March 19, 2012

Melanie Bella
Medicare-Medicaid Coordination Office
Center for Medicare & Medicaid Services
200 Independence Ave. SW
Washington, DC 20201

RE: Comments on the Massachusetts Plan for Dual Eligibles, Submitted February 16, 2012

Dear Ms. Bella:

The Home Care Alliance of Massachusetts welcomes this opportunity to provide comments regarding the ambitious plan for creating a globally paid, privately-managed integrated care system for dual eligible individuals ages 21 – 64 in Massachusetts. The remarks we are providing are similar to those that we submitted to the Massachusetts Executive Office of Health and Human Services before the submission of the state's final draft. Given that the federal government will provide approximately three-quarters of all the money (including the 50% share of the Medicaid costs) for the program, these comments place a stronger emphasis on areas where we believe CMS needs to seek clarifications or commitments from Massachusetts EOHHS ***before initiation of the demonstration.***

I. Provider Network Building, Credentialing and Service Authorization

A. Network

An experienced and qualified provider network will be *essential* to the success of any Integrated Care Organization and to the eligible members' confidence in their continuity of care. This is an area of particular interest for the home health community given that MassHealth data indicated that there are approximately 13,600 duals receiving home health services. Many of the "duals" that we currently serve pose both the greatest challenge to ICOs, and also present the greatest opportunity for improved care management and cost savings.

The language in the state's proposal indicates a strong commitment to holding ICOs accountable for maintaining a broad network of providers with existing relationships with eligible members and for maintaining standards for provider access "as required in Medicare managed care contracts." However, the proposal as currently written leaves the ICOs with sole responsibility for provider network credentialing,

and yet credentialing is not defined. A related concern is – absent specific requirements - how consistent or inconsistent this might be across different ICOs.

The Home Care Alliance believes it critical that all state contracts with ICOs include very specific requirements in this provider network and credentialing area. The starting point should be that for the provision of all Medicare defined benefits and Medicaid state plan services, providers must be those that are certified by Medicare/Medicaid. We also believe strongly that the ICO contract should further stipulate that ICOs may choose to use non-Medicare certified providers for other long term support services (LTSS), such as personal care, homemaking and coaching, that are not part of the Medicare or Medicaid state plan benefit package. Given the lack of state licensure for these service providers, the ICOs should be directed to acquire certain LTSS from private agencies that have been accredited by the Home Care Alliance.

B. Service Authorization

The state proposal suggests an intention to hold ICOs accountable for keeping plan enrollees out of expensive institutional settings, through a maximization of community based services. The clients in the demonstration have histories of using home health agencies both in a "post acute" and chronic long term care capacity. The traditional managed care model of authorizing services in one, two to three visit increments will not be beneficial to the goal of a cost effective care plan. In fact, requiring agencies that are providing chronic nursing and aide support services to get authorization every few visits is simply the opposite of the "administrative simplicity" this program design calls for, and would potentially be disruptive to continuity of care.

The Alliance believes that if the demonstration is to truly embrace a community-oriented focus in terms of the service plan, CMS must insist that the state work with ICOs and community based providers to develop authorization processes and payment policies that do not create added cost and complexity that discourage providers from joining the network. Specifically, the **Alliance strongly recommends that in advance of signing any agreements with ICOs, the state develop <u>global authorization</u> protocols and parameters that allow home health services to be authorized in 30, 90 or 120 day increments, depending on a patient's chronic condition, and physician orders.**

Likewise, specific contract language must be introduced with regard to **medical supplies**, excluding DME. Under Medicare PPS for most conditions, payment for routine and non-routine supplies has been bundled into the episodic rate. For MassHealth, supplies have traditionally been billed separately. It will be critical to determine the specific payment criteria for medical supplies before any agreements are made with the ICO, to prevent disruption in this service for the beneficiary.

C. Claims Submission

It **will be critical that before contracts are awarded there is agreement on a universal format for submissions of claims**. Unless there is agreement on the claims format, it will mean providers who work with multiple ICOS may have to replace two billing systems (Medicare and Medicaid) with multiple forms and formats.

