

Disability Advocates Advancing our Healthcare Rights

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Health Policy Commission
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Sent via email to: HPC-Certification@state.ma.us

To the HPC:

Disability Advocates Advancing Our Healthcare Rights (DAAHR), a coalition of disability, elder, healthcare, and legal services organizations and people with disabilities, thanks you for the opportunity to provide input on the HPC ACO certification criteria. DAAHR works in close partnership with Mental Health Legal Advisors Committee (MHLAC) and Healthcare for All (HCFA), both members of DAAHR, and we endorse the recommendations put forward by both entities. The recommendations below are to supplement those put forward by MHLAC and HCFA.

Our recommendations are in two sections. Section One covers DAAHR's specific recommendations that go beyond the framework set forth by HPC. Section Two provides recommendations that correspond to the points outlined in the HPC table.

DAAHR is supportive of the systems transformation taking place in the state's 1115 waiver application. And we wish to emphasize that we are acutely sensitive to the historical "medicalization" of people with disabilities and chronic conditions. People with disabilities are frequently viewed as "patients" rather than members, enrollees, or beneficiaries by medical entities, even in the delivery of nonmedical services.

The disability movement and the passage of the Americans with Disabilities Act emerged in direct response to this patient-centric view. This view has resulted in innumerable human rights violations and is partially the cause of the high costs in medical care today for people with disabilities. This is what prompted the rebalancing initiatives to community-based services called for in the Affordable Care Act. The costs of medicalization of disability are seen not only in direct medical care, but in the large number of people with disabilities living in Skilled Nursing Facilities or other segregated settings who might otherwise live higher-quality lives in community-based settings.

DAAHR has worked closely with MassHealth on the creation and implementation of One Care (OC). We have seen a number of positive outcomes from OC, including reduced Emergency Department (ED) visits and unnecessary hospitalizations. However, we have not been provided evidence of expanded consumer choice in Long-Term Services and Supports (LTSS) nor has there been needed exploration of any limitation of true conflict-free care and/or conflict-free care assessment of consumer needs.

It is imperative that the HPC require that ACOs demonstrate the capacity to partner with Community Based Organizations (CBOs) to conduct independent conflict-free member assessments, particularly in the assessment of LTSS needs.

Section One: DAAHR Recommendations for HPC

Hospital reorientation: ACOs need to have a transformation plan that invests in outpatient services and that supports robust contracting with Community-Based Organizations (CBOs). DAAHR believes HPC has an obligation to protect CBOs that have unique cultural histories and relevance to populations they serve. This is particularly true of entities such as Independent Living Centers, Recovery Learning Communities, Aging Services Access Points (ASAP), and other disability organizations and service providers. These entities have developed over time and in direct response to historical discrimination, including actions carried out by a range of medical providers. Creating a seamless system of care can only occur with the development of trust-based relationships between medically-based providers and providers of nonmedical behavioral health, Long-Term Services and Supports (LTSS), and other nonmedical services.

Americans with Disabilities Act: DAAHR urges HPC to require ACOs to demonstrate compliance with the ADA as part of credentialing. By law, all entities must comply with the ADA, but in practice this is not the case. DAAHR requests HPC to require that all entities seeking to become ACOs complete the Massachusetts Department of Public Health disability compliance tool, or create a plan for completing the tool within the first year of becoming credentialed as an ACO. In areas where the ACO is not in compliance with the ADA after completing the tool, the ACO should create a transition plan that includes a timeline and budget for complying with the ADA, along with its contracted providers and other vendors. Disability advocates must be brought into this process at all stages. *In 2016, 26 years after passage of the ADA, it is utterly unacceptable to develop health initiatives for people with disabilities that perpetuate serious health disparities because of inaccessibility of care and services.* The DPH compliance can be accessed at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/health-disability/ada-compliance/the-massachusetts-facility-assessment-tool.html>

Commitment to the Olmstead mandate: ACOs should be able to measurably demonstrate a commitment to meeting the goals of the Olmstead mandate of the ADA (1999 Supreme Court decision) by creating quality metrics and developing benchmarks for reducing the number of members in Skilled Nursing Facilities (SNFs). HPC should use a carrot and stick approach to Olmstead by providing positive financial incentives to ACOs that reduce members living in the SNFs and penalizing ACOs that have increasing numbers of members living in SNFs.

