incidences of health disparities.

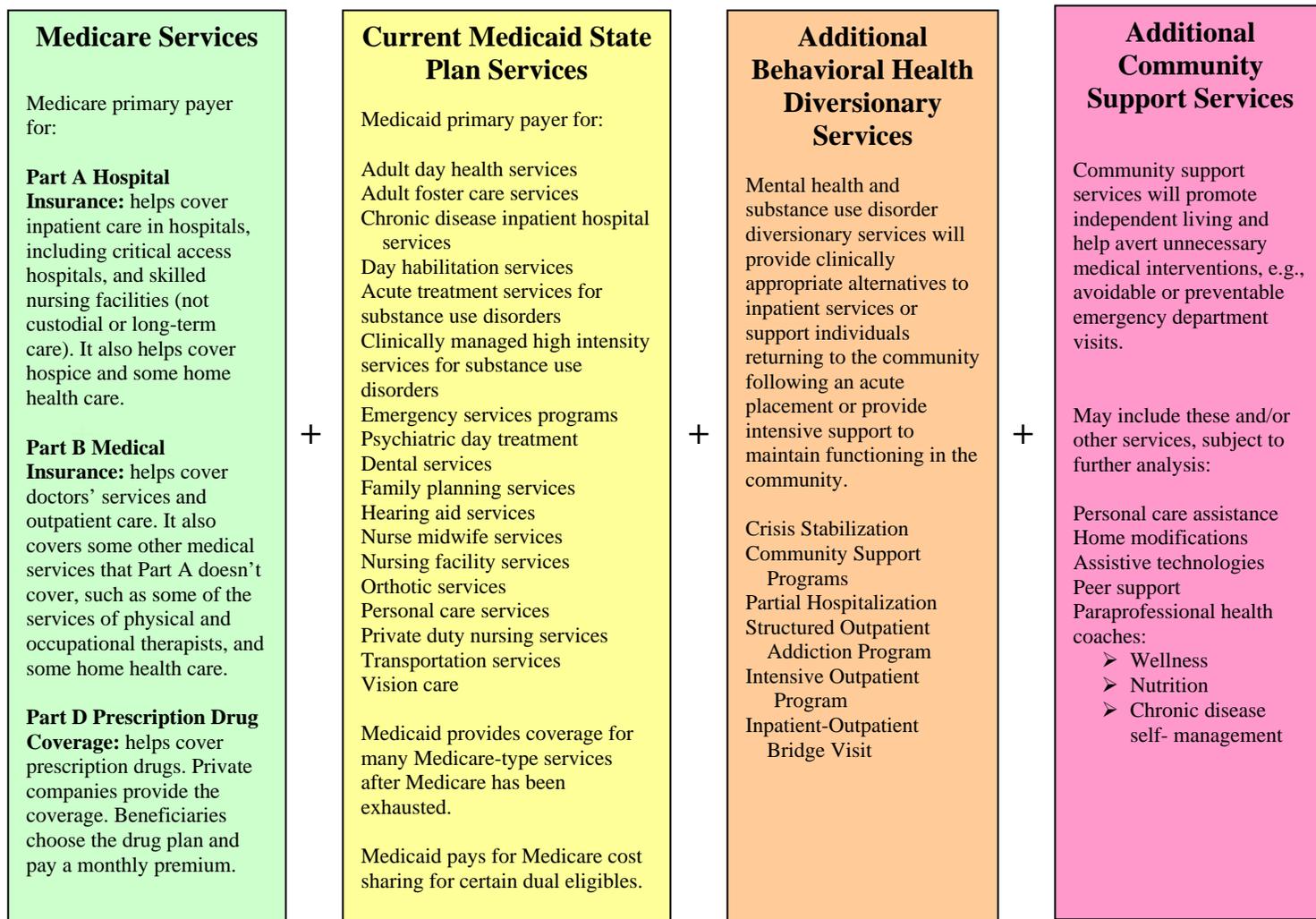
MassHealth's efforts would be geared toward attracting as potential bidders a variety of existing and emerging entities to provide integrated care. These include, but are not limited to: managed care entities (MCOs, SCOs, and other Special Needs Plans), direct care provider networks, community health centers, patient-centered medical homes, acute hospital networks, and accountable care organizations. The entities must demonstrate experience and a broad range of competencies to deliver care to disabled persons, persons with chronic behavioral health diagnoses and those with chronic medical problems. MassHealth is interested in considering innovative approaches to care delivery and entities that can successfully address the diverse needs of the target population consistent with the design principles of this new model. Massachusetts seeks technical assistance and funding under the contract award for this demonstration to develop the standards, criteria, and quality metrics for participating integrated care entities.

