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Sent: Tuesday, December 13, 2011 10:57 AM

To: Duals (EHS)

Subject: Integrating Medicare and Medicaid for Dual Eligible Individuals - Draft Proposal for Public Comment

My name is Ana Karchmer and I work at the Executive Office of Elder Affairs coordinating a grant we received from ARRA to build capacity and disseminate the Stanford University Chronic Disease Self-Management Program (CDSMP). In Massachusetts the program has been branded with the name: "My Life, My Health" – "Mi Vida, Mi Salud". "My Life, My Health" is a low-cost program that helps adults (18 +) with chronic conditions learn how to manage and improve their own health, while reducing health care costs. The program focuses on problems that are common to individuals suffering from any chronic condition such as nutrition, exercise, medication management, exercise, emotions, and communication with doctors. Led by a pair of trained facilitators, many of whom have their own chronic health problems, workshops meet for 2.5 hours for 6 weeks. During this program participants (10 to 15 in a group) focus on building the skills they need to manage their conditions. CDSMP:

- Helps people with diverse medical needs develop the coping strategies they need to manage their symptoms;
- Employs action planning, interactive learning, behavior modeling, problem solving, decision making, and social support for change;
- Is available on line and through in-person community based settings
- Has a Spanish culturally adapted version that focuses more on nutrition and exercise (Tomando Control de su Salud – in MA "My Life, My Health").

Currently, different community based organizations around the state have the capacity to hold the in-person sessions. Current leaders are a diverse and committed workforce that includes volunteers, agency staff, and community health workers.

I would like to propose that on P.18 (see paragraph below) of the demonstration proposal you mention the Stanford Program specifically by name since it is one of the only evidence based programs (if not the only one) that teaches self-management and self-efficacy skills with proven results. The Commonwealth Care Alliance, a Senior Care Organization operating in various parts of the State, has successfully embedded this program into their chronic care model for seniors, but the program works for any adult.

P. 18 - Additional Community Support Services and Community Health Workers

Dual eligible members ages 21-64 are a diverse group of individuals: culturally, linguistically, ethnically, and with regard to primary disabling conditions and the constellation of chronic illnesses and secondary medical and non-medical concerns. The Demonstration will address this diversity in an appropriate and cost-effective way. ICOs must employ trained non-medical community health workers, either directly or through contract, to support PCMH practices to implement care plans with regard to: wellness coaching to engage the enrollee in prevention activities (smoking cessation, exercise, diet, screenings, etc); evidence-based practices and techniques for chronic disease self-management (e.g. The Stanford University Chronic Disease

Self Management Program); peer support for mental health and substance use disorder recovery activities and for other disabling conditions as appropriate.

In the past year, with support from ARRA, a total of 2510 adults have participated in “My Life, My Health” and “Mi Vida, Mi Salud” workshops and 1960 of those have completed four out of the six sessions. Workshops have been offered in a variety of settings among them community health centers and hospitals, libraries, senior centers, residential settings, adult day health centers, and wellness centers.

“My Life, My Health” workshops are not appropriate for every single individual. Care Coordinators would have to be trained to triage those appropriate for the program, but for those that are appropriate, the program helps participant learn the self management and self efficacy skills they need to develop their own care plans and work on their personal goals. Moreover, the demonstration could encourage Care Coordinators to receive the training needed to continue to encourage the use of goal setting and problem solving, key skills learned in the workshops.

For more information on CDSMP please check:

<http://patienteducation.stanford.edu/programs/cdsmp.html>

If you have any questions or concerns about this program please do not hesitate to contact me.

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DAAHR Dual Eligibles Legislative Proposal

11/22/11

SECTION __. Chapter 118E of the General Laws is hereby amended by inserting after section 9E the following section:—

Section 9F. (a) As used in this section, the following words shall have the following meanings:

“Dual eligible”, or “dually eligible person”, any person age 21 or older and under age 65 who is enrolled in both Medicare and MassHealth or CommonHealth; provided that the executive office may include within the definition of dual eligible any person enrolled in MassHealth or CommonHealth who also receives benefits under Title II of the Social Security Act on the basis of disability and will be eligible for Medicare within 24 months, provided that the executive office may limit eligibility to those who will be eligible for Medicare within a prescribed number of months that is less than 24.

“Integrated care organization” or “ICO”, a comprehensive network of medical, health care and long term services and supports providers that integrates all components of care, either directly or through subcontracts and has been contracted with by the Executive Office of Health and Human Services and designated an ICO to provide services to dually eligible individuals pursuant to this section.

“Medically necessary”, a service reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions or daily activity functioning in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, result in illnesses, impairment, or infirmity, or inhibit integration into the community; or that is reasonably calculated to promote habilitation, wellness, recovery, or integration into the community.

[establish program]

(b) (1) Notwithstanding any general or special law to the contrary, the executive office of health and human services may, subject to appropriation and the availability of federal financial participation and pursuant to a memorandum of understanding or contract with the federal Centers for Medicare & Medicaid Services (CMS), establish a program of medical and functional long-term services and supports, known as the MassHealth integrated care organization initiative, for Massachusetts residents who are dually eligible. The executive office shall contract with integrated care organizations to provide or arrange to provide a comprehensive network of medical, health care and long term services and supports that coordinates and integrates all components of care, either directly or through subcontracts.

[enrollment and outreach]

(c) (1) Enrollment in the program shall be voluntary and shall be initiated at the request of a dually eligible person. Members may disenroll from the program or transfer to a different integrated care organization at any time. Enrollment and disenrollment shall be effective immediately upon receipt of a request by the executive office.

(2) The executive office shall contract with the Health Equity Alliance (“the Alliance”), created under subsection (p), to facilitate and coordinate enrollment into the program. The Alliance shall educate dually eligible persons, their families and their caregivers regarding the program, enrollment choices, the various integrated care organizations, and other matters to assure that persons who choose to enroll in the program understand the benefits and options of the program and of alternatives under Medicare and Medicaid. The Alliance shall prepare

materials for dissemination by the executive office and outreach organizations, including a definition of an ICO and how it functions; enrollment eligibility standards; the location of ICOs; a complete list of their participating providers supplied and updated monthly by the ICOs; the range of available services; consumer rights under Medicare and Medicaid; an assistance worksheet for determining care options under the program, Medicare and Medicaid; and quality of care measurements reported to the executive office.

(3) The Alliance shall designate non-profit community organizations as dual eligible outreach organizations. Sufficient outreach organizations shall be designated to reach all of the dually eligible persons in the Commonwealth, including persons best reached through organizations that focus on a particular language, ethnicity, race, geographic region or type of disability. The outreach organizations shall conduct outreach and education programs regarding the program, and refer interested dually eligible persons to the Alliance. The executive office shall provide grants to the outreach organizations to support their work under this section.

[benefits]

(d) (1) ICOs shall provide participants in the program with all medically necessary services to members, including, but not limited to,

(A) all services covered by Medicare parts A, B and D;

(B) all Medicaid services provided under MassHealth standard coverage;

(C) Medicaid services provided under waiver programs as of January 1, 2012, and any additional service provided under waivers implemented or expanded after January 1, 2012;

(D) long term services and supports, which include personal care services and supports that help people with disabilities meet their daily needs for assistance, promote recovery, and improve the quality of their lives. Such services include assistance with activities of daily living such as bathing and dressing, and instrumental activities of daily living, such as laundry and shopping, alternative housing options, peer services, recovery oriented behavioral health services, durable medical equipment, assistive technology, and transportation. Long term

services and supports may be provided over an extended period in homes and community settings, or in facility-based settings, and shall be provided in the most integrated and least restrictive setting possible. The ICO shall maintain contractual agreements with entities capable of providing long term supports and with entities capable of providing independent care coordination, which shall have the capacity to oversee the evaluation, assessment and plan of care functions, and to assure that services and supports are designed to support the member in the least restrictive setting appropriate to the member's needs. **A member determined to be clinically eligible for long-term services and support shall be given a choice of care setting which shall include at a minimum nursing facility services and community-based alternatives, including housing and supportive services on a twenty-four hour per day basis;**

(E) interpretation services, including interpreting services for the deaf and hard of hearing, in hospital and rehabilitative settings as well as other settings that are part of the beneficiary's treatment plan, including, but not limited to, wellness and other preventive care services and programs;

(F) additional services, including services necessary for the treatment, recovery from, or prevention of mental illness or substance abuse, as designated by the executive office and CMS;

(G) counseling regarding all state and federal employment incentive programs and regarding vocational rehabilitation and assistance services; and

(H) additional services determined by the member's care team to be medically necessary.

(2) Medical services provided to members of the program by an ICO shall be provided through patient-centered medical home models of care. The executive office shall establish standards for certification of medical homes. These standards shall require medical homes to provide proactive, accessible, continuous, coordinated and comprehensive patient-centered care managed by the care team and directed by the member.

(3) Members shall not be charged copayments or other cost sharing in connection with receiving services through the program.

[care team]

(e) Care shall be directed by the member, with the assistance of the member's care team. The care team shall include the member, and other participants of the team as determined by the member, including an independent community care coordinator and a primary care clinician, unless the member determines that the independent care coordinator or primary care clinician shall not serve on the member's care team. A member's care team shall be led by the member, with assistance as needed or desired from a representative or the member's surrogate or guardian, if any, or other persons of the member's choosing. The care team shall prepare a plan of care through an assessment and service planning process directed and led by the member that will identify the strengths, capacities, preferences, needs, and desired outcomes of the member, and the services necessary to achieve those needs and outcomes. The plan shall reflect transparency, individualization, recognition, respect, linguistic and cultural competence, and dignity, and provide an ongoing focus on member service. The planning process shall allow the member to identify and access a personalized mix of covered and non-covered services and supports that assist the member in achieving personally-defined outcomes in the community or other settings.

[care coordinator]

(f) Members of the program shall initially be provided an independent community care coordinator by the ICO, who shall be a participant in the member's care team. The member may direct the withdrawal or reinstatement of the independent care coordinator at any time. The community care coordinator shall assist in the development of a long term support and services care plan. The community care coordinator shall:

(1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status;

(2) arrange and, with the agreement of the care team, coordinate and authorize the provision of appropriate institutional and community long term care and supports and services, including assistance with the activities of daily living and instrumental activities of daily living,

housing, home-delivered meals, transportation, and under specific conditions or circumstances established by the ICO, authorize a range and amount of community-based services; and

(3) monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the care team; and

track member satisfaction and the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the care team.

The ICO shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long term services and supports on a compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. In the case of a member in the program age 60 or older, the member shall be offered the option of the services of an independent care coordinator as designated by the executive office of elder affairs pursuant to the provisions of section 4B of chapter 19 A. For purposes of this section, an organization compensated to provide only evaluation, assessment, coordination and fiscal intermediary services shall not be considered a provider of long term services and supports.

[open networks]

(g) (1) An ICO shall provide members access to out-of-network providers, other than primary care physicians, if the provider will accept the ICO rate for the comparable service offered and the ICO determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

(2) An ICO shall not, directly or indirectly:

(A) impose a monetary advantage or penalty under a benefit plan that would affect a member's choice among in or out-of-network health care providers who participate in the ICO according to the terms offered. For purposes of this subsection, a "monetary advantage or penalty" includes:

(i) a higher copayment;

(ii) a reduction in reimbursement for services; or

(iii) promotion of one health care provider over another by these methods;

(B) impose upon a member any copayment, fee, or condition that is not equally imposed upon all members when a member is receiving services from a provider pursuant to the member's care plan; or

(C) prohibit or limit a provider that is qualified under relevant licensing requirements, if any, and is willing to accept the ICO's operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in that plan or enter into a single case agreement to provide services to a member.

(3) Nothing in this subsection shall prevent an ICO from instituting measures designed to maintain quality and to control costs, including, but not limited to, the utilization of a gatekeeper system, as long as such measures are imposed equally on all providers; provided, however, no condition or measure shall have the effect of excluding any type, size, or class of provider qualified under relevant licensing requirements, if any, to provide that service.

(4) Nothing in the subsection shall require a provider to fulfill ICO network affiliation requirements or to contract to provide services to all of the ICO's members or any subpopulation in order to provide services to a member under a single case agreement.

[minimum medical loss ratios]

(h) During the first 3 years of the program, an ICO shall conform to the minimum medical loss ratio established by the executive office for its category. At the end of each fiscal year, the integrated care organization shall provide to the executive office an audited statement of its medical loss ratio for the past year. Two years after the implementation of the program, the executive office shall have 6 months to review the data and audited statements and shall have an additional 6 months to implement revised loss ratios. Beginning with the fourth year of the program and upon renewal of the contract with the executive office, an ICO shall conform to the revised minimum medical loss ratio established by the executive office for its category. Beginning with the fourth year of the program and upon renewal of the contract with the executive office, if an ICO's audited medical loss ratio is below the minimum as determined by

the executive office for its category, the ICO shall provide additional benefits or services to its enrollees in the following contract year in an amount that would raise its medical loss ratio to the minimum level established by the executive office for its category, and shall submit a plan to the office detailing how such benefits or services shall be provided to its program members.

[risk adjustment]

(i) Payments to ICOs shall be adjusted using risk adjustment measures that take into account validated measures of functional status in addition to diagnosis and other relevant socioeconomic and cultural factors.

[quality measures]

(j) The executive office shall implement transparent quality measures for evaluation of ICO performance, and shall make public each ICO's results on the quality measures. The executive office shall take quality measure performance into account in setting payment rates to ICOs. Payment rates shall include the cost of compliance with the Americans with Disabilities Act, pursuant to the requirements under subsection (k)(1). Payment rates shall also include funding for communication and interpreting services to beneficiaries, including, but not limited to, those who are blind, deaf, hard of hearing, or speech-impaired, or whose primary language is not English. The quality measures shall measure the degree to which services for members and populations increase the likelihood of desired health, functional, and other care outcomes. These measures shall include effectiveness of care in maintaining or improving health and functional capacity, health promotion, equity, patient centeredness, safety and timeliness. Measurement tools and information gathering methodologies shall reflect contemporary conceptualizations of disability and patient participation. Quality measurements shall include measurement of prevention of secondary disability, patient confidence, attainment of patient goals and engagement, and provision of services in the most integrated, least restrictive setting, ensuring that health and long term supports and services are provided in a manner that meets

the highest standards of quality care and equal to that provided to other patients with regard to administrative procedures, diagnostic procedures, treatment, communication, use of appropriate medical equipment, training of staff, and removal of architectural barriers. Quality measures shall also include increases in employment among members, the proportion of members provided employment counseling, and overall member satisfaction. The executive office shall contract with consumer-focused organizations of people with disabilities to measure member satisfaction. The executive office shall include health care and long term supports and services outcome and unjustifiable treatment disparities, as delineated by sex, age, disability, mental health status, income, race, sexual orientation, gender identity and expression, and such other categories as determined by the executive office, in the calculation of quality of services rendered by ICOs and in the determination of any payments correlated to quality.