ACO Lock-In: DAAHR is opposed to a one-year “lock-in” of ACO members. This provision has the potential to harm to members with complex needs that may not be met by an ACO lacking network adequacy. While DAAHR understands the importance of having a stable membership, much churn is a result of people being unenrolled from Medicaid rather than switching between plans. DAAHR instead recommends that ACO members be offered the opportunity to dis-enroll from an ACO on a monthly basis.

Independent ombudsman program: DAAHR recommends that ACOs contribute to a fund to establish an independent ombudsman program, though it must be independent of the health plans, providers, and MassHealth in order to support innovation, protect members on an individual basis, and address systemic concerns as they arise. Other consumer protections, such as rights to appeal services, also must be established.

Single-case agreements: Requiring ACOs to permit single-case agreements for continuity of care and for people with complex needs is imperative. The principles of network adequacy that work for the general population can result in harm to people with complex physical, psychological, behavioral and chronic conditions. Members with complex needs must have the right to access providers and specialists with the unique credentials and relationships required to address their unique needs, needs that are often difficult to find in any network. Persons with behavioral health challenges are best served by providers with whom they have an existing positive therapeutic relationship.

Supportive housing services: Homelessness and unstable housing are a primary cause of unnecessary ED visits and hospitalizations. HPC should require all ACOs to demonstrate how they will implement contracts with entities to provide community-based supportive housing services such as those services provided by entities like the Massachusetts Housing and Shelter Alliance. Only by requiring ACOs to invest in the services that will reduce chronic homelessness and support community-based housing will these issues be effectively addressed.

Habilitation services and alternative therapies: ACOs should demonstrate a commitment to provision of habilitation services and alternative therapies for people who can benefit from ongoing services including acupuncture, massage therapy, physical therapy, occupational therapy, speech therapy to improve daily living skills and capacity to participate in the community. Quality metrics should include measures of the types and duration of habilitation services and alternative therapies afforded to ACO members.

Health inequities: ACOs should demonstrate the capacity to address inequities in health care access and outcomes by population. Quality metrics should include the capacity to cross tabulate by race, ethnicity, gender identity, sexual orientation, disability status and housing status. ACOs should be held to demonstrate population-based strategies to reduce inequities in health care access and outcomes, including people with disabilities and those with mental health needs.

Technical assistance for providers: In order for ACOs to be credentialed, they will be provided technical assistance. The same opportunity for technical assistance must be given to CBOs if CBOs are to participate equitably in contracting partnerships with ACOs.

Section 2. DAAHR Recommendations Based on HPC Points

#3 DAAHR supports the inclusion of more than one patient or consumer or patient representative. Given the diversity of populations within an ACO, however, DAAHR urges HPC to require ACOs to ensure that all ACO governance structures include a diversity of consumer representatives including a representative of the disability community. This representative should be someone recommended by a partner community-based organization that serves people with disabilities, and

preferably an organization whose board membership or equivalent represents 50 percent or more of the population it serves.

#4 DAAHR recommends that the ACO governance structure should also have meaningful participation of organizations that provide Long-Term Services and Supports (LTSS) and organizations that provide community-based services such as housing, WIC, fuel assistance, etc. It is imperative that these non-medical entities be part of the governance structure to help the ACO rebalance spending towards LTSS and investment in services that address social determinants of health. Housing status and those with unstable housing arrangements are the primary reason for the high rate of potentially preventable hospital and emergency department visits.

#6 DAAHR recommends that the quality assurance committee should report not only to the governance structure, but also to the public by providing a public-facing dashboard with quality information specified by the HPC and OPP, and offer ACO members the opportunity to provide feedback to ensure transparency and assure that quality metrics are meaningful to members and representative of priorities within member experience.

#7 DAAHR urges that the risk stratification of the population encompass functional status as defined by activities of daily living (ADLs) and instrumental activities of daily living (IADLs). In addition to ADLs and IADLs, we further submit that ACOs collect information on the social determinants of health such as housing status and also include this information, because of the close relationship between disability and poverty. Without this risk stratification requirement "cherry picking" and/or "lemon dropping" may result because providers will not receive appropriate reimbursements for providing care to people with the most complex needs in the population.