The baseline requirement is that integrated care entities must administer Medicare and MassHealth benefits jointly so that participants will experience their coverage as a single, integrated care program. The entities will be built on a foundation of

primary care practices that possess the core competencies for patient-centered medical homes as defined by Massachusetts’s multi-payer Patient-Centered Home Initiative (PCMHI)⁴, meet certain health information technology requirements and have highly developed acute, primary care, behavioral health, and LTSS provider networks.

Covered services: MassHealth would contract with the integrated care entities to deliver all Medicare covered services, MassHealth Medicaid state plan services, an expanded continuum of community-based diversionary behavioral health services, and key community support services that promote health and independence. Access to this expanded set of community-based services and supports is intended to facilitate stability in the community and to prevent or reduce frequent hospitalizations, emergency room use, and long-term care facility stays. A major focus of the design work will be to continue to leverage Medicaid and merged data sets; to obtain stakeholder input from beneficiaries, advocates, providers, insurers, and academics; and to conduct actuarial analysis to solidify the specific set of services to include in the globally-paid unified benefit package.

DRAFT COVERED SERVICES



Financing Model:

CMS Medicare payment to MassHealth: MassHealth proposes creating a new financing mechanism that combines, at the state level, the Medicare and Medicaid funds for dual eligible adults ages 21-64 who enroll in an integrated care entity. MassHealth proposes that CMS provide Massachusetts with Medicare funds for these individuals along with the responsibility for ensuring provision of that care. CMS would provide MassHealth with a negotiated Medicare payment per participant, which Massachusetts will put in a protected account, to be joined with Medicaid dollars to pay the integrated care entity. The level of Medicare funding would be consistent with the amount that Medicare would have spent for these individuals absent the savings

⁴ The PCMHI Core Competencies are described in a white paper, available at: http://www.mass.gov/Eeohhs2/docs/eohhs/healthcare_reform/med_home_framework.pdf.
Massachusetts’ Response to RFP-CMS-2011-0009

created by this new model. MassHealth expects to use the design phase of this project to develop with CMS the methodology to determine the appropriate level of Medicare payment and to assess risk adjustment approaches and mechanisms, such as shared savings and/or risk corridors.

MassHealth payment to integrated care entities: MassHealth plans to provide a global payment that reflects the full set of covered services, as well as administrative and care management costs. MassHealth proposes using risk adjustment to ensure the overall payment is sufficient given the risks and health needs of the population, and that appropriate risk and shared savings arrangements are established. Planning funds would be used to finalize the service package, develop risk adjustment methods, create appropriate rating categories for the subgroups of dual eligible adults ages 21-64, and model shared savings arrangements and quality metrics that appropriately reward the integrated care entities for high-quality performance and health outcomes.