[ICO requirements]

(k)(1) The executive office shall require every ICO and its network of providers to comply with the Americans with Disabilities Act, 42 U.S.C. 12101 *et seq.* (“ADA”) in the rendering of all care and services at the time of contract, or to provide a transition plan for full compliance with the ADA within six months of the contract date, prior to an award by the Commonwealth of a contract to serve dual eligibles. In order to determine ADA compliance, the ICO shall contract with a community-based organization (“CBO”) with a governing board membership comprised of 51% or more of people with disabilities that is certified by the Department of Public Health to assess compliance with the ADA. Contract awards shall be contingent on the CBO’s determination that the ICO meets ADA compliance requirements. Compliance with the ADA shall include ensuring that health services are provided in a manner the meets the highest standards of quality care and equality with regard to administrative procedures, diagnostic procedures, treatment, communication, use of appropriate medical equipment, training of staff, and removal of architectural barriers. The executive office shall promulgate regulations establishing a cost ratio formula which will be used to set a rebuttable presumption of reasonable burden under the ADA. Following contract approval, the CBO shall monitor implementation of transition plans and continued ADA compliance for each ICO. The CBO shall develop requirements for compliance plans, timetables for compliance, enforcement, and

penalties for failure to comply with the requirements under this subsection, including removal of certification as an ICO. The CBO shall report on continued ADA compliance to the Health Equity Alliance created under subsection (p). Such CBOs shall have full access to records and facilities to perform their duties, subject to agreements to protect the confidentiality of individual patients. The executive office shall develop regulations to implement this subsection.

(2) The executive office shall by regulation require every ICO to establish an advisory council or other meaningful direct mechanism for dually-eligible consumers to advise the ICO. The advisory council or other mechanism shall primarily include members enrolled in the ICO, and may also include family members, legal guardians, or unpaid caregivers of members enrolled in the ICO and representatives of consumer advocacy organizations. The advisory council shall meet at least quarterly throughout the year and shall annually elect a participating consumer, family member, or advocate who shall have a seat on the ICO's governing body; the elected person or his or her designee shall also sit on the Executive Office's advisory committee created under subsection (o). The ICO's consumer advisory council or other mechanism shall advise the ICO on all policies and practices of the ICO affecting the members' experience of care, shall have access to such information regarding the ICO's policies and practices as may be necessary for said purpose, and may make recommendations for changes in policy or practice to be presented to the ICO's governing body. The ICO shall assure that participation is accessible to individuals with diverse disabilities and to those not proficient in English.

(3) The executive office shall by regulation require every ICO to demonstrate its capacity to reduce disparities in care and provide culturally competent services that are appropriate to the complex needs of a diverse population in language, ethnicity, disability, including compliance with all CLAS (culturally and linguistically appropriate services) standards promulgated by the department of public health. Every ICO shall demonstrate that the providers in its network have cultural competency in working with different populations of people with disabilities including but not limited to intellectual disabilities, physical disabilities, AIDS/HIV, behavioral health disabilities, people who are deaf, have visual impairments, chemical sensitivities, or other sensory impairments. Every ICO shall demonstrate progress in reducing disparities in care based on sex, race, ethnicity, disability or disability status, age, sexual orientation, and gender identity and expression.

(4) The executive office shall by regulation prohibit an ICO from discriminating based on sex, race, ethnicity, disability or disability status, age, sexual orientation, and gender identity

and expression. Nothing in this section shall prohibit an ICO from limiting its enrollment to a particular geographic region or disability population if authorized by the executive office.

[privacy protections]

(l)(1) Psychiatric records of enrollees, including the fact that the enrollee is receiving or has received mental health services, notes of mental health clinicians, and records of psychiatric medication, shall be segregated from the physical health record of enrollees. Psychiatric records of an enrollee shall not be released to or accessed by any person, unless there exists written authorization, signed by the enrollee, which includes all of the following:

(A) The specific information relating to an enrollee's psychiatric record being released, and the names of the persons or entities to whom the psychiatric record or portions thereof is being released;

(B) A statement of the specific intended use of the information;

(C) A statement that the information will not be used for any purpose other than its intended use;

(D) A statement that the enrollee has a right to release discrete portions of his or her psychiatric records;

(E) The date the authorization expires, which shall be no more than one year from authorization and may be revoked in writing at any time;

(F) A statement that no entity or medical professional may refuse medical or mental health care as a result of an enrollee's refusal to release his or her psychiatric record; and

(G) A statement that if, as a result of withholding all or a part of his or her psychiatric records, the enrollee suffers damages, the entity or medical professional who caused the damage as a result of this withholding of records shall not be liable for the damage so caused.

(2) Psychiatric records shall be maintained so as to allow for the release of information as to psychiatric medications used by the enrollee separately from other psychiatric records. The ICO shall maintain a record for each access to an enrollee's psychiatric record, the name of each person accessing the psychiatric record and the date(s) of that access. The ICO shall adopt

procedures to ensure that only persons to whom the enrollee has given authorization shall access that enrollee's psychiatric record.

(3) Nothing in this section shall be construed to grant any additional authority to a provider of health care, health care service plan, or contractor to disclose information to a person or entity without the patient's consent. Nothing in this section shall be construed to alter existing law concerning the release of records for the purpose of criminal or investigatory proceedings of governmental entities.

[appeals]

(m) The executive office shall by regulation establish the right of all members of an ICO to advance notice of any adverse action denying, reducing, modifying or terminating a requested service and the right to a due process hearing to appeal any such adverse action, including the right to appeal a care plan. Each ICO shall develop an internal grievance and appeal process, including procedures for expedited decisions, and members may file a grievance or appeal regarding any adverse action or other dispute with the ICO to be reviewed by individuals not involved in the original decision. The decision of an ICO shall be in writing and notify the member of the right to file a further appeal with the MassHealth Board of Hearings. Any member aggrieved by an action of the ICO shall have the right to a due process hearing before the Board of Hearings of the office of Medicaid, including the right to have benefits continued pending appeal. All procedural rules applicable to timely and adequate notice and fair hearings with respect to MassHealth Standard shall apply to all disputes regarding eligibility, enrollment or services from an ICO, provided that such procedures shall be modified to the extent needed to provide additional procedural protections, identified by the executive office in consultation with consumers and consumer advocates, that are available in Medicare. Such additional protections shall include, but not be limited to, the rights to: file an appeal within 60 days of an adverse action, establish good cause for a late appeal, to have pharmacy appeals heard on an expedited basis, and to appeal a non-coverage determination or other decision by an integrated care organization not to pay a provider for a service on the grounds that the service is not covered or is not necessary. In any appeal regarding the medical necessity of a requested service, the individual appealing the decision shall have the right to obtain an independent second opinion of medical necessity at no cost to the individual.

The right to have existing benefits continued pending appeal shall extend to benefits that the individual was receiving prior to enrollment into an integrated care organization.

[involuntary disenrollment]

(n) An ICO may not involuntarily disenroll an individual from the ICO; or orally or in writing, or by any action or inaction, request or encourage an individual to disenroll, except in the case of disruptive behavior and after the ICO has complied with the requirements of this subsection. Disruptive behavior is behavior which substantially impairs the ICO's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment. An ICO may disenroll a member whose behavior is disruptive only after it meets the requirements described in this subsection and after the executive office has reviewed and approved the request. The ICO must make a serious effort to resolve the problems presented by the individual, providing the member with a choice of alternate providers both in and out of the ICO network and providing reasonable accommodations, as determined by the executive office. Thirty days before making a request for permission to disenroll a member of the executive office, the ICO shall notify the member in writing of the reasons for disenrollment, the member's appeal rights, and community and legal resources to assist the member. In the event that the executive office approves a request to involuntarily disenroll a member, the member shall be given an advance notice with appeal rights including the right to remain enrolled in the ICO pending the appeal.

[advisory committee]

(o) The executive office shall establish an ICO advisory committee to advise the office regarding the ongoing operations of the program. The advisory committee shall include the elected representatives of the ICO advisory councils or other mechanism pursuant to subsection (j) and in addition, at least a majority of the members of the advisory council shall include representatives of consumer and disability rights advocacy organizations including, but not limited, to the Statewide Independent Living Council, Arc of Massachusetts, Mass Home Care, Disability Policy Consortium, Health Care For All, the Transformation Center, M-Power,

Massachusetts Senior Action Council, National Empowerment Center, Massachusetts Advocates Standing Strong, the Disability Law Center, Greater Boston Legal Services, and the Mental Health Legal Advisors Committee. The executive office shall provide the committee with the staff and technical assistance as is necessary to enable the committee to make effective recommendations, and such accommodations as necessary to enable participations by individuals with diverse disabilities and to those not proficient in English. The executive office shall seek the advice of the advisory committee prior to any change in contracts, regulations, policies or procedures affecting the provision of care in an ICO. The executive office shall consult with the committee on risk adjustment, quality and outcomes measures, monitoring of network adequacy and consumer satisfaction, the number and types of grievances and appeals, enrollment and disenrollment, ADA compliance monitoring, and other relevant matters. The executive office shall record recommendations made by the advisory committee and report back at the following meeting whether the office will be adopting the recommendations or not and its reasons.

[community advocacy and ombudsman]

(p) (1) There is hereby established the Health Equity Alliance, referred to in this subsection as the Alliance. The Alliance shall be an independent advocate of members of the program to provide quality assurance, performance monitoring and ombudsman services to integrated care organization members. The Alliance shall facilitate and coordinate enrollment into the program, pursuant to paragraph (2) of subsection (p).

(2) The Alliance shall be composed of 19 members, including 10 members designated by Disability Advocates Advancing our Healthcare Rights, 4 designated by the executive office, and 5 designated by integrated care organizations. Members shall serve for 3-year terms. The executive office shall establish procedures for the appointment, renewal, and replacement of vacant positions on the Alliance. The Alliance shall select a chair from among the members designated by Disability Advocates Advancing our Healthcare Rights.

(3) The Alliance shall assist members of the program who have concerns or questions regarding the program and individual ICOs. The Alliance, at the request of a member, may assist with the filing and appeal of grievances and denials of services. The Alliance shall have the authority to review, in collaboration with the designated community-based organization

(“CBO”), as defined in paragraph 1 of subsection (k), compliance and transition plans for full compliance with the Americans with Disabilities Act, and, as reported by the CBO, shall report noncompliance with the ADA to appropriate authorities. The Alliance shall additionally have the authority to review quality and performance data; review eligibility and enrollment coverage policies; and review medical necessity criteria and protocols. The Alliance shall perform the outreach and enrollment functions described in paragraph 3 of subsection (c).

(4) The executive office shall assess each ICO a per capita monthly fee reasonably calculated to collect approximately \$350,000. The executive office shall annually transfer this fee revenue to the Alliance, for the purposes of this subsection.

[*disparities*]

(q)(1) The executive office shall manage the program with a goal of reducing disparities in health care access and health outcomes for people with disabilities based on sex, age, disability, mental health status, sexual orientation, gender identity or expression, income, race, geography and other categories, including social determinants of health disparities.

(1) Each ICO shall be directed by regulation to report data on disparities in health care access and health outcomes using the health indicators as developed by the Massachusetts Behavioral Risk Factor Surveillance System and the health disparities council based on sex, age, disability, mental health status, sexual orientation, gender expression or identity, income, race, geography and such other categories to the disability disparities working group within the health disparities council pursuant to subsection (e) of section 16O of chapter 6A. The data shall compare disparities between people with disabilities and those without disabilities, and within the disability community.

(2) Each ICO shall be required to comply with the recommendations of the disability disparities working group’s annual report pursuant to said subsection (e), with the goal of reducing health disparities for dual eligibles.

SECTION __. Section 16O of chapter 6A of the General Laws is hereby amended by adding the following subsection:–

(e) The council shall by regulation establish a disparities working group on disabled persons which will set standards for data reporting and set minimum benchmarks for the elimination of health disparities for disabled individuals. A majority of the members of the working group shall be persons with disabilities. The working group shall collect data from each Integrated Care Organization (“ICO”), as defined by section 9F of chapter 118E, on disparities in health care access and health outcomes based on sex, age, disability, mental health status, sexual orientation, gender expression or identity, income, race, geography and such other categories pursuant to subsection (q) of section 9F of chapter 118E. The working group shall prepare and publicly release an annual report to the secretary of health and human services on the progress of each ICO in reducing health disparities. The content of the report shall be dictated by the disability disparities working group pursuant to regulation.

What We Know About the Integrated Care Organization Plan

Testimony From Mass Home Care Before EOHHS December 16, 2011 in Worcester

1. This is the first time the state has tried to combine long term services and supports (LTSS) with medical care into a mandatory enrollment program. The existing SCO plan, which serves 18,000 low income elders, is voluntary by statute.
2. This ICO plan *today* is for people up to age 64, but it is clear that it will be the template for serving the elderly as well. As people turn 65, they will remain enrolled in their ICO plan. The plan says: “ there is a clear expectation that the program designed as part of this initiative will be used to provide invaluable information about how to enhance the options available to dual eligible members of all ages and to MassHealth members regardless of their Medicare eligibility.”
3. The Congressional Research Service told Congress in 2006 that possible concerns of dual eligibles about joining a managed care program may include the following 5 concerns that we share
 - (a) the limitations to an individual’s choices and flexibility in the services he or she receives;
 - (b) the expertise of the managed care plan about disability and chronic conditions;
 - (c) the breadth and scope of covered benefits;
 - (d) the continuity with existing physicians/service providers; and
 - (e) the concern that the financial incentives for savings will ultimately result in limiting services and quality.
4. This plan by design gives all the Medicare and Medicaid money to large insurance-based or provider-based entities---most of which have little or no experience with long term care.
5. The LTSS portion of what MassHealth spends on the duals is more than \$3.6 billion. For this reason, the ICO plan will attract large, investor-owned insurance companies and managed care plans that are vertically integrated to own or control a direct service network. This plan puts all the money in their hands, with no medical loss ratios to control excess profit-taking.
6. This ICO plan looks more like a provider-centric model than a patient-centered model.