Finally, it is also our sincere hope that Integrated Care Organizations (ICOs) will achieve savings from the enhanced coordination of care rather than paying the lesser of Medicare and Medicaid rates. TO ensure this, we would like to see some reference to set rates, at least for the first year of the demonstration.

II. Quality Measurement

The state's proposal indicates a strong commitment to work with stakeholders to develop quality measures for evaluating the success of the ICOS and their contracted providers in meeting the quality outcome expectations of the payors and patients. This is an area that, again, the Alliance suggests that CMS requires more specificity ***prior to any contracts being awarded***

A. Assessment

Quality of care measurement starts with good comprehensive assessment. **For clients using community –based services, the Alliance asks that CMS require the use of the OASIS-C document, which is now the standard in home health care**. Given the large number of elements on the OASIS form, we would like to see the state agree with ICOs on a uniform subset of OASIS measures for all ICOs to use. ***These system need to set up in advance and be based on electronic submission; providers should not have to take on an additional burden of submitting any data manually***

Additionally, MassHealth data indicates that nearly 80 percent of dual eligible individuals in Massachusetts have a physical diagnosis while nearly two-thirds have a behavioral diagnosis. With these facts in mind, the Home Care Alliance recommends that assessment should be conducted, all or in part, by a registered or psychiatric nurse from a certified home health agency that has experience in identifying both physical and behavioral issues. At the very least, this professional, who is well-equipped for the assessment task, could also be in a clinical care manager role.

The Massachusetts proposal also includes a Long Term Services and Supports (LTSS) Coordinator, which we believe has a part in the assessment and care planning. We concur with the demonstration design which allows that LTSS Coordinators will likely come from multiple sources depending on the individual's support service needs, whether it is an Independent Living Center or Aging Service Access Point. The Home Care Alliance believes that the proposal should also allow home health agencies and private pay home care agencies with experience caring for the dually eligible to

provide the LTSS coordinators as in many ways they have the greatest familiarity with the patient's needs from the perspective of inside the home.

B. Quality Measurement

Since the complete OASIS document is transmitted at Start and End of Care to the state for uploading to Medicare, we also believe that the state and the plans –should agree in advance – that any home health quality measurements be drawn from the OASIS. Once the decision of which OASIS elements to use and report is decided, the state must develop a process to extract these at the patient level and provide them to the ICOs. ***These processes of electronic quality measurement elements submission needs to be established in advance of the demonstration so that providers do not have to take on an additional burden of submitting any data manually.***

Among the measures, we recommend be part of the process are: timeliness of admitting patient to home care, acute hospitalization rates, and screening for falls and depression.

If the decision is made for any reason not to use the OASIS in lieu of another outcome assessment tool, then the industry must insist that OASIS completion be waived for these patients

III. Benefit Design

The Home Care Alliance supports the proposed home health benefit design that allows for use of home health care plan regardless of whether the patient is homebound or participates more in community activities. The addition of a broader array of community support services not traditionally covered by either payor is also welcome.

A. Telehealth

The Alliance is concerned that the proposal provides no reference in any of the narrative or appendices to the use of remote monitoring or telehealth, which has become a routine part of post acute care for a significant cohort of Medicare beneficiaries. Medicare has allowed for telehealth to be included in a home health plan or care, and it has proven effective as both a patient self management tool, and an early warning system for readmission at-risk patients. This services needs to explicitly be included as covered and reimbursable in the community support services listing.

B. Community Health Workers

The addition of a community health worker – either "employed directly or by contract" seems a welcome addition to the care team. However, careful attention to care team planning and coordination is vital to ensuring that many

different workers are not providing functions in the home – especially simultaneously – that can be a subtraction, not an addition to a patient's experience. The Home Care Alliance believes that there is a ready-made workforce in home health aides who can receive extra training to provide the necessary services as needed by dually eligible individuals. Using exiting workers to provide new functions would be preferable to establishing an entirely new workforce.

Finally, the Alliance is concerned about the scope of this demonstration. Moving to statewide implementation before all details have been vetted, and any plans have been tested, feels a bit premature. The Alliance suggests a rolling implementation, with new geographic areas added as demonstration success indicators are met in the early adapting regions.

Sincerely,

Patricia M. Kelleher
Executive Director