The integration of Medicare and Medicaid funding at the state level is the key innovation of this demonstration model. The existing fragmentation of the funding streams for acute care and LTSS expenses prohibits an incentive structure that rewards an integrated care solution. Even though an integrated care model is expected to generate overall savings for the target population, it is difficult for states to justify pursuing such a strategy without a financial mechanism in place to share savings with Medicare. Because expected savings in the formative years of the program are predominately associated with acute care spending, they would accrue almost exclusively to Medicare while the state would carry the cost of developing, implementing and monitoring such a program, as well as new service costs from an expanded benefit package. By fully integrating the Medicare and Medicaid funding streams as proposed in this model, MassHealth endeavors to eliminate the systemic fragmentation that would otherwise preclude both Massachusetts and CMS from realizing savings that could be directed toward more appropriate care, and potentially have savings to share with the integrated care entities that meet defined quality standards.

Potential Savings - Summary of Preliminary Actuarial Analysis: A number of additional variables need to be more fully analyzed in the demonstration design phase to refine savings estimates to reflect program design decisions, to determine adequate enrollment levels, and to eventually support rate-setting. Preliminary actuarial analysis positively supports the prospects for this proposed program model to generate overall (Medicare + Medicaid) savings in year one. This analysis of linked Medicare and Medicaid data for Massachusetts' dual eligible adults indicates that this proposed model is expected to impact inpatient hospital, emergency room and pharmacy costs by expanding service options and by placing participating integrated care entities at risk for providing the right care at the right time in the right setting.

The analysis suggests that an integrated care model creates potential for significant savings in many of the areas that have historically been cost drivers for the target population. More specifically, experience from similar programs implemented in other states on comparable populations indicate that savings of 15% to 20% on inpatient hospital (including psychiatric) services, 5% to 7.5% on outpatient hospital (including emergency room) services, and 15% or more in pharmacy expenditures (due to factors such as duplicative prescriptions and non-optimal brand/generic mix) are possible. Other areas with potential for savings include outpatient mental health and substance abuse services and laboratory and radiology services.

The prevalence of chronic diseases and co-morbidities within the target population and the unmanaged FFS environment also tend to promote an inefficient balance in primary care provider/specialty physician utilization. A high-level analysis of the target population's use of these services indicates that better coordination and management of these individuals could yield savings in the range of 2.5% to 5%. Initial savings projections for long-term care and support services are mixed in the early program years, with modest savings in institutional care likely to be offset by the proposed increases in home and community based services. However, overall savings for long-term care and support services are expected to grow in future years as the participating plans have more opportunity to effect utilization patterns of enrollees.

In aggregate, these high-level savings estimates project 1.5% to 2.0% of savings (which breaks down to a decrease of approximately 5.5% on Medicare-covered services and an increase of approximately 1.25% on Medicaid-covered services) in the first year of the program after accounting for the additional administrative expenses and including the proposed enhancements to the service package. Furthermore, these savings would be projected to grow in subsequent years. MassHealth believes the unprecedented level of integration possible through the demonstration model will achieve better health outcomes for the target population and more effectively use the combined Medicare and Medicaid resources. The integrated care entities will be responsible for using clinical practices that more effectively prevent or reduce unnecessary hospitalizations and readmissions and avoidable emergency department visits, and that allow for investment in areas such as behavioral health services and LTSS. MassHealth is optimistic that this approach also will provide more flexible mechanisms and the appropriate incentives to allow individuals to transition more easily from facility-based settings into less restrictive community settings.

C. Policy Rationale for Massachusetts' Proposal

Ineffective payment incentives, absence of comprehensive care coordination, insufficient care options, conflicting rules and practices in parallel silo systems, and lack of full accountability for a person's care and quality of life are all noteworthy reasons why both Medicare and MassHealth spend significantly more on their dual eligible populations than on their non-dual eligible populations, and why these beneficiaries experience less than optimal outcomes. MassHealth proposes removing these barriers, and adopting the following principles for the care it provides for dual eligible adults in the target population:

- 1) Replace financial incentives for discrete services with incentives for holistic, person-centered care;
- 2) Incent and allow flexibility for the individual and care providers to develop and engage in care together;
- 3) Create a single clear path of accountability for outcomes, individuals' satisfaction, and optimal use of resources;
- 4) Protect individuals' rights consistent with both Medicare and Medicaid principles; and,
- 5) Create opportunities for shared risk and mechanisms to share savings with the integrated care entities, and invest in additional supports and services that will improve the beneficiaries' outcomes and experiences.