- 7 Although most LTSS for younger disabled people is spent in the community, it is reversed for older people: 66% of LTSS for seniors is spent in nursing facilities. Medical homes, the building block for this plan, have no expertise in providing LTSS.
- 8 There are roughly 221,500 poor people who use long term care services in this state, and they would end up enrolled in this plan.
- 9 35% of MassHealth spending on these younger duals today is for LTSS---equal to the *combined spending* on inpatient hospital care (22%) and physician care (14%). So LTSS is a huge part of this plan.
- 10 The ICO plan lets MCOs do their own care coordination of LTSS in the community. It contains no “independent, conflict free care manager” to serve as the “agent” for the consumer, and to balance out the highly medicalized design of this plan.
- 11 The federal CMS has told states that the delivery of LTSS should provide consumers with a conflict free care manager. EOHHS has had 10 years of experience with this under SCO plan, using “geriatric support services coordinators” who are not owned by the SCOs.
- 12 At a minimum, we want every member who turns 60 to have a geriatric support services coordinator provided by Chapter 19A, section 4B agencies added as an independent agent on the care team.
- 13 Coordination of benefits for the elderly means including state-funded home care, and federally funded Older Americans Act services—which are not currently part of the ICO plan.
- 14 The ICO plan guarantees members access to a nursing facility as part of the Medicaid state plan---but it fails to guarantee the equivalent level of support in a small community-based home setting. This lack of “residential habilitation” violates the provisions section 9 of chapter 118E, the equal choice law---which promises people on Medicaid care in the least restrictive setting.
- 15 Although the federal government has given states the option to make enrollment mandatory (the euphemism is ‘passive enrollment’) we believe that under section 1932 of the Social Security Act, Medicare beneficiaries are exempted from being required to enroll in a managed care plan.
- 16 If the Governor and the legislature decide to end the fee-for-service system, then this ICO plan will be like a medical Hotel California: “you can check out anytime you want---but you can never leave.”
- 17 Stakeholders repeatedly told EOHHS they wanted a “voluntary opt in” plan.

- 18 This plan is predicated on performance based contracting for managed care companies---yet there are no quality measures in place yet that address LTSS and functional outcomes.
- 19 It appears that people age 60 to 64 in the elderly waiver would be enrolled in an ICO but still receive waiver services under their current arrangement. But over time the frail elderly waiver would be phased out as members die.
- 20 Likewise, the future of the SCO program is unclear. The ICO plan says “The Commonwealth expects the distinction between SCO and the new Demonstration to diminish over time, especially since Demonstration enrollees will be allowed (but not required) to remain in the Demonstration as they turn 65.”
- 21 EOHHS believes it has “broad authority” to implement the ICO plan, but we believe that any plan which will impact a quarter of a million poor people in our state, and involve several billion dollars in taxpayer spending, should have a legislative framework to protect consumers, and we are urging the General Court to seriously consider the legislation that disability rights advocates---including Mass Home Care---have drafted.

Mass Home Care has worked for years for full integration of health and LTSS---but we cannot support this ICO plan until the major design changes mentioned above are addressed. Our full testimony is attached.

**Response to the
STATE DEMONSTRATION TO INTEGRATE CARE FOR
DUAL ELIGIBLE INDIVIDUALS**

**Prepared by Mass Home Care
December 16, 2011**

Mass Home Care Background

Mass Home Care represents 30 non-profit agencies which serve the elderly and disabled on Massachusetts. Our mission is to help individuals with disabilities to live in the least restrictive setting possible, at their highest level of functioning possible, for as long as possible. 27 of our members are designated by the Executive Office of Elder Affairs as Aging Services Access Points (ASAPs) pursuant to Chapter 19A, 4B.

Under this statute, ASAPs “coordinate services on behalf of Medicaid eligible elders,” and conduct “intake, comprehensive needs assessments, preadmission screening and clinical eligibility determinations for elders seeking institutional and community care services from Medicaid or the home care program. ASAPs are responsible for arranging, coordinating, authorizing and purchasing community long-term care services.” Home care corporations were created in 1973 under Chapter 19A, s. 4. A majority of the governing body of home care providers are persons sixty years of age or older who reside in the cities or towns served.

In 1996: home care corporations became ASAPs. In addition to managing LTSS care for more than 60,000 individuals annually in the home care programs, the ASAPs provide geriatric support service coordinators (GSSCs) to the elderly dually eligible population enrolled in the Senior Care Options programs.

General Comment

Mass Home Care appreciates the motivation and effort of EOHHS to create a more integrated approach to the provision of health and Long Term Supports and Services (LTSS). This is a very ambitious goal given the financial constraints facing federal and state governments.

There are certain design elements that Mass Home Care finds lacking in the latest iteration of the ICO plan. As one of the “stakeholders” that attended almost every meeting conducted by EOHHS, none of our recommendations below should come as any surprise.

We are profoundly disappointed that EOHHS has chosen to omit any reference to the role of the well-established LTSS delivery system created by the Commonwealth and managed through the Executive Office of Elder Affairs (EOEA). Lack of coordination and integration through this network is one of the major flaws we see in this plan. In fact, the ICO plan as drafted represents one of the major setbacks in the coordination of LTSS services in the past two decades.

This may be because EOHHS is not responsible for, nor familiar with, the Chapter 19A system of home and community-based LTSS, or because a medical model framework is more

comfortable and convenient to contemplate. Regardless, this ICO plan resembles an early version of the Senior Care Organization (SCO) plan first presented by EOHHS almost 15 years ago – which also was a medically-driven model not mediated by the need for LTSS coordination.

Fortunately, the General Court created a legislative framework for the SCO plan that was ultimately accepted, and that plan created a place for a non-medical community care coordinator on the consumer’s care team – a position that became the “geriatric support services coordinator.” SCOs and ASAPs alike have praised this model, and touted its success in keeping people living in the least restrictive setting. This was not something that EOHHS created for the SCO—and the same hands that are crafting this ICO plan have omitted it again. One of the worst sins a planner can commit is to fail to understand and appreciate the history of relationship that predated the launching of a new plan.

Without better coordination between the medical and functional supports that members will need, and without the presence of an independent, conflict free care coordinator who can function as the agent for the member—not owned by the ICO—Mass Home Care cannot support this plan, and will actively oppose it.

We understand that there are those who think that ICOs are the “next new thing,” but our experience over the years with managed care plans suggests that some checks and balances described below are needed to prevent the plan from putting shareholder needs higher than patient needs, and medical interventions higher than functional supports. LTSS and medical supports work best when they are equal players on the care team, subservient first and foremost to the aspirations and goals of the consumers who place their hopes and dreams into our hands.

LTSS and the Duals Population

The provision of LTSS services to the duals population is a very significant part of the care plan mix. Functional supports are a critical part of many health care plans, because if an individual cannot accomplish the basic activities of daily living, the medical care plan at home is likely to fail. An underlying medical condition may cause certain functional deficits which cannot be treated with a medical service at all.

According to the Kaiser Family Foundation, 60% of the spending on services for duals in Massachusetts in 2007, or \$2.86 million, was for LTSS. MassHealth spending per duals in 2007 was \$18,268 for disabled adults, and \$24,274 for elderly adults.

In what setting the LTSS dollar gets spent varies significantly by age group. For younger disabled people, most LTSS money is spent in the community. For seniors, most LTSS spending is in nursing facilities. This EOHHS analysis from the Money Follows the Person (Jan. 2011) Operational Protocol illustrates the dramatic difference in spending emphasis:

Setting	Members			Spending	
	Elders (65+)	Disabled (<65)	Total	Elders (65+)	Disabled (<65)
Community	58,532	110,691	169,223	\$736 million	\$1.235 billion
Facility-based*	41,941	10,430	52,371	\$1.411 billion	\$293 million
Total	100,473	121,121	221,594	\$2.147 billion	\$1.558 million

Data from a September, 2011 Massachusetts Medicaid Policy Institute study of the non-elderly (age 21 to 64) duals population indicates that LTSS is a major part of the care utilized by dual eligibles, and that most people in this age group are age 45 and up. Spending on LTSS care equaled the total of spending on doctor and inpatient hospital combined:

- 30% of the non-elderly duals are age 55 to 64, and 63% are over the age of 45
- 6% of these duals account for 37% of the spending
- 35% of the combined Medicare and Medicaid spending was for LTSS – nearly half of that was for home and community based waiver service
- 30.7% of these duals need LTSS services either in the community, or in an institution
- LTSS spending in MA for duals age 19 to 64 was \$860 million
- Spending on LTSS (35%) was about the same as spending on inpatient hospital and physician care as combined (36%)
- The cost of duals in institutions (\$101,900) was nearly 5 times higher than spending on duals in the community (\$21,500)
- Individuals that experienced extended episodes in institutional facilities made up 5.3 percent of the total population, yet accounted for over 20% of Medicare spending and nearly 30% of Medicaid spending
- Nearly 8 out of 10 duals have a physical illness or disability, 6.5 out of 10 have a behavioral health issue
- 59% of duals have two or more major diagnoses and account for 83% of all spending
- Nearly half (47%) of this population have a combination of physical and behavioral disabilities, and they account for 48% of the spending.

This data suggest that for the ICO project, LTSS is a major component of service plan need, and should be a significant part of any planning initiative – especially if this ICO model is going to be used for seniors as well as non-elders adults.

Phasing Out Senior LTSS Programs

Because the ICO plan states that “MassHealth intends allow members to stay enrolled in ICOs when they turn 65,” and that PACE and Medicare Advantage enrollees “will have the option to change their enrollment to the Demonstration,” Mass Home Care assumes that several existing elderly LTSS programs over time will be diminished or phased out entirely:

- The Senior Care Options plan for duals (~ 18,000 people) would be transferred to ICO plans run by SCOs. ICOs have no GSSC requirement.
- The ASAP Community Choices plan for MassHealth members (6,128 people)
- The ASAP home care program for individuals on MassHealth ((~10,600 people)

This means that close to 35,000 elders on MassHealth now being care managed by ASAPs would be shifted from the ASAP caseload to ICOs.

Recommendation: The ASAPs should remain involved in the ICO plans and provide the geriatric support services coordinator for ICO enrollees.

Interdisciplinary Functions & Funding

For years, Mass Home Care has advocated for integrating LTSS – not only with primary and acute care providers – but also with funding sources, such as Medicare, Medicaid and state-funded home care LTSS.

Historically, LTSS services were fragmented along funding lines, with Medicaid LTSS controlled by EOHHS, and state funded home care controlled by EOEA. We played an active role in the 2003 statutory reorganization of EOHHS agencies which placed the management of both Medicaid and state funded LTSS under EOEA. According to chapter 19A, section 1: “The secretary [of EOEA] should administer chapter 118E relative to medical care and assistance to eligible persons age 65 and older except for acute care services... The secretary shall be responsible for administering and coordinating a comprehensive system of long-term care benefits and services for elderly persons, including institutional, home-based and community-based care and services.”

The expectation of this reorganization was that EOEA would be able to better integrate disparate funding sources to create a “comprehensive system” of LTSS. Acute care was specifically left out of EOEA’s oversight, because EOEA expertise was in LTSS, not in primary or acute care. In practice, EOHHS maintained control over MassHealth LTSS, and elder rights groups brought this concern to EOHHS, charging that EOEA’s role under the reorg had been diminished to a Department level. As a case in point, the ICO plan – which includes LTSS – was written by EOHHS, not by EOEA. But the coordination between the ICO plan for LTSS and the EOEA state home care programs is not mentioned in the ICO narrative.

With the Integrated Care Organization (ICO) plan, EOHHS is formally taking LTSS back from the agency which was supposed to manage it, and transferring LTSS – including home and community based care—over to primary and acute care providers – who have no expertise or experience with LTSS. According to home care program data, only 3% of all referrals to home care come from doctors. This dramatic change in the organization of LTSS delivery is not consistent with current statute, and in fact has no legislative framework at all. EOHHS told Mass Home Care that medical homes would not be involved in LTSS – and that there was no mechanism to pay for LTSS. The ICO plan involves medical homes as the coordinator of LTSS – a role they have never performed.

Recommendation: Medical homes should not be given the duties and powers of overseeing

the provision of LTSS for elders. This function should remain part of EOE, and based in the Chapter 19A, 4B designated agencies.

A recent study of LTSS services across the nation indicated that in Massachusetts, the percent of new Medicaid LTSS user's first receiving services in the community (2007) was only 31%, compared to the all states median rate of 49.9%. The AARP Survey concluded that:

“If Massachusetts improved its performance to the level of the highest-performing state: 10,203 more new users of Medicaid LTSS would first receive services in home and community based settings instead of nursing homes; 3,945 nursing home residents with low care needs would instead be able to receive LTSS in the community; 2,616 unnecessary hospitalizations of people in nursing homes would be avoided.

Massachusetts has one of the oldest and largest community-based LTSS networks in the nation, and the ICO plan fails to build on the infrastructure that the state has invested in since the mid 1970s. This system involves more than \$280 million in funding annually to help older consumers live independently at home. This home care network is: non-profit; community-controlled; financially free of direct service conflicts. Rather than build on this existing infrastructure for LTSS, consultants at EOHHS have designed a system that pulls apart LTSS services by funding source, creating a Medicare/Medicaid silo, and a home care silo. The ICO offers a chance to integrate funding and function – but fails to do so in its current design. It should be noted that this same consultant recommended to EOHHS that the SCO plan (see below) also not use the existing home care

infrastructure—but the General Court rejected that advice in the late 1990s when the SCO legislation was being written.

A more comprehensive, coordinated approach would be to create an interdisciplinary team that combines not only primary, acute, behavioral health and LTSS—but funding streams like Medicare, Medicaid and state-funding home care as well. Such a system contains checks and balances between the primary/acute health care needs of the consumer, and their LTSS needs.