#9 DAAHR recommends that ACO effectiveness in collaboration with community-based providers of LTSS should include measurable rebalancing and spending towards providers who provide LTSS and other services that reduce ED visits and hospitalizations. Contracts between ACOs and providers of LTSS should also include upside risk sharing for LTSS providers to align incentives between the ACOs and the LTSS providers. In this way HPC can measure the efforts being undertaken by the ACO to comply with the Affordable Care Act rebalancing requirements as well as their commitment to measurable partnership with community-based groups.

#13 DAAHR recommends that ACOs build the capacity to regularly provide cost, utilization and quality information to the public via a forward-facing portal that contains information necessary for potential members to make informed decisions about the quality of care provided by the ACO. The HPC and OPP should collaborate to standardize a minimum information set.

#14 DAAHR recommends that surveys of patient and family experience should be multi-modal and accessible to people of a variety of abilities. Surveys should be created in ADA-appropriate formats to ensure that all members have an equal opportunity to provide feedback to the ACO. Surveys should include questions about the quality of LTSS services and social service agencies to address the social determinants of health, as well as medical indicators.

#22 DAAHR recommends that ACOs demonstrate capacity to provide palliative care for members with long-term chronic conditions and disabilities. Palliative care should also include access to

behavioral health, LTSS and services that address the social determinants of health in addition to medical care.

#24 DAAHR recommends that the network of preferred providers include providers of behavioral health and LTSS services that go beyond geographic regions. Furthermore, quality, rather than cost, should be the primary basis for designating a provider as a “preferred” provider.

#27 DAAHR recommends that ACOs demonstrate the capacity to provide recovery services that go beyond traditional services. HPC should follow the lead of New York and require ACOs to provide short-term crisis respite as part of expanded Home and Community-Based Services under their 1115 Research and Demonstration waiver. Ideally these respites would be exclusively peer run. See <http://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-parachute-nyc.page>

#31 DAAHR recommends that an assessment of needs and preferences should also include an assessment of capability to meet the needs of persons with disabilities in addition to other patient population identifications i.e. race, ethnicity, etc. Assessment of need must also extend to Deaf culture. DAAHR recommends that HPC require ACOs to adhere to the following:

Interpreter Services Report to the Health Disparities Council:

<http://www.mass.gov/hdc/docs/2011/march/medical-interpreter-services-report.doc>

Recommendations for Hospital-based Interpreter Services:

<http://www.mass.gov/eohhs/docs/dph/health-equity/best-practices.pdf>

DAAHR also requests that ACOs demonstrate their capability to meet the minimum requirements for Virtual Remote Interpreting (VRI) technology and equipment. There are limits of VRI for effective communication beyond those caused by defective or improperly set up equipment, e.g., when there are multiple people involved in a conversation, for certain procedures or during child birth. The issue of having input and choice on what’s effective for any individual is a huge issue for people who are deaf. And the limits of the technology and the limits of some in using VRI for effective communication are not well understood in the industry.

See VRI requirements <https://nad.org/issues/technology/vri/position-statement-hospitals>

HPC should also require that all interpreters whether providing services in person or through VRI meet the Massachusetts Commission for the Deaf and Hard of Hearing Obligation of Medical Professionals to Provide Interpreters. See <http://www.mass.gov/eohhs/docs/mcdhh/obligations-medical.pdf>

In addition, the ACO should demonstrate that it also meets the certification criteria of NCRA.

<http://www.ncra.org/Certifications/content.cfm?ItemNumber=8657&navItemNumber=516>

ACOs should also demonstrate an understanding and capacity to provide certified Interpreters for the Deaf (CID).

The recommendations contained in this document are by no means exhaustive. DAAHR looks forward to an opportunity to communicate further with you about ACO certification requirements specific to the needs of people with disabilities. We would appreciate an opportunity to meet with the HPC to discuss the unique needs of the disability community, particularly those people with complex needs, as you continue to establish accreditation criteria for ACOs.

Sincerely,

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