By combining funds and program administration, Massachusetts believes that it can achieve better results for Medicare, MassHealth, providers, and most importantly, for dual eligible adults ages 21-64. Individuals will benefit from an enhanced menu of services, the support of a care team and from assistance with service coordination activities. They will have clarity with one set of rules, covered services, and procedures from a single plan; this will also illuminate a clear path for issue resolution. Dual eligible adults will receive one combined explanation of benefits, carry only one card, and have a single unified enrollment process. MassHealth predicts that in addition to giving the beneficiaries more control and simplicity, their care and services will complement rather than contradict each other, improving health outcomes and quality of life.

Providers will benefit from improved infrastructure to support communication and collaboration about the care they are providing to beneficiaries. Financial incentives would encourage practice reforms that embrace person-centered care. The new integrated care entities would make a wider breadth of information available to inform beneficiary and provider decision making and help providers and care teams understand how to implement interventions that will meet the needs of beneficiaries.

At the same time, the federal government and Massachusetts would benefit under the proposed model from new assurances that their scarce resources are being more efficiently and effectively used. Integrating care will ensure that providers work collaboratively to meet a person's care needs, and do so in the right setting. Duplication and conflicting treatments would be identified and eliminated by the care team, which would have the tools to identify and address early warning signs of new or worsening issues before they require emergency treatment. Ultimately, the key innovation of the proposed model is that, unlike the Special Needs Plan (SNP)-based SCO program, the contracted entities would have a single clear path of accountability to MassHealth, rather than dual sets of responsibilities to both MassHealth and Medicare. MassHealth is well-poised to address issues quickly and locally. The agreement between Massachusetts and the federal government will clearly delineate specific expectations for MassHealth's contract management, but these details need not complicate the front-line relationship MassHealth will have with the contracted integrated care entities.

Massachusetts will also use experience it gains with this new integrated care model to inform potential improvements for service delivery to dual eligibles who are elderly, as well as for service delivered to MassHealth only members. The new model should provide useful quantitative and qualitative data to provide comparisons with existing care models in Massachusetts. MassHealth will use lessons learned and best practices to improve care for all of its members.

These joint concepts of sole accountability from the integrated care entity to the state, and complete service integration for a seamless member experience, are easily replicable in other states interested in using contracted care arrangements to integrate comprehensive care packages for their dual eligibles in partnership with the federal government. The model also provides significant flexibility for states to build in new payment reform concepts and opportunities introduced in federal health reform.

MassHealth has experience with many components of the proposed model: contracting for managed acute, primary care, and expanded behavioral health services to serve adults ages 21-64 with disabilities in its managed care programs; and contracting for a comprehensive benefit package managed by a single plan, (but with bifurcated accountability and financing), to serve older dual eligibles in SCO and PACE. The concepts of integrated financing and consolidated accountability at the state level are new and Massachusetts is eager to test these ideas.

2. Overview of Massachusetts Capacity and Infrastructure

Massachusetts will build its integrated care demonstration model using MassHealth's extensive knowledge and experience with managed care programs for elder dual eligibles and for Medicaid-only beneficiaries. For nearly two decades MassHealth has had mandatory enrollment in managed care for individuals who are: under age 65, without third party insurance or Medicare, and not residing in a facility. MassHealth also worked closely with the federal government to develop and implement voluntary Massachusetts' Response to RFP-CMS-2011-0009

comprehensive managed care programs for elders. PACE was implemented in Massachusetts in 1990 and SCO was implemented in 2004.