Recommendation: The ICO plan should integrate LTSS into the health care system not just by function, but by funding as well, The way to fully integrate health services with functional LTSS services is to understand that they involve different disciplines that can be coordinated and balanced by involving both disciplines as separate entities on the consumers' care team.

The Role of Conflict-Free Care Management

This balance of disciplines can be best achieved through an interdisciplinary care team that includes an independent care coordinator for LTSS. This was one of the strong recommendations of stakeholders who attended the hearings held by EOHHS regarding this ICO plan. The conflict free care manager on the team serves as the independent evaluator, independent assessor, and the agent for the consumer, as explained below:

The duties and functions of the conflict free care manager have been defined by CMS in section 10202 of the Affordable Care Act, as part of the Balancing Incentive Payment Program (BIPP) as follows:

“Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary’s caregivers) in directing the provision of services and supports for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary’s needs and achieve intended outcomes.”

In directing states how to prepare a conflict free care management approach, CN4S said:

“For purposes of Balancing Incentive Program, States will establish conflict of interest standards for the independent evaluation and independent assessment. In this section, we refer to persons or entities responsible for the independent evaluation, independent assessment, and the plan of care as —agents to distinguish them from —providers of home and community—based services. The design of services, rate establishment, payment methodologies, and methods of administration by the State Medicaid agency may all contribute to potential conflicts of interest. These contributing factors can include obvious conflicts such as incentives for either over- or under-utilization of services; subtle problems such as interest in retaining the individual as a provider of services. Payment to the independent agent for evaluation and assessment, or qualifications to be an independent agent, cannot be based on the cost of the resulting care plans.”

Definition of Provider vs. Care Coordinator

In the past, EOHHS has considered entities like ASAPs to be “providers” in the very narrow sense that anyone managing a service for MassHealth had to have “provider’s” number. But in the case of the ASAPs, for example, these entities were performing more of an independent care management role, and not direct hands on’ care. Whether the Medicaid service was Adult Foster Care, Personal Care Attendant, or other contractual services, the ASAI was not providing the direct care, but was performing more as an agent on behalf of the consumer.

Because of this narrow interpretation from MassHealth in the past, disability advocates included the following language in their ICO legislation:

“For purposes of this section, an organization compensated to provide only evaluation, assessment, coordination and fiscal intermediary services shall not be considered a provider of long term services and supports.”

The advocates’ legislation also included the following language to ensure the provision of conflict free care coordination:

“The ICO shall maintain contractual agreements with entities capable of providing long term supports and with entities capable of providing independent care coordination, which shall have the capacity to oversee the evaluation, assessment and plan of care

functions, and to assure that services and supports are designed to support the member in the least restrictive setting appropriate to the member's needs.... The ICO shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator.”

The SCO Model

Under Chapter II 8E, section 9D, dual eligibles enrolled in a Senior Care Options (SCO) program must have a geriatric support services coordinator, which is defined under statute as:

“Geriatric support services coordinator”, a member of a senior care organization primary care team who is employed by an aging services access point, is qualified to conduct and is responsible for arranging, coordinating and authorizing the provision of appropriate community long-term care and social support services.”

In the SCO model, the GSSC is employed by an entity designated by EOEI under Chapter 19A, 4B,

“ASAPs under contract with SCOs shall employ geriatric support service coordinators, who shall be members of the primary care team and shall be responsible for: (i) arranging, coordinating and authorizing the provision of community long-term care and social support services with the agreement of other primary care team members designated by the SCO; (ii) coordinating non-covered services and providing information regarding other elder services, including, but not limited to, housing, home-delivered meals and transportation services; (iii) monitoring the provision and outcomes of community long-term care and support services, according to the enrollee's service plan, and making periodic adjustments to the enrollee's service plan as deemed appropriate by the primary care team; (iv) tracking enrollee transfer from one setting to another; and (v) scheduling periodic reviews of enrollee care plans and assessment of progress in reaching the goals of an enrollee's care plan..”

Recommendation: 1) The ICO plan, as in the SCO plan, should be amended to add the requirement for an independent, conflict free LTSS care coordinator on every member's interdisciplinary care team. 2) Organizations which are compensated to provide only evaluation, assessment, coordination and fiscal intermediary services should not be considered a provider of long term services and supports. 3) The ICO should not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. 4) At a minimum, all individuals enrolled in a ICO plan, when they reach age 60, should have a geriatric support services coordinator added to their team, as provided for under Chapter uSE, section 9D.

Recommendation: The ICO plan also needs to clarify what will happen to the existing SCO plan under Chapter 118K. If the current SCOs become ICOs, will the SCO side of their operation be phased out? Will enrollees in an ICO follow the rules of a SCO plan or an ICO plan?

Contracts with Independent Care Coordinators

The EO1-IHS plan says that “The PCMH will provide care coordination and management services to support the enrollee across care settings... ICOs must have internal capacity or make contractual arrangements to ensure availability of all services in a member’s care plan – includingproviders of LTSS, home care and other community supports)’

The ICO plan says: “.PCMHs will provide a Care Coordinator to serve on the enrollee’s care team. The Care Coordinator and enrollee will work together to determine the enrollee’s needs and medical and non-medical care options. The Care Coordinator will help the enrollee access services and will facilitate bringing together the care team, including providers outside of the PCMH, to develop a person-centered care plan.”

The medical home should directly employ the clinical care manager, hut the LTSS Care Coordinator should be a community based organization not owned by the medical home or the ICO. To the degree the ICO plan converts medical homes into LTSS care coordinators, it completely replicates the existing LTSS care coordination system currently available through the ASAP system. This is wasteful of resources, and will fragment care delivery for people over 60 based on funding stream.

The plan also says that “the ICO will be responsible for ensuring that a sufficient number of appropriate providers, including community-based LTSS providers, are available to deliver all covered services to the ICO’s anticipated enrollees.” This is the role of the independent care coordinators, and the community-based LTSS provider networks have already been established by Chapter 1 9A, 4B agencies.

CBO Requirement Similar to the Care Transitions CMS Grant

This requirement that a medical home have a community based organization partner that provides conflict free care management is similar not only to the federal Balanced Incentive Payment Program (BIPP), but also to the Community Based Care Transitions Program (CCTP) solicitation released by CMS last spring under section 3026 of P.L. 111-148 (the “Affordable Care Act”). The CCTP program required hospitals seeking to receive grant funds to reduce readmissions to partner with a CBO (Community Based Organization). The CBO was defined as follows:

“CBOs are defined as community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals and whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers.”

CMS explained to hospitals that frequent readmissions were not just a hospital problem: that the hospital was just the locus of the problem, but the source was at least partially in the community. For this reason, CMS encourage hospitals to reach out to the community to find a CBO partner.

In similar fashion, when crafting a plan that encompasses a very broad scope of services beyond primary and acute care, it is critical to ensure that medical homes have a community based partner with expertise in LTSS---an area in which medical homes have little or no experience---but one in which the state has direct experience, including a statutory framework for care coordination and management.

Providing medical homes with the support of a geriatric support services coordinator is also similar to BOHHS selecting a single entity statewide to provide a comprehensive behavioral health program for the MassHealth Primary Care Clinician Plan (PCC Plan), with a particular focus on the integration of behavioral health and medical care by improving coordination between providers of care and providing a care management program to specified individuals with complex medical and/or behavioral health conditions enrolled in a medical home.

Recommendation: Medical homes within the ICOs should be required to have a contractual arrangement to ensure the independent care coordination of LTSS services. If an ICO provided this service internally, it would not be independent, and would create potential conflicts of interest. The plan should also require that people age 60 and over shall have a geriatric support services coordinator (see SCO plan).

Enrollment

It is disingenuous to describe the ICO enrollment “voluntary.” The ICO plan says: “MassHealth proposes a voluntary opt-out enrollment process. This will be the underpinning of MassHealth’s efforts to enroll as many eligible members as early as possible in the Demonstration. . .All dual eligible members will have the opportunity to opt out of the Demonstration,. . .The Commonwealth proposes that there be no lock-in period and that members may change ICOs within the Demonstration, or select the FFS option, at any time.”

But the ICO plan is more accurately described as a “mandatory opt out” program, since enrollees will have to opt out on their own. This “opt out” also is misleading, because the Governor has submitted global payments legislation which says:

“Payments will move from predominant fee-for-service to global and other alternative payment methods for the provision of health care services. All public and private payers in the commonwealth will move to reimbursements that are based on the quality rather than the volume of services.”

As the ICO plan narrative points out: “The [Governor’s] bill encourages movement away from current FF5 payment structures and directs public payers to implement alternative payment methodologies by January 2014. The question remains: If the Governor, or the General Court, eliminate fee for service, how will people in an ICO plan be able to opt out? There will be no ‘out’ for them. The ICO plan as it stands now, is like a medical Hotel California: “You can check out anytime you want---but you can never leave.”

According to CMS’ *Medicare & You* Booklet:

“If you’re in a Medicare health plan, you will automatically return to Original Medicare if you don’t choose to join another Medicare health plan.”

Under Medicare law, for example, if a beneficiary joins a Medicare Advantage Plan but want to return to Original Medicare, he or she have the right to switch back to Original Medicare. Given the possibility that Massachusetts may eliminate FF8 altogether, the ICC plan needs to clarify with CMS if Medicare beneficiaries can enroll in an ICC and still retain the right to return to Original Medicare

In January of 2011, a group of Medicare rights groups wrote a memo to the Secretary of DHHS about the dually eligibles and the CMS office of Innovations, which stated:

“Beneficiaries’ right under both programs to free choice of provider is fully protected such that beneficiaries are not required to join any particular demonstration or type of service delivery system to get services;

At almost every stakeholder’s meeting, advocates were clear that if the ICO plan was a great benefit plan, that members would join without being passively enrolled. Stakeholders urged EOHHS to use the 5CC model as a template---which is a voluntary plan. Given the knowledge that FF5 is being phased out, EOHHS has some additional negotiations to do with CMS to clarify specifically whether or not Medicare beneficiaries can be locked into a managed care plan which provides no access to Original Medicare.

Recommendation: People on Medicare are supposed to have the right to access the Original Medicare fee for service regardless of what other Medicare plan they may have enrolled in. If there is no fee for service in Massachusetts, the ICO plan needs to clarify with CMS if ICO enrollees will be allowed to switch back to Original Medicare, and under what conditions. EOHHS should obtain a legal ruling of what rights a Medicare beneficiary has if there is no FFS option left in their state.

Scope of Services: Alternatives To Nursing Facilities

The ICO plan says “the Commonwealth has identified that a broader range of LTSS and community support services would be effective for dual eligible adults.”

The plan also says, “MassHealth proposes that the ICO’s benefit package bring with it not only those State Plan services as they are currently covered, but also expansions of certain State Plan services. These include: preventive, restorative, and emergency oral health (dental) benefits; personal care assistance that includes cueing and monitoring.” Mass Home Care strongly supports oral health expansions, behavioral health expansions, and cueing and supervision for PCA services.

Mass Home Care supports the provision of this broader range of services—especially broader behavioral health and dental services.

We regret, however, that the ICO does not include “residential habilitation” services as part of the ICO service package. The plan as developed includes nursing facility services as part of the basic IvlassHealth state plan, but a 24/7 alternative in the community, such as a small home for up to 4 individuals, is not included. This should have been corrected five years ago with the passage of the Equal Choice law, Chapter 1 1SF, section 9.

Recommendation: The ICO plan should be amended to add “residential habilitation” to the list of additional services that ICOs are expected to have the capacity to purchase for members. This service should be defined as “24/7 housing with services for individuals who are eligible for LTSS and supports at an institutional level.” Without this addition, the service scope in the 1CO plan is an “institutional first” plan.

Elderly Waiver Carve Out

The ICO plan becomes very confusing and obscure on the subject of how people in existing HCBS waivers will relate to the new JCO plan. At one point, it **seems to suggest a LTSS** carve out for people in the 1915c elderly waiver:

“For those enrolled in a HCBS waiver, though, it is possible that, within the three- year period of the Demonstration, ICOs may not be able to replicate the extensive and fundamental LTSS needed by these specific populations, or to add sufficient value for these members. The Commonwealth therefore seeks consultation with CMS on the feasibility and desirability of offering a different benefit “tier,” which includes access to a PCMFJ and all other 1CO services, except LTSS, for those Demonstration enrollees who are enrolled in HCBS waivers., frail elders ages 60 to 64, who use HCBS waiver LTSS that are managed by state agencies, could continue to access those services through current arrangements so as not to disrupt essential care. With this option, HCBS waiver participants would enroll in the ICO and continue to receive LTSS and case management through the operating agency of the HCBS waiver. The ICO’s capitation rate would be adjusted to exclude these designated services. The ICO would remain fully responsible for all other aspects of the enrollee’s care, and would be required to consider the enrollee’s state agency waiver service plan in his or her care plan, and to include the waiver case manager on the care team, if that is agreeable to the parties.”

Recommendation: The ICO plan needs to clarify its relationship with all the waiver programs affecting the elderly and disabled, especially since younger people enrolling in an ICO plan will remain in an ICO plan when they become age 65. This suggests that the waiver programs would eventually end through attrition.

Other Issues

Minimum Loss Ratios

ICOs will have to manage the provision of care to ensure that they do not exceed their per member per month capitation, which is the fundamental principle behind all managed care. This

could prove especially disadvantageous to consumers with high cost care plans. The ICO plan should adopt clear minimum loss ratio language to prevent excessive profit-taking by plans.

Recommendation: Loss ratio language found in the SCO law can serve as a starting point for MLR language in the ICO plan

Quality Measures

The Quality measures that have been discussed with stakeholders thus far are vaguely defined, and for LTSS almost non-existent. The outcome measures listed are either medically oriented, or very process-oriented instead of care-outcome measures. For example, people being discharged from a hospital have this performance measure: “telephonic or in-person follow-up with their care team within two days of discharge.”

For this plan to work, providers must be driven by performance outcome incentives, and sanctions for poor performance. Given the lack of measures under review, this raises the concern that performance outcomes will use only medical metrics, and will minimize the importance of functional outcomes

Recommendation: A thorough presentation of performance outcome measures should be put in place, for both medical and LTSS measures, before any care management work begins at any ICO. Attention to functional, LTSS metrics should be as critical as medical outcome measures.