MassHealth has a long history of supporting the administration of services also covered under Medicare Parts A, B, and D in both FFS and managed care programs. MassHealth operates a primary care case management program with a managed behavioral health care component, contracts with MCOs, and has an established infrastructure for rate-setting, capitation payments, claims processing, quality improvement efforts, and for capturing utilization and encounter data. With few exceptions, Massachusetts' MassHealth-only beneficiaries with disabilities under the age of 65 are enrolled in one of the Medicaid managed care products. Massachusetts also plans to leverage the knowledge and experience of its state agency case managers at the Department of Developmental Services, the Department of Mental Health, and other agencies who coordinate HCBW services or other state-funded LTSS for dual eligible adults as it incorporates comprehensive care management into the demonstration model.

MassHealth has been working for nearly two years on the development of the state's next generation of integrated care, targeting dual eligible adults ages 21-64. The state is actively engaged in the planning phase and has created a conceptual design of the model, has outlined the responsibilities of the integrated care entities, is pursuing data and financial analytical resources and is in ongoing communication with key stakeholders. MassHealth plans to use additional resources to expand stakeholder and member involvement throughout the planning and implementation processes.

MassHealth is uniquely positioned to apply its knowledge and expertise to contract with and manage integrated care entities on behalf of Medicare and Medicaid. MassHealth has a strong platform of infrastructure, experience, and institutional history working collaboratively with CMS, as well as extensive experience administering acute, specialty, primary care, behavioral health, and facility-based and community-based LTSS. MassHealth is currently evaluating external resources and their ability to support the demonstration design work.

Key state staff supporting design and implementation of this proposal includes representation from the following areas: MassHealth's, Member Policy and Program Development Unit, Office of Behavioral Health, Office of Long Term Care, Community Based Waiver Programs, Office of Clinical Affairs and Quality Measurement, Purchasing Strategy Unit and the Office of Acute and Ambulatory Care. In addition to the MassHealth staff, other key staffs working on the initiative come from the Executive Office of Health and Human Services Office of Disability Policy and Programs, the Executive Office of Elder Affairs and the Department of Mental Health.

While MassHealth has a sound infrastructure foundation to implement the demonstration, additional resources will be needed during the implementation phase activities including: (1) actuarial analyses to (a) support the development of a Databook and the design of financial and non-financial monitoring tools, and (b) develop an appropriate rating structure (including incentive payments and risk mitigation mechanisms) and global payment rate ranges; (2) information services resources for implementation and monitoring; (3) resources to support outreach, marketing and enrollment activities; and (4) personnel resources for the implementation team.

3. Description of Current Analytic Capacity

Analytic Capacity: MassHealth has extensive experience using both FFS claims data and MCO encounter data (submitted monthly by MassHealth MCOs) to support program management, policy and program development, rate development, risk adjustment, and financial and quality measurement. Massachusetts' resource constraints can be addressed through the use of funds made available through this design contract; Massachusetts otherwise has the analytic capacity to develop and interpret the data needed to support this proposed initiative. MassHealth plans to use federal planning funding to increase analytic staff time and for consulting support as needed.

Linked Medicare and Medicaid Data: MassHealth has access to linked Medicare and Medicaid data for dual eligible adults ages 21-64. MassHealth has had extensive experience, over multiple years, working with the linked Medicare and MassHealth data for elders. The new merged Medicare and Medicaid dataset includes Medicare Part A, Part B and Part D claims, enrollment data, minimum data set (MDS), and Outcome and Assessment Information Set (OASIS) data from 2004 through 2008, linked to the MassHealth data. The 2009 data will be available to MassHealth in early 2011. The linked Medicare and MassHealth data contains a line-item level database that consists of all services billed through a Medicare or MassHealth claim, a code-level database that includes every procedure, NDC, DRG and diagnosis (primary and secondary) found on a Medicaid or Medicare claims for an individual beneficiary, and a person-month database that reports programs status for a beneficiary.

The linked dataset does not include Medicaid MCO encounter data since the target population is not currently eligible for managed care in MassHealth. Massachusetts is actively exploring the transfer of the linked Medicare and Medicaid data directly to the MassHealth data warehouse. Data warehouse integration would allow for easier incorporation of the Medicaid

data for analyses, such as risk-adjusted comparisons, which include beneficiaries who are not dually eligible and experience for dual eligible beneficiaries who were previously in a MassHealth managed care plan. In addition, MassHealth intends to work directly with CMS to access Medicare claims and managed care enrollment and payment data on an ongoing basis.

MassHealth developed a draft analytic and actuarial plan that will be refined based on information from stakeholders and ongoing iterative analyses. This ongoing analytic work will expand the profile of the target population, identify the service mixes that would improve their successful independent living and reduce utilization of high cost services, project population based savings, model different strategies for providing global payments to the integrated care entities including appropriate incentives for quality improvement (shared savings, quality thresholds, performance incentives), and development and testing of methodologies for integrating the Medicare and Medicaid funds at the state level (e.g., risk corridors, shared savings options).

4. Summary of Stakeholder Environment

MassHealth is committed to robust and meaningful stakeholder engagement. MassHealth has a strong and proud history of engaging and partnering with stakeholders to inform and support changes in the MassHealth program. This history of partnership with affected constituencies is largely responsible for the passage, successful implementation and ongoing public support for Massachusetts' 2006 health reform law.

MassHealth has convened a consumer advocates group of more than thirty organizations that serve dual eligible adults ages 21-64. This group includes organizations such as: Health Care for All, AARP, Massachusetts Law Reform Institute, Independent Living Centers, Disability Law Center and Massachusetts Housing and Shelter Alliance. MassHealth laid out the problem and asked for their partnership in building, creating and supporting a service delivery model that fully integrates Medicare and Medicaid for dual eligible adults ages 21-64. The group has been willing to meet with MassHealth to help design a service delivery model that they could support and promote because it would better serve the population. Some of their initial ideas were very specific including: allowing members to keep their existing providers, the need for a broader continuum of behavioral health services, improved durable medical equipment purchasing and repairs, improved access to community support services, scheduling specialist appointments, need for meaningful measures focused on community living, and modifications to prior authorization processes. MassHealth will continue to engage with stakeholder groups throughout the design and implementation process.

MassHealth is currently developing plans to broaden its stakeholder engagement to include focused beneficiary input and public meetings for all interested parties, including but not limited to potential bidders, providers, health plans, professional associations, academics, advocacy groups and MassHealth's contracted managed care plans (SCO, PACE and MCOs). In order for the new program to be appealing to a significant percentage of the target population, MassHealth understands that it needs to hear directly from the beneficiaries themselves about what they would like to see from the model. MassHealth wants to gather input from providers and potential delivery systems partners on the design of the model, tools providers have and need to meet the needs of the population, and ideas for adequate reimbursement and risk and savings arrangements.

MassHealth also has engaged other state agencies that serve the target population. These discussions have focused on the needs of the target population and the conceptual design of the demonstration model. The state agencies actively engaged in these discussions include the Executive Office of Health and Human Services Office of Disability Policy and Programs, the Executive Office of Elder Affairs, the Department of Mental Health, the Department of Developmental Services, the Massachusetts Rehabilitation Commission, the Department of Public Health, the Massachusetts Commission for the Blind and the Massachusetts Commission for the Deaf and Hard of Hearing.

MassHealth will seek input from a broad spectrum of stakeholders through the release of a Request for Information (RFI) on integrating Medicare and Medicaid for dual eligible adults ages 21-64. The RFI is scheduled to be released later in February 2011. MassHealth is confident that by involving all of the appropriate stakeholders early in the process and building their suggestions into the development of the program, this initiative will have a high level of success and support.