Need For A Legislative Framework

EOHHS suggests that legislation is not needed for this ICO plan, that they have the statutory authority to implement the plan without legislative approval, although some aspects might need legislative review, they say. ‘The SCO plan, the state’s integrated care plan for the elderly, had a legislative framework put into place. No SCO regulations were ever written. The ICC plan should have similar statutory roles and duties spelled out in law, to ensure consistency across future Administrations. This project will also need an appropriation from the General Court---no specific price tag is mentioned.

Recommendation: EOHHS should review the legislation that DAAHR advocates developed, and work with the Joint Committee on Health Care Financing to ensure that a legislative framework for the ICO plan is written into law, as was the SCO law.

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January 4, 2011

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Deputy Director Callahan:

1199SEIU represents 45,000 members who work in hospitals, nursing homes and as Personal Care Attendants across the Commonwealth. We respectfully offer this written testimony on the EOHHS/MassHealth draft *Demonstration Proposal on Integrating Medicare and Medicaid for Dual Eligible Individuals*.

Combining both Medicaid and Medicare funding/services, the proposed Demonstration offers a creative new integrated model of care delivery for dual-eligible adults aged 21-64. Already, the 1199SEIU-represented PCAs and other workers play an essential role in providing care for this population. We estimate that approximately 10-25% of the current MassHealth PCAs serve disabled individuals aged 21-64 who are dually-eligible. Our ongoing work with this population and for the PCA consumers enrolled in the similar Senior Care Options program has been very positive and we are therefore optimistic about the proposed initiative even as we have some remaining concerns:

PCA Services Utilization: The primary concern for 1199SEIU about the proposed Demonstration is the system by which the "Integrated Care Organizations" (ICOs) will assess eligibility and need for PCA services. Depending on the ICOs selected and their preferred long-term care support services (LTSS) model, there is a risk that utilization of PCAs by this population could be dramatically reduced. So that consumer-direction is fully promoted and to protect the integrity of the PCA program, it is important to mitigate the conflict-of-interest an ICO would have in both planning for and providing all LTSS. First, it is essential that PCA consumers enrolling in the Demonstration continue to receive needed training and support services from the Independent Living Centers and other PCA program managers. These community-based organizations help people through the process of getting on the program and provide considerable expertise in managing a PCA independently. In order to further address these issues, we also join our consumer advocate allies and the DAAHR Coalition in supporting a mandate that the ICO contract with appropriate and existing LTSS care planning entities.

PCA Worker Representation: 1199SEIU is committed to working with the Administration to ensure that every PCA, including those serving Demonstration enrollees, enjoys the rights and benefits of the existing collective bargaining agreement between 1199SEIU and the PCA Workforce Council. We are confident that together we can ensure resolve these issues as the Demonstration is further developed.

PRESIDENT
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Tim Foley - Political Director
Celia Wcislo

VICE PRESIDENTS
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Tyrek Lee

Enhanced Home Care Worker Role: 1199SEIU continues to strongly support the Demonstration's stated intent that the program's ICOs be permitted to incorporate PCAs creatively as part of the multi-disciplinary team-based approach to care. While fully respecting consumer-direction, PCAs are well-positioned to serve as an early-warning system for the ICO's care team. Under this Demonstration, it is wisely proposed that ICOs may expand PCA eligibility to cover additional tasks (i.e. cueing) and populations (i.e. mental health/DD). 1199's experience working with the existing SCOs shows that PCAs can play an important and enhanced role in a properly-designed managed long-term care program. If utilized well in an expanded role under this Demonstration, we believe that PCAs could be extremely helpful in reducing costs, facilitating care delivery and improving health outcomes. 1199SEIU intends to collaborate on projects with the chosen ICOs to help increase the use of PCAs, offer additional training for PCAs, and expand career ladder opportunities for PCAs.

We thank you for your leadership and full engagement of the advocacy community in offering this draft *Demonstration Proposal on Integrating Medicare and Medicaid for Dual Eligible Individuals*. 1199SEIU stands ready to support all efforts to improve health care access and health outcomes for dually-eligible and Medicaid populations. As proposed and with a few modifications, this Demonstration will improve the quality of care for the covered population, reform the unnecessarily complex dual-eligible payment and delivery systems, and help to reduce overall costs of care.

Though we remain concerned about some aspects of consumer choice and consumer control (as detailed above), we respectfully offer our full assistance in working with the Administration on this Demonstration in the coming year. Thank you for your time and consideration of the issues detailed in this letter.

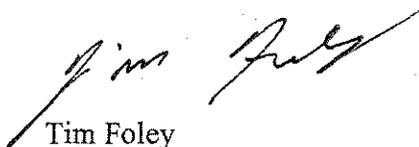
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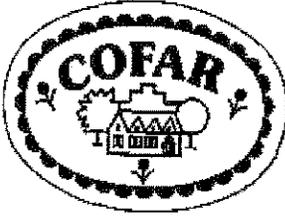
Veronica Turner
Executive Director - Massachusetts



Rebecca Gutman
Vice President of Home Care



Tim Foley
Vice President & Political Director - Massachusetts



**THE MASSACHUSETTS COALITION
OF FAMILIES AND ADVOCATES, INC.**
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COFAR testimony for Executive Office of Health and Human Services (EOHHS) public hearing on dual eligibility proposal

January 4, 2012

Thank you for the invitation to testify before your agency concerning the proposal by the Executive Office of Health and Human Services to change the way services are managed to clients with disabilities who are dual eligible for Medicare and Medicaid.

We join many of the other advocates testifying on this matter in urging you to exempt waiver-based services for persons with intellectual disabilities from this proposal. If those community-based services are not carved out of the proposal, it is our understanding that private vendors, known as Integrated Care Organizations (or ICOs) would be hired to manage these services to thousands of persons in Massachusetts.

As such, we are concerned that this proposal appears to be another step in this administration's quest to privatize key services to the state's most vulnerable people and to remove government from its responsibilities in that area.

As we understand it, thousands of both public and private-sector service jobs could be lost while private ICOs rake in profits should this proposal be adopted. Among the positions that would be eliminated are state service coordinators, who help clients choose from among available services in the community system and ensure that the correct services are provided.

We agree with SEIU Local 509 that if this proposal is implemented, Massachusetts would compete with other states in a "race to the bottom" in care for the disabled. We would also note that the Association of Developmental Disabilities Providers and the Arc of Massachusetts have stated that they "do not believe there is current research available that validates significant cost savings attained by turning over large parts of State Medicaid programs to managed care companies."

Thank you for your consideration.

David Kassel
Communications Director
COFAR
112 West Bare Hill Road
Harvard, MA 01451



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**TESTIMONY OF AARP
REGARDING
PROPOSAL TO THE CENTER FOR MEDICARE AND MEDICAID
INNOVATION
STATE DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE
INDIVIDUALS
BEFORE THE EXECUTIVE OFFICE OF HEALTH AND HUMAN
SERVICES**

January 4, 2012

Boston, Massachusetts

Good morning. My name is Debbie Banda and I am the director of the AARP Massachusetts state office. AARP is a nonprofit, non-partisan membership organization for people 50 and over. We have about 37 million members nationwide – 825,000 here in the Commonwealth. Thank you for the opportunity to comment on this demonstration proposal to Integrate Care for Dual Eligible Individuals. We commend the Commonwealth for its efforts to improve access, quality and cost of care for people who depend upon Medicare and Medicaid.

As you are aware, those who are eligible for both Medicare and Medicaid are among the poorest, sickest, and costliest of all Medicare beneficiaries - and that makes them the most vulnerable to receiving inadequate care or falling through the cracks. To meet their needs for health care and long term services and supports, they or their families must navigate between two separate programs and systems for delivering services - programs that do not have a history of communicating well with each other or coordinating services.

There are *many* improvements for beneficiaries age 21-64 contained in this Proposal. AARP has submitted detailed comments in writing, and cites in those comments what we think is good about this proposal, including the fact that it uses a medical home care model with choice of primary care providers and allows for the involvement of family, informal caregivers, advocates, peers and others into care planning.

However, we also have some serious concerns about several aspects of the proposal. Therefore, in the interest of time, I will limit my comments this morning to just a few of those concerns as we know you will read our written comments in their entirety.

Enrollment:

AARP supports voluntary enrollment and disenrollment, and not a process whereby individuals are placed into a system and then have the option to disenroll if they do not believe it will best meet their needs - as is contained in this proposal. These voluntary features mean individuals are free to continue fee-for-service arrangements or disenroll at any time and return to the full services available in traditional Medicare and Medicaid with no interruption of eligibility and no interruption of service.

Bottomline: we are concerned that mandatory or passive enrollment, as this proposal requires, does not provide the greatest amount of consumer protection for dual eligible individuals. We have concerns about the potential disruption to enrollees in established relationships and access to their health care providers. If these individuals cannot access services in a timely manner they may seek care at higher cost settings, such as emergency rooms, or may not seek care at all.

Quality of Care:

AARP believes there should be an expansion of baseline measures of the quality of services provided by the ICO. While the Proposal appropriately requires NCQA accreditation for the primary care medical home (PCMH), it sets no quality standards for the ICO selection of other health and support service providers. Minimum quality and accreditation standards for all providers within the ICO network must be incorporated. However, an exception should be made for consumer directed care where the ICO would pay family, informal caregivers, or personal care attendants selected by the consumer.

Appeals:

AARP supports the elimination of differences between the timeframes for filing and resolving an appeal related to benefits, access to external review, benefits pending appeal, and notice of appeal rights. We believe it is critical to protecting vulnerable consumers and we support a unified system for grievances and appeals.

Where due process and notice and appeal rights diverge, the ICO should provide the beneficiaries access to the standard that is most favorable to the individual and his/her family. In addition, enrollees should have access to an independent, external ombudsman to assist in the grievance and appeals process.

Elders and Senior Care Options (SCO)

AARP is pleased that the Commonwealth is committed to the continuation of the SCO program in the short term and is not pursuing a change to the current SCO enrollment process. However, we have concerns about the future of the program and how it will interface with this proposal over time. As you are aware, two-thirds of duals are over age 65 and 60 percent have multiple chronic conditions.

LTSS

Finally, we want to stress that all efforts should incentivize the provision of home and community based services. Any rule, regulation, and process which favors institutional care must be revised.

Conclusion

In closing, AARP applauds the Commonwealth for working to break down barriers between Medicare and Medicaid with the goal of achieving better care for some of our most vulnerable residents. However, we must be sure the complex care needs of each individual are met, and are coordinated across the entire spectrum including acute, rehabilitative, behavioral and long term care.

Testimony on Dual Eligible Proposal
Submitted by Jini Fairley

Good Morning

My name is Jini Fairley, and I am the Director of Services at the MetroWest Center for Independent Living in Framingham

I work with consumers with disabilities, and just about every day I help consumers either acquire or keep their health insurance, whatever that takes. Often that means contacting the eligibility departments of MassHealth and Medicare/Social Security

There have been many issues with the MCO program for MassHealth only members, especially with the names of the plans so similar to some of the Commonwealth care plans.

In addition, there have been many issues with doctors/providers dropping their participation in these MCO plans and the consumer then needs to scramble to find another primary care physician or specialist.

I have had issues with customer service, both at MassHealth and Commonwealth care, where I have gotten different answers to the same question/case.

And the only person who can fix the eligibility issues is the eligibility department who don't answer their phone despite staying on hold for an hour or more, who tell me they are short handed and they are only answering emergencies?? It has taken me days and sometimes weeks to resolve an eligibility issue.

What happens to the dual eligible that is in a new PCMH plan and runs into a glitch with MassHealth eligibility, often not the fault of the customer? Who will help this customer maintain their status in their PCMH when MassHealth has kicked them off because MassHealth didn't acknowledge receiving their Eligibility Review form, which was sent in promptly/on time, but MassHealth is so backed up that it was not processed?

Customers received letters that are confusing and need to be "interpreted" from someone completely trained in the complexities of all the MassHealth plans and the possible options.

In this draft proposal for dual eligible, many of these issues have been addressed and look great on paper. But how will they really work out for the customer.

Here are my concerns and questions:

Although I understand the rationale for automatically enrolling customers in a PCMH, and then letting them voluntarily opt out, I don't like this approach and it leaves the

customer who has difficulty understanding letters from MassHealth, which is just about everyone, to figure out what just happened to their insurance plans.

One of the main fears is about losing autonomy and access to their existing group of providers and other caregivers, if switching is necessary, forget it!

Regarding Customer Service, from the draft proposal, what does this mean? MassHealth expects to use its customer service contractor as an impartial enrollment broker, and is reflecting that expectation in a customer service re-procurement process now underway.

Is MassHealth prepared to really beef up their infrastructure to be able to handle the implementation of such a major change for 115,000 customers?

And regarding “Clear Information”, from the proposal:
Massachusetts will focus on developing clear and accessible information

My question, does MassHealth really know what accessible information is? To my knowledge, MassHealth has never offer alternative formats, such as large print, Braille, or electronic formats to their blind and visually impaired customers. How will that happen for the dual eligibles, if it is not happening right now?

Will the customer be randomly placed in an PCMH within an ICO, or will the customer have choices of more than one PCMH/ICO?

This reminds me of the randomness when Medicare Part D was introduced in 2006 and MassHealth randomly enrolled their dual eligible customers in one of 5 Part D Prescription plans with no regard for the prescriptions the customer was taking. This continues to happen and it becomes very difficult for customers to realize and acquire a better Part D plan more tailored to their prescriptions, and would save them money.

If not random, will the customers Primary Care Physician determine which PCMH a customer is assigned/attributed to?

And how quickly will they be able to determine if there PCP and all their specialists are in the PCMH/ICO ?

What additional benefits will the customer receive that would help them decide whether to stay in an ICO? Is it true that enhanced dental services will be offered by all ICOs?

Do all specialists a customer is seeing currently have to be a provider of the ICO in order to continue care with that specialist?

Is this the answer:

“MassHealth will require ICOs to 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. MassHealth is also considering, under certain defined circumstances (What would these be?), requiring ICOs to offer single-case out-of-network agreements to providers who are currently serving members and are willing to continue serving them at the ICO's in-network payment rate, but who are not willing to accept new patients. The advantage of using out-of-network providers to encourage continuity of care needs to be balanced with the advantages of the enhanced information sharing and coordination of care possible within the contracted provider network. In all cases, whether members continue with current providers or transition to new ones, the ICO will be responsible for ensuring continuity of care."

And how quickly and smoothly can a customer opt out of the ICO, without any detrimental effects to their care and eligibility in MassHealth and Medicare?

Will we see full transparency? This is key to customer buy-in and engagement.

What are the customer's rights and responsibilities? How will the state ensure the protection of these rights? Will there be an ombudsman? What will the appeals process look like?

How will the state ensure that customers have adequate access to the full range of health care providers and support services that they may need?

Finally I am most concerned of the care coordination that is mentioned throughout this proposal. I feel this needs to begin with the day a customer is notified of the PCMH he/she has been enrolled in and continue throughout the process. Will all customers be eligible for care coordination, or only certain sub-populations? How will customers obtain care coordination?

Thank you for this opportunity to voice my concerns and questions.

From: Chet Jakubiak [cjakubiak@maoamass.org]

Sent: Wednesday, January 04, 2012 10:56 AM

To: Duals (EHS)

Cc: Chet Jakubiak; Chet Jakubiak

Subject: MA Association Of Older Americans Testimony on Integrate Medicare-Medicaid Project

Dr. JudyAnn Bigby, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Ma 02108

Dear Dr. Bigby:

Attached please find written testimony on MassHeath's proposal for an Integrated Medicare-Medicaid demonstration project in Massachusetts.

We believe this has exciting possibilities. We hope our comments are helpful and that a strong proposal will emerge from the discussions we are having in Massachusetts.

Thank you for the opportunity to share our thoughts with you and with Dr, Harris

Yours truly,

Chet Jakubiak, Executive Director
MA Association of Older Americans, Inc.



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January 4, 2012

Dr. JudyAnn Bigby, Secretary
Executive Office of Health and Human Services
Commonwealth of Massachusetts
One Ashburton Place, Room 1109
Boston, MA 02108

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

Dear Secretary Bigby:

AARP is a nonprofit, non-partisan membership organization for people 50 and over. We have more than 37 million members nationwide and 825,000 members in the Commonwealth. AARP appreciates the opportunity to comment on the Proposal to the Center for Medicare and Medicaid Innovation, State Demonstration to Integrate Care for Dual Eligible Individuals. We commend the Commonwealth for its efforts to improve access, quality and cost of care for people who depend upon Medicare and Medicaid.

Those who are eligible for both Medicare and Medicaid are among the poorest, sickest, and costliest of all Medicare beneficiaries. Two-thirds are over age 65 and 60 percent have multiple chronic conditions. Dual eligible individuals are most vulnerable to receiving inadequate care and to “falling through the cracks,” as they or their families try to meet their needs for health care and long term services and supports by navigating between two separate programs and systems for delivering services - programs that do not have a history of communicating well with each other or coordinating services. Therefore, we applaud the Commonwealth for seeking to implement new policies and practices designed to break down barriers between Medicare and Medicaid to advance better care for beneficiaries, improve health for vulnerable populations, and lower costs through improvement in care.

There are many improvements for beneficiaries age 21-64 contained in this Proposal. AARP supports a final Proposal with care models that use the medical home model with choice of primary care providers; requirements for NCQA accreditation of medical homes; ADA compliance; provisions to ensure multi-cultural accommodations; use of a single medical record; the ability to involve family, informal caregivers, advocates, peers and others into the care planning; the use of non-traditional communication; outreach and education to improve health literacy; inclusion of behavioral health, preventative care, dental benefits, personal care attendants, durable medical equipment, non-medical transportation, respite care, and home modifications; a unified grievance and appeals system; inclusion of Medicare Part D benefits; and enhancing continuity of care by allowing existing providers the option of joining the care networks.

However, we also have concerns about some specific components of the Proposal and offer recommendations regarding them:

Enrollment:

- AARP supports voluntary enrollment and disenrollment, and not a process whereby individuals are placed into a system and then have the option to disenroll if they do not believe it will best meet their needs as is contained in this proposal. These voluntary features mean individuals are free to continue fee-for-service arrangements or disenroll at any time and return to the full services available in traditional Medicare and Medicaid with no interruption of eligibility and no interruption of service.
- We firmly believe that enrollment into coordinated care programs, such as the so-called Integrated Care Organizations (ICOs), will result when better, more flexible models are presented to meet individuals needs.
- Enrollment should be structured in ways that maintain beneficiaries' freedom of choice and provide opportunities to make enrollment changes as may be needed.
- Transition protections should ensure timely access to providers and treatments as beneficiaries enroll and disenroll from ICOs.
- Dual eligible individuals and their family caregivers should have access to navigation assistance to help them access the health and long term services and supports they need. This may mean building on or reinforcing the existing systems in the aging and disability communities, such as the SHINE counselors or the independent care coordinators at the ASAPs.

Bottomline: we are concerned that mandatory or passive enrollment, as this proposal requires, does not provide the greatest amount of consumer protection for dual eligible individuals. We have concerns about the potential disruption to enrollees in established relationships and access to their health care providers. If these individuals cannot access services in a timely manner they may seek care at higher cost settings, such as emergency rooms, or may not seek care at all.

Appeals:

AARP supports the elimination of differences between the timeframes for filing and resolving an appeal related to benefits, access to external review, benefits pending appeal, and notice of appeal rights. We believe it is critical to protecting vulnerable consumers and support a unified system for grievances and appeals.

Where due process and notice and appeal rights diverge, the ICO should provide the beneficiaries access to the standard that is most favorable to the individual and his/her family. In addition, enrollees should have access to an independent, external ombudsman to assist in the grievance and appeals process.

Behavioral Health:

AARP is pleased behavioral health services are included as part of the Proposal. It is well documented that the Medicare limits on behavioral health services have impeded access to needed mental health services for elderly and disabled beneficiaries. For historical reasons, Medicaid's coverage of behavioral health has been far broader than Medicare. Given the vast number of dual eligible individuals who have at least one mental or cognitive impairment, services for behavioral health must be incorporated into the service delivery package. However, it is critically important that additional consumer protections be established to ensure that ICOs provide appropriate care for enrollees and do not limit access and per enrollee expenditures within the capitated payment system. Some modifications to the Commonwealth's existing extensive prior approval system should be considered.

Access to and Continuity of Care:

Continuity of care and safe and effective care transitions are important for all individuals, but especially for dual eligibles, who may be more vulnerable to gaps in care and poor transitions across settings. ICOs must incorporate evidence based care transition approaches that address these issues.

Interoperable health information systems across providers, including electronic health records, play an important role in addressing care transitions.

Quality of Care:

AARP supports the expansion of baseline measures of the quality of services provided by the ICO. While the Proposal appropriately requires NCQA accreditation for the PCMH, it sets no quality standards for the ICO selection of other health and support service providers. Minimum quality and accreditation standards for all providers within the ICO network must be incorporated. An exception should be made for consumer directed care where the ICO would pay family, informal caregivers, or personal care attendants selected by the consumer.

Out of Network Care:

AARP recommends payment for out-of-network care be included in the Proposal and could be based on the Medicare Advantage requirements regarding urgent and emergent care when access to network providers is not immediately available.

Elders and Senior Care Options (SCO)

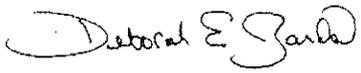
AARP is pleased that the Commonwealth is committed to the continuation of the SCO program in the short terms and is not pursuing a change to the current SCO enrollment process. However, we have concerns about the future of the program and how it will interface with the Proposal over time.

As you move forward, we suggest the work be guided by the following principles:

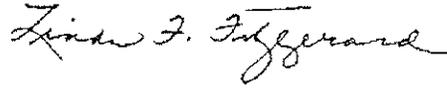
- Integration of benefits for dual eligibles should ensure that Medicare and Medicaid are aligned to meet the needs of the dual eligible population with the goal of improving the quality of care and quality of life for this population. Individuals should have access to benefits that best meet their individual needs and preferences, and the final model must incorporate a person- and family-centered approach to care.
- All efforts should incentivize the provision of home and community based services. Any rule, regulation, and process which favors institutional care should be revised.
- Dual eligible individuals rarely know they are “dual eligibles” or understand the complexity of what this means for securing high quality care. Therefore, individuals should experience a seamless system from their perspective as they access the services and benefits they need.
- Any new model should promote an integrated service delivery where acute care, physical and behavioral health, long term services and supports, and other social services are coordinated to meet the holistic needs of the individual and their family caregiver in a person-centered way.
- Dual eligible individuals must be able to access the full range of providers they need to meet the needs of the “whole person”.
- Financial barriers should be removed for dual eligible individuals and cost-sharing burdens should be reduced.
- Where Medicare and Medicaid provide two different coverage standards for the same benefit, beneficiaries should be assured access to the benefit that most closely meets their individual needs.

AARP is pleased to have been part of the consumer stakeholder input process. We realize all stakeholders have a role to play in addressing this important Proposal. We look forward to continuing our engagement on this effort. Please do not hesitate to contact Jessica Costantino, Director of Advocacy, at 617.305.0538 or jcostantino@aarp.org, if you have question or concerns or if we can provide you with additional information.

Very truly yours,



Deborah E. Banda
State Director



Linda F. Fitzgerald
State President

Cc: Secretary Ann Hartstein, Executive Office of Elder Affairs

Please substitute previous testimony submitted by Local 509 with the enclosed. the only difference is the enclosed has the correct date of 1/4/12.

Thank you.

Medicaid/Medicare Dual Eligibles Testimony

DDS Chapter President Stu Dickson

Local 509, SEIU

January 4, 2012

Massachusetts must explicitly modify it's 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 then the care of human beings. Cost effective case management for human beings requires far more of a skill set then 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 its 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 its most vulnerable citizens. Please act to explicitly correct this Proposal soon!



*For people with intellectual
and developmental disabilities*

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Achieve with us.

Christopher Andry, Ph.D.
President

Leo V. Sarkissian
Executive Director

Comments for the Public Hearing on the Draft Proposal to Integrate Medicare and Medicaid for Dual Eligible Individuals

By The Arc of Massachusetts

January 5, 2012

The Arc is the largest organization which advocates on behalf of persons with intellectual and developmental disabilities. Established in the 1950s, the organization represents a constituency of more than 200,000 people in Massachusetts. The Arc has been in a leader in achieving policy outcomes such as special education, community based services for adults with disabilities and opportunities for housing and employment.

We commend the administration for its efforts to advance health care and long-term supports for persons with disabilities. **We agree that health care needs to be improved for persons with disabilities.** We also appreciate the administration's willingness to discuss the project in depth with stakeholders. This demonstration project entails a complex transition in need of guideposts.

It is difficult to comment on this proposal because it is a series of concepts that both puts us at ease and raises concerns. While it references safeguards, the proposal will allow new entities to retain the responsibility to provide health care and long-term supports through a capitated rate for tens of thousands of people.

We recognize that there will be time to work with the administration as the proposal evolves into something that can be implemented. However, for the purpose of this testimony, we are commenting on how the proposal stands now.

We believe that:

- there is little health care coordination for adults with disabilities in Massachusetts,
- the most complex care needs of any Medicare or Medicaid members are "dual eligibles" under 65 years old,
- there is a limited understanding about the costs of providing coordinated health care services to persons with disabilities and complex medical conditions and even less for those with impaired intellectual or cognitive functioning, and

The Arc in Massachusetts Includes the Following Local Chapters:

*Arc Community Services • Berkshire County • Bristol County • Brockton Area • Cape Cod • Center of Hope Foundation
Charles River Center • EMARC • Greater Haverhill-Newburyport • Greater Lawrence • Greater Plymouth • Greater Waltham • Minute Man AHS •
Northeast • South Norfolk County • South Shore • The United Arc*

- health care and long-term supports have different benefit structures, different outcomes and different measurements.

Consequently, the decision to execute this demonstration upon the entire population of dual eligible recipients under age 65 with the possible exception of those persons in waiver services worries us. The Arc’s response to **this proposal would have been more encouraging if a targeted route had been chosen** with the possibility to test different options.

At the outset, we believe **long-term support and health care costs will need to be tracked separately** even with one capitated rate. If costs are not analyzed separately, decision makers may assume strategies that would succeed in health care will work in long-term supports and services. “Integrated Care Organizations” or ICOs will have to guess at strategies to address differences in benefits structure, outcomes and measurements. This belief drives some of our recommendations.

The chart below identifies some differences between health care and long-term supports (LTSS). The following are key points:

- LTSS cost growth is highly predictable based on students graduating from high school and youth who have complex medical or behavioral needs. Historically, the system has reflected little growth in cost of living for long-term support services.
- Health care cost growth has spiraled and it is based on a number of factors.
- There are many insurers for health care, but only one primary insurer for LTSS, namely Medicaid.
- Outcomes for LTSS mainly relate to day-to-day living, whether they be activities throughout the day (washing/toileting, dressing, meal prep, etc.) or instrumental activities (money management, safety, travel, etc.)

	Outcomes	Measurements	Payers	Cost Triggers
Health Care	-Infant mortality -Life expectancy -Addressing health conditions as needed	-Screenings -Surveys related to health -Response to treatment -RX use -Use of ER	-Medicare - Medicaid - <u>Many</u> private insurers	-RX including new medicines -New technology -Compensation of health professionals -Overutilization of ER departments
Long-Term Supports/Services	-Family Life -Employment -Access to Community -Housing -Daily living	-Ability to perform life activities -Safety Skills -Length of time on job (above tracked through person-centered plans)	-Mainly <u>Medicaid</u> -LTC insurance & private dollars have little impact	-Youth with disabilities graduate school -Adults with complex medical needs -Growth in Autism -Boomers aging

Due to the above and other differences, we support MassHealth’s request to the Centers for Medicare and Medicaid Services (CMS) for a second tier (capitation) for individuals served through home and community-based waivers, which would not include LTSS in the second tier. In other words, we would like to see such a tier to be possible for all persons with disabilities, thus offering the *three choices* to duals:

- Full integration of Medicare and Medicaid health care and long-term support dollars, which is reflected for the majority of duals in MassHealth’s present proposal draft,
- Tier two including only integration of Medicare and Medicaid health care, behavioral health, durable medical equipment and rehabilitation services funding, or
- Opting out of this demonstration program altogether.

The Commonwealth recently initiated the person-centered medical home (PCMH) demonstration. The decision was made to not track a specific subset of individuals with intellectual/cognitive impairments (disability and frail elder) and complex medical needs despite advocacy to encourage that this take place. Ironically, the data from the PCMH project could have been very helpful for this proposal.