5. Timeframe

For more than two years, Massachusetts has focused on developing a new concept of service delivery to meet the needs of dual eligible adults ages 21-64. During that time, it has worked extensively on developing a working model by, among other things, convening a steering committee of executive staff, meeting with a workgroup of state agency partners, holding a series of meetings with consumer advocates, drafting an RFI to gather further information from stakeholders, developing a merged Medicare/Medicaid dataset, beginning the analytic and actuarial work necessary to support the model under consideration, and conducting preliminary discussions with CMS. MassHealth also participated in a multi-state initiative sponsored by the Center for Health Care Strategies, Inc. called *Transforming Care for Dual Eligible Individuals*. This eighteen month initiative offered

the opportunity to learn about the benefits, challenges and opportunities of integrating care, and helped further MassHealth’s concept of the model that would better serve the younger dual eligible adult population.

The funds and technical support available through a design contract will allow MassHealth to complete the steps needed to fully design the model. MassHealth’s key milestones towards successful implementation include: releasing a RFI in February 2011, drafting the Request for Responses (RFR) in the fall of 2011, releasing the RFR in January 2012 and awarding contracts to integrated care entities by fall of 2012.

State legislation will be needed for MassHealth to administer the Medicare funds and benefits. MassHealth will put forth legislative language that protects and specifies appropriate uses for Medicare’s funds. Historically in Massachusetts, legislative approval moves quickly when legislation is based on an approved agreement with CMS.

6. Budget and Use of Funds

Massachusetts is requesting \$1M to develop its integrated care demonstration model. Below is a description of how the funds will be used and a budget outlining the requested amount.

1. **Staffing and Consulting:** Increase contracted staff time and use consulting support in the following areas: Project management and program development staff to oversee all activities in the design phase; Analytic staff to support all activities associated with the design phase (e.g., in-depth analysis of the linked Medicare and Medicaid data set and supporting actuarial work); and Information Services staff to design the technical implementation plan for the demonstration proposal and to execute the direct transfer of the Medicare A, B and D data to the MassHealth data warehouse. This request includes five contracted positions: project manager, analytic lead, program development analyst, two MMIS analysts and consulting support for analytics and program development.

2. **Actuarial Support:** Use consulting support to: Evaluate reimbursement mechanisms (e.g., rate cell structures that align financial incentives with program goals, incentive payments that promote program goals, and possible risk mitigation techniques); Evaluate the potential for selection bias, the need for regional rate adjustments, and the prevalence of specific disease conditions and complex cases that will inform program design decisions and refine savings estimates and support rate-setting; Evaluate how proposed contributions from Medicare and Medicaid would support the model; and propose and evaluate calculations for shared savings.

3. **Member Input/Stakeholder Engagement Activities:** Use consulting support to broaden MassHealth’s stakeholder engagement. Develop and initiate activities to gather focused input from beneficiaries and potential delivery system partners, and to hold public meetings for all interested parties. The specific tasks include organizational logistics, meeting materials, facilitation and documentation of activities associates with the stakeholder meetings, provider forums and member discussion groups.

4. **Quality Metrics and Evaluation Plan Development:** Use consulting support as needed to create an evaluation design, including key metrics that will be used to examine the model’s quality and cost outcomes for the target population such as beneficiary experience, access to care, level of care coordination, and diversion from avoidable acute care. The deliverable will be a comprehensive evaluation plan for all aspect of the demonstration model. This deliverable must include detailed quality metrics that will be used to measure the performance of the integrate care entities.

5. **Travel:** Use funds for state staff travel necessary to support the design activities and discussions with federal partners.

	Design Budget: Use of Funds	Requested Amount
1.	Staff and Consulting Support	\$690,070
2.	Actuarial Support	\$200,000
3.	Member Input/Stakeholder Engagement Activities	\$75,000
4.	Quality Metrics and Evaluation Plan Development	\$29,930
5.	Travel	\$5,000
	Total	\$1,000,000