Having stated a strong objection to a large rollout of this demonstration impacting the entire duals population in a short period of time and a recommendation for a second tier to be fully available, we also have the following questions and recommendations.

The proposal requires further clarity on the enrollment period and opt-out process. We appreciate and hope the state holds true to the absence of a "lock-in" period, but we need assurance that the present PCC and fee-for-service system will be in place for these recipients. Will the present PCC and FFS system remain?

If appropriately structured, ICOs could be incentivized to provide early and intensive services (i.e., inpatient hospital rehabilitation, intensive mental health services) as well as primary and specialty services throughout the post-acute care continuum at sufficient intensity and duration to minimize long term costs downstream. However, if inappropriately structured, ICO's may seek to avoid certain high cost patients, limit services to reduce costs, and generally stint on patient care. If this is the path taken by ICOs, these new delivery models will fail to achieve their promise and will only result in financial rewards to ICO provider participants at the expense of patients. Independent care managers are one protection against such a development. A second protection would be to ensure consistent rates established by state regulatory authorities (Mass Health, Health Care Finance and Policy, etc.) for services and products (health care and LTSS) which is reinforced below. There is no question that variance among rates is important to address in such a determination (e.g., teaching hospitals vs. community hospitals, LTSS rates from 1980s vs. more recent rates) but it would be unsafe to leave such rate determination to ICOs.

The use of neutral enrollment brokers, though helpful, is not enough when one considers the built-in incentives to cap services or reduce interventions. We believe **independent care managers are essential to ensure that the right care plans are developed**, which identify the corresponding services needed in regard to health care or LTSS. This role could be provided by private and state coordinators presently functioning in the long-term supports system.

Moreover, how did the proposal writers determine that obtainable savings of ½ to 2% exist (pages 31-32)? Would it be more accurate to state that this is your savings goal? There is no trail within the document that would lead someone outside of MassHealth to believe that this goal is realistic, given the expansion of the care coordination and care management that will take place.

Although we agree with much of the functions described under section ii Benefit Design (pages 11-16) for the "person-centered medical home," some attempt at determining caseload number ratios should be done prior to the RFR process. It is critical for potential ICOs to have more information on the ratios needed for necessary care coordination or clinical care management.

As stated above, two major areas concern us in regard to the potential stinting of care to save money. First, needed services for enrollees' may be left out of their person-centered plan by managers employed or contracted through the ICOs, and secondly, rates, if set by ICOs, may be too low to pay for quality services and supports. How will CMS and MassHealth choose among qualified ICOs if there is no basis in fact for decisions on specific metrics? This is addressed again below in our recommendations.

Further recommendations are divided by category below:

Access:

1. Rates should be maintained and increased as they would be under present statute and regulations (ICOs would not be allowed to "discount rates" etc.).
2. There should be requirements for accommodations in practices and equipment at the outset of the demonstration; for example, wheelchair scales, overhead lifts, and separate waiting areas for those who

need decreased sensory input. Practices must be allowed to provide access outside of their offices and in an enrollee's home instead.

3. Integrated Care Organizations should provide training to health providers to ensure that they are knowledgeable as they deliver service to adults with intellectual, developmental and other disabilities.
4. The regulatory definition of medical necessity that is contained in the current specialty and long term support services is maintained as the basis for authorizing services. A second opinion of medical necessity should not be an additional cost to enrollee. Broadening the definition of medical necessity is also recommended since it may allow for more cost-effective, non-traditional services in behavioral health and LTSS.
5. The array of services approved by CMS under the current specialty services and long-term supports/services plan is fully maintained in the dual-eligibles model, such that services are specified and available as a matter of entitlement based on need, as determined using a person-centered planning process. Thus there should be an opportunity for enrollees to be able to appeal a denial of access to or restriction from use of specialty services under the Fair Hearings provisions.
6. Any definitions of disability, general or specific, to establish eligibility should be consistent with national definitions or norms.

Oversight:

1. Rates for all products and services should be set by the state, not the ICO. The state should include defined services and rates that ICOs must offer and pay.
2. MassHealth should have an empowered entity corresponding to the officer in charge of ICO contracting, which has 50% primary and secondary consumers (secondary consumers are family members of consumers in the program).
3. Consumers and family members should be involved in review and oversight of the ICO's services providers.
4. MassHealth should monitor and approve an ICO's methods for monitoring provider quality in the provision of services & supports.
5. The current rights of recipients, enumerated in the regulations, must be maintained.
6. This demonstration's objectives are to provide support and care while achieving savings. Therefore there should be public dissemination of process and outcomes data to insure that the proposed objectives are being met. Stakeholders should have a role in determining those measures and reporting periods.

Consumer Choice:

1. Joining the plan should be an "opt-in," voluntary decision on the part of eligible individuals.
2. Enrollees should be able to choose their providers without penalties, regardless if they are in an ICO network.
3. Enrollee choice of the person(s) to provide supports coordination or supports must be assured (care management or coordination.)

Quality:

1. The system should include tracking of unmet needs, delay in services, and utilization of services by disability type.
2. The care team should be led by enrollee (or family member/guardian if necessary).
3. ICOs should include in their oversight processes a board or empowered committee that is composed of one-third primary and secondary consumers (secondary consumers are family members of consumers in the program). Utilize oversight board for input and review of quality measurement pieces.
4. An entity independent of ICO should offer enrollees' (and family members if necessary) consumer satisfaction surveys.
5. There should be transparency of the results of quality monitoring and plan evaluation, such that enrollees and their allies can make informed decisions about choosing and maintaining a particular plan or a provider within the plan.
6. There should be measures included to address documented health inequities.
7. Ensure that ICOs are competent in intellectual and developmental disabilities and LTSS.
8. There should be defined education and outreach on plans and services and enrollees' options.
9. ICOs should monitor and ensure quality standards of providers in network.

10. There should be training and oversight of services to support individuals with difficult behavior issues, in order to assure that a positive approach is used successfully by providers.
11. Include policies guiding the development of person centered planning at the ICO, including but not limited to:
 - a. Training in self-determination and person centered planning (PCP), so that ICO's provider will attain competency in the use of the person-centered planning process.
 - b. Provisions for access to and use of trained independent PCP facilitators who can assist a person during the PCP process.
 - c. Surveys and random interviews with plan members to evaluate the program in general and PCP in particular
 - d. Self-determination arrangements that provide individuals with meaningful control over the funds allotted for their individual budget must be available.
12. All enrollees are provided with information that informs them of the costs of their services and supports as soon as their planning process is concluded.

Thank you again for this opportunity to provide input on the state's "duals" draft proposal. Any questions can be directed to Leo Sarkissian (Sarkissian@arcmass.org or 781-891-6270, ext. 106.) The Arc of Massachusetts hopes you consider our questions, recommendations, and further input. We look forward to working with the administration throughout the next steps in this process.



January 6, 2012

Dr. JudyAnn Bigby, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Dear Secretary Bigby:

LeadingAge Massachusetts, formerly known as MassAging, is an association representing not-for-profit providers of aging services in Massachusetts across the continuum including skilled nursing facilities, continuing care retirement communities, residential care facilities, assisted living residences, independent and supportive housing programs, adult day programs and other home and community based providers. Governed by community-based boards of directors, our members serve more than 25,000 older persons and those with special needs across the Commonwealth. We are committed to ensuring that seniors and those with special needs get the services they need, when they need them in the place they call home. **On behalf of LeadingAge Massachusetts, I am writing to provide comments on the Commonwealth's Proposal to the Center for Medicare and Medicaid Innovation for a State Demonstration to Integrate Care for Dual Eligible Individuals.**

The challenges of dealing with two separate payment systems with different rules, administrative processes and limitations in coverage has led to a fragmented system of care where services are provided in silos and individuals' needs and preferences are not always met. Therefore, we applaud the Commonwealth's efforts to improve quality and access to health care services and needed supports to the 110,000 dually-eligible individuals between the ages of 21-64 living in Massachusetts. We believe that a well-designed integrated care system, which is truly person-centered, has the ability to transform and improve access to primary, behavioral and long term services and supports, for younger dually-eligible individuals just as the Senior Care Options program (SCO) has improved quality, access and cost for seniors participating in that program.

The Commonwealth's proposal includes many important provisions in creating an integrated system of care that is based on consumer preferences, needs and quality. We strongly support the concept of the Primary Care Medical Home (PCMH) as a central feature of this integrated care model and requirements that the Integrated Care Organization (ICO) be responsible for contracting for other needed services including long term services and supports. The requirement for ICOs to reach out to enrollees current service providers for inclusion in their networks is critical in ensuring continuity of care.



However, one major concern we have is that the proposal neglects to include the important role that an individual's housing situation plays in their ability to access needed care, supports and services, therefore failing to include those important resources in the overall coordination of care.

For example, residential care facilities (RCFs also known as rest homes) are community-based supportive housing environments where many dual-eligible individuals under the age of 65 currently reside. While RCFs are not medical facilities, they provide housing and 24 hour support for individuals, many who live with chronic and behavioral health needs. RCFs already serve as care coordinators by ensuring that residents get to their medical appointments and follow medical orders. In many cases they serve as extended family members helping individuals access a range of services that enhance the quality of their lives. **We suggest that ICOs be required to reach out to the residential care facilities where their enrollees may be residing to include them as part of any care planning and facilitation of care coordination. ICOs should also consider the benefits of contracting directly with RCFs if there are more than a few residents living in the RCF who are dual-eligible.** The RCF may be able to efficiently provide additional supports that would otherwise be unavailable to these individuals with the additional resources provided by the ICO, leading to enhanced 24 hour support for the enrollees.

Similarly, subsidized housing developments (such as Section 202, 811) are the homes to many individuals who will be eligible for this demonstration. Like RCFs, subsidized housing providers should be considered as essential partners offering ready-made access to residents through trusted staff. With service coordinators already in place, housing providers offer information and resources to support individuals to remain in their homes. **For individuals who are enrolled in the demonstration who already live in a congregate housing setting, we ask that ICOs be required to include the housing service coordinator in communication and care planning efforts.**

At the same time, many of the targeted population for this demonstration are challenged in having their needs met due to the fact that their living situation is inadequate. **We believe that the care coordinator must have a strong knowledge of housing and housing resources and should include the housing needs of individuals as part of their overall responsibilities in working with enrollees.**

The proposal states that ICOs will provide an enhanced payment per member per month to the PCMH which, among other things will help to enhance the PCMH's ability to put Electronic Health Records (EHR) in place. The E.H.R. is a critical component of seamless transitions and coordination between providers that need to



take place. Providers offering long term services and supports outside of the PCMH network will also need access to the Electronic Health Record and will need some financial support in order to develop their capacities as well. **We strongly suggest that payments to providers outside of the PCMH also include the need to develop E.H.R. capacity as well.**

We are hopeful that the Commonwealth's proposal to CMS will be accepted with our further recommendations and we look forward to working in partnership with EOHHS in the coming months to implement this exciting initiative that we believe will help to dramatically improve the quality of life of those enrolled.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Elissa Sherman".

Elissa N. Sherman, PhD
President



MASSACHUSETTS HOUSING AND SHELTER ALLIANCE

INITIATING SOLUTIONS TO END HOMELESSNESS

January 9, 2012

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

Via e-mail

Dear Ms. Wong:

Please accept the following comments of the Massachusetts Housing and Shelter Alliance (MHSA) on the State Demonstration to Integrate Care for Dual Eligible Individuals (State Demonstration).

MHSA is generally pleased by the vision and aspirations of the State Demonstration proposal. We are very pleased with the sensitivity shown regarding homelessness as a unique need worthy of focus by Integrated Care Organizations (ICO's). It clearly articulates that ICO's maintain relationships "with organizations expert in serving homeless persons and other populations with unique needs (p.7)". This reflects the concern demonstrated by EOHHS and the Office of Medicaid toward homeless persons and the unique difficulties created by the dual-eligibility status.

Having noted this sensitivity, I believe there are a few other places within the State Demonstration to indicate the importance of the homeless issue. For example, H. i. d., Aligning provider capacity and competency with member populations, would benefit from recognizing the unique needs of a chronically homeless population. (p.36). Here also, permanent supportive housing could be stressed as a topic for shared learning as a critical component of integrated care.

Regarding homelessness, Massachusetts has been a leader nationwide in utilizing Medicaid for serving chronically homeless persons in housing through the Community Support Program for People Experiencing Chronic Homelessness (CSPECH). MHSA has been contacted by state Medicaid agencies from around the country to learn more about this unique initiative. Although the State Demonstration highlights Community Support Programs (CSP) as a benefit (p. ix, appendices), it nowhere mentions CSPECH. Given the issues created by dual-eligibility for this formerly homeless population, MHSA would request that CSPECH be specifically included within the document. CSPECH captures the core elements of President Obama's plan to link homelessness, housing and health care. MHSA believes Massachusetts should embrace this program and include mention of it within the State Demonstration.

MHSA appreciates the incredible amount of hours that went into this document. We also appreciate your inclusion and consideration of homeless persons and providers. This document lays out the future of health care in Massachusetts and MHSA stands ready to assist in ensuring those most in need are not left out.

Sincerely,

Joe Finn
President & Executive Director

To: Massachusetts Executive Office of Health and Human Services, Office of Medicaid

From: Work Without Limits, University of Massachusetts Medical School

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

Date: January 10, 2012

We appreciate the opportunity to provide comments on the state's proposal to the Center for Medicare and Medicaid Innovation for a *Demonstration to Integrate Care for Dual Eligible Individuals* in Massachusetts. With this demonstration targeted to approximately 115,000 **dual eligible members ages 21 to 64**, Massachusetts has the opportunity to be a national leader in ensuring that **working age dual eligible individuals** have access to care that is truly comprehensive, person-centered and embraces the independent living and recovery philosophies, providing not only primary care but also access to a wide range of long-term services and supports to allow people with disabilities to live full and independent lives in the community.

We believe that integrated care organizations providing service to dual eligible MassHealth members under this demonstration must be required to consider members' preferences and goals for **employment** when developing comprehensive care plans for these individuals. Being a worker is the normative life role for adults in our society. Employment provides an identity and a sense of contributing to society, and research shows that employment enhances physical, mental and economic well-being. Working age dual eligible MassHealth members are individuals who have worked at substantial levels in the past and, as workers, have paid into the Social Security Disability Insurance (SSDI) program. Following the onset of a disabling condition that disrupts their ability to work at substantial levels, these individuals become eligible for both SSDI and Medicare. While the assumption might be that dual eligible members are, by definition, unable to work and do not desire to return work, research conducted by *Work Without Limits* researchers at the UMMS Center for Health Policy and Research show that this assumption is unfounded.

Work Without Limits is a statewide initiative dedicated to widely promoting employment opportunities and outcomes for individuals with disabilities in the state, particularly those receiving public benefits and/or served by public agencies. *Work Without Limits* has been primarily funded by a Medicaid Infrastructure and Comprehensive Employment Opportunities (MI-CEO) Grant from the Centers for Medicare and Medicaid Services and in fact, in 2011 and 2012, we have been awarded funds from CMS specifically to work with MassHealth to ensure employment and employment supports are included in the integrated care plan for dual eligible members. Housed at the UMMS' Center for Health Policy and Research, *Work Without Limits* is managed in partnership with the

WorkWithoutLimits

Putting abilities to work in Massachusetts

Massachusetts Executive Office of Health and Human Services. *Work Without Limits* includes a strategic priority focused on ensuring that health care providers and services promote employment for people with disabilities. Over the years, *Work Without Limits* staff have worked closely with MassHealth policy makers to ensure that MassHealth policies, procedures and services targeted to people with disabilities support employment.

Findings from a 2006 survey of community-dwelling working-age MassHealth members conducted by *Work Without Limits* researchers (the MassHealth Employment and Disability Survey¹), shows that **17% of working age dual eligible MassHealth members are currently working**. If we estimate that 100,000 of the 115,000 dual eligible members targeted by the demonstration are living in the community, then about **17,000 dual eligible members are currently working**. In addition, many non-working members want to work. Data from the survey also show that, among non-working members, about **11% are currently looking for work** and another **18% plan to look for work within the next few years**. Thus, we can estimate that **an additional 23,000 dual eligible members want to work**. Importantly, the MHEDS data show that the majority of members who either want to work or are currently working feels that their **health would not get worse** if they went to work or worked more.

Despite the fact that as many as 40% of dual eligible MassHealth members are either working or want to work, and the fact that members do not think that work will cause their health to get worse, the survey also found that **only about 25% of members reported that a health care provider talked to them about work** in the year prior to the survey; among members whose provider did discuss work, **30% reported that the provider told the member not to work**.

Health care services and health care providers play a critical role in supporting individuals with disabilities to fully participate in their communities. Members of the health care team can be particularly influential in members' decisions regarding work. Through the integrated care demonstration, MassHealth has the opportunity to create a system of care that encourages employment and makes available the supports people need to work. As part of the integrated care demonstration, we believe MassHealth should require that Integrated Care Organizations (ICO's):

- Consider dual eligible members' goals and preferences regarding employment during the person-centered assessment and care planning process
- Communicate the belief that work is health promoting and possible

¹ Henry, A. D., et al. (2006). Disability and Employment: Findings from the MassHealth Employment and Disability Survey. Center for Health Policy and Research, University of Massachusetts Medical School.

WorkWithoutLimits

Putting abilities to work in Massachusetts

- Provide work incentives benefits counseling services so that dual eligible members can make informed decisions about the impact of work and earnings on disability benefits, including Medicare, Medicaid, SSDI and SSI
- Possess the necessary knowledge about employment services and supports and have the capacity to refer members to appropriate employment services and supports, such as those provided by the Massachusetts Rehabilitation Commission and other community rehabilitation providers
- Track dual eligible members' employment status as a health outcome.

Respectfully submitted,

Alexis D. Henry, ScD, Director

Alexis.henry@umassmed.edu

Kathleen Petkauskos, Associate Director

Kathy.Petkauskos@umassmed.edu

Work Without Limits

**Groundhogs
25 Bigelow St.
Cambridge,MA 02139**

To Whom It May Concern:

The Groundhogs are grass-roots Consumer/survivor leaders in Mass. representing ten different consumer-run advocacy groups (Transformation Center, CQI, 6 RLCs, MPOWER,NEC) dedicated to developing policies that facilitate recovery, wellness and resilience for people with lived experience of mental health issues, trauma, and extreme states.

The Groundhogs submit the following recommended changes on the Dual Eligibles Demonstration Project draft proposal before it is submitted to CMS:

- 1) Groundhogs propose that passive enrollment into the proposed demonstration project be replaced with voluntary enrollment by consumers.
- 2) Groundhogs propose that consumers have the choice of providers, and that Integrated Care Organizations (ICOs) be required to adopt an open-network policy with out-of-network providers that a consumer wishes to retain on their treatment team.
- 3) Groundhogs propose that ICO treatment teams be consumer-led and that the consumer makes the final decisions on all team recommendations.
- 4) Groundhogs propose that an independent Long Term Service and Support (LTSS) peer care coordinator be offered to every consumer as part of the treatment team. "Independent" means the peer care coordinator who is not employed by the ICO who can provide unbiased information, recommendations, and referrals to community based organizations (CBOs) that might be useful for the consumer as part of their recovery-based treatment.
- 5) Groundhogs propose that capacity-building money be available to independent CBOs (including Recovery Learning Communities and other peer-led organizations) in order to provide support services for the enormous number of new dual eligibles who will be referred to CBOs by the independent LTSS care coordinators. This money might be raised by assigning a "tax" on each consumer enrolled in an ICO plan.
- (6) Groundhogs proposes the creation of an independent, non-profit disability (consumer-run) group to oversee ADA and Olmstead compliance by the ICOs. Further, we request that this consumer-led board include at least 33% of consumers with lived experience of mental health conditions, as is reflected in the statistics of the dual eligible population in Massachusetts (MMPI data, 2008).

7) Groundhogs propose that Certified Peer Specialists in Mass. be reimbursable by Medicaid. Groundhogs member the Transformation Center has trained hundreds of peers as Certified Peer Specialists (CPS) and wellness coaches. In 22 other states, CPSs are reimbursable under Medicaid. CPSs provide the integrated community services that dual eligible consumers with mental health conditions will need in order to achieve their full recovery.

8) Medical necessity be expanded as the Michigan definition has been expanded to include recovery and community integration as goals for services, not merely symptom reduction: Michigan's Medicaid Office has added a much broader dimension to medical necessity and their definition was approved by the federal Medicaid Center. Here is the additional dimension they added:

"Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment [which are]:

**Designed to assist the consumer to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity."

As stated in the EOHHS draft proposal, 34.9% of the dual eligible population in Massachusetts had a diagnosis of serious mental illness in 2008. The Groundhogs assert that unless the long-term support services (LTSS) of these consumers include robust community-based peer supports, the demonstration project will not succeed in its objectives of achieving comprehensive delivery system and payment reform in Massachusetts' health care system, nor will the care provided to these consumers be of sufficient value for them to achieve full recovery from mental health conditions. Thank you for supporting the growth of person-centered care and independent living for consumers in Massachusetts. We believe that with the above noted changes, Massachusetts has the opportunity to be the leader of truly innovative healthcare reform and a beacon for the rest of the United States of America.

Sincerely,

Anne Weaver, MA
In behalf of Groundhogs



PROPOSAL to the CENTER FOR MEDICARE AND MEDICAID INNOVATION
for a
STATE DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS
DRAFT for PUBLIC COMMENT – DECEMBER 7, 2011

Comments of
Brian Biles, MD, MPH
Richard Windsor, PhD, MPH
Professor, Department of Health Policy
Professor, Department of Prevention and Community Health
School of Public Health and Health Services
George Washington University
January 10, 2012

Massachusetts Proposal

Massachusetts has proposed a “State Demonstration to Integrate Care for Dual Eligible Individuals” to the CMS Center for Medicare and Medicaid Innovation.

The proposed demonstration would auto-enroll up to 109,000 low-income Medicare beneficiaries who are under the age of 65 into State designated private health plans. These 109,000 individuals are Medicare beneficiaries because they are permanently and totally disabled as determined by standards set by the Federal Social Security Disability Insurance program. These Medicare beneficiaries are also covered by Medicaid because they have low-incomes and modest assets.

The proposed demonstration would “use combined Medicaid and Medicare funding to contract with Integrated Care Organizations (ICO)...to provide integrated, comprehensive care for dual eligible adults under age 65.” ICOs would “be responsible for the delivery and management of all covered services for each of its enrollees.” ICOs would “receive a global payment for carrying out this responsibility.”

The proposed demonstration would use the capitated three-way contract described by CMS in a letter to State Medicaid Directors on July 8, 2011. The Massachusetts proposal indicates that the State would be seeking “significant flexibility” to achieve these alignment features.

All non-elderly Medicare beneficiaries who are also covered by Medicaid would be automatically enrolled in a specific state selected ICO managed care plan unless the beneficiary actively opted-out of the demonstration program.

Massachusetts and its actuaries project “that the initial savings estimates of 1.5 to 2 percent within the term of the demonstration project appear to be obtainable.” The actuarial analysis “supports the prospects for this model with expanded benefits to produce both short term and longer term savings, offsetting the costs of providing the additional behavioral diversionary services.”

CMS Center for Medicare and Medicaid Innovation (CMMI)

The CMS Center for Medicare and Medicaid Innovation (CMMI) was established by Sec. 3201 of the Patient Protection and Affordable Care Act (PPACA) as a new Sec. 1115A of the Social Security Act.

The purpose of the CMMI, as provided by the new Sec. 1115A (a)(1), is to “test innovative payment and service delivery models to reduce program expenditures under the applicable titles (Title XVIII, XIX or both) while preserving or enhancing the quality of care furnished to individuals under such titles.”

The new Sec. 1115A (b)(1) provides that: “The CMMI shall test payment and service delivery models...to determine the effect of applying such models under the applicable title on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.”

The 18 potential models listed to be tested includes: “(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management of oversight of all funds under the applicable titles with respect to such individuals.”

The new Sec. 1115A (b)(3) provides that HHS shall terminate or modify the design of models tested by the CMMI unless the Secretary determines and the Chief Actuary of CMS certifies that the model “is expected to improve quality of care without increasing spending under [title XVIII, title XIX, or both], reduce spending under [title XVIII, title XIX, or both] without reducing the quality of care, or improve the quality of care and reduce spending,”

The new Sec. 1115A (d) provides that the Secretary of HHS is authorized to “waive such requirements of Titles XI and XVIII...as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).”

Comments on Massachusetts Proposed Demonstration

These comments discuss three important aspects of the Massachusetts proposal for a state demonstration in light of the CMMI statutory authority:

- First, the proposal does not describe in meaningful detail how the demonstration program would reduce, or at least not increase, Federal spending under Medicare and Medicaid.
- Second, the proposal does not describe in meaningful detail how the demonstration program would improve, or at least not reduce, quality of care provided to Medicare beneficiaries who are also covered by Medicaid.
- Third, the proposal does not describe a demonstration program that would “test and evaluate” the changes in care provided to Medicare dual beneficiaries.

It should be noted that the proposed program would transfer to the State of Massachusetts, a projected \$1.2 billion in Federal Medicare funds in the first year of implementation and more than \$15 billion over 10 years for 109,000 Medicare dual beneficiaries.¹

Nationally, a program that would shift all 7 million Medicare full dual beneficiaries to state programs would transfer to the States a projected \$80 billion of Federal Medicare funds in one year and more than \$1 trillion over 10 years.

Reducing, or Not Increasing, Medicare and Medicaid Spending. A proposal to transfer \$1.2 billion a year and \$15 billion over 10 years in Federal funds to the state government, and private plans in the state, should document how the program intends to pay private plans without increasing Medicare costs. While Medicare dual beneficiaries have relatively high costs in Medicare, and therefore potential reduced costs may be possible in the future, the demonstration program described by the Massachusetts proposal does not explain in any detail why reduced costs may be expected.

Since the Massachusetts program would auto-enroll Medicare dual beneficiaries from Medicare FFS into the new State managed care ICO plans, it can be assumed that these

Medicare beneficiaries would otherwise in Medicare FFS. The baseline to determine if the new Massachusetts program increases Federal costs should be based on average costs per beneficiary in Medicare FFS, adjusted to the risk score of the Medicare beneficiary participants in the demonstration.

There are two reasons for concerns about the proposed Massachusetts program in regard to Federal spending.

First, the assertion in the Massachusetts proposal, on page 32, that the new program would reduce Federal spending by 1.5 to 2 percent for the Medicare beneficiaries auto-enrolled into private plans is not consistent with the experience of Medicare Advantage private plans in Massachusetts.

An analysis of the costs to provide Medicare benefits by all MA plans and by Dual Special Needs plans (Dual SNP plans) to their enrollees in Massachusetts in 2009 finds that MA plan have costs that are not less than Medicare FFS costs but average 106% of FFS costs. Dual SNP plans have costs that average 112% of FFS costs. This is an average of \$557 more per Medicare enrollee per year than Medicare FFS costs for all MA plans and \$1,095 more for Dual SNP plans.^{2,3}

These findings reflect the costs of providing Medicare benefits by the major health plans in Massachusetts – including Tufts, Fallon, Blue Cross/Blue Shield of Massachusetts and United Healthcare– that have been Medicare MA health plans for many years. They also reflect the costs of all of the MA Dual SNP plans in Massachusetts.

Second, the Federal Medicare Advantage program has a very detailed plan payment system that has been refined over more than 10 years. This system is based on county specific payment benchmarks blended with individual plan costs to provide Medicare benefits. Payments are adjusted for plan risk scores.

The national experience in Medicare over 30 years is that without strict requirements and vigilant enforcement in many financial areas, private plans will inevitably manipulate the payment system to achieve higher payments.

The current MA payment system requires all MA plans to file detailed information on their costs, utilization of services, and administrative expenses in June of each year. This system is web-based and instructions to the plans include more than 100 pages of specific details. Federal payments to MA plans are subject to Federal audit and millions of dollars of excess payments to plans have been recovered. The Medicare MA plan system also includes an

extensive system to risk adjust plan payments for the health plans based for the health status of the enrollees in individual plans.

The proposal, primarily on pages 26 to 28, includes no similar specific details on the methodology for calculating payments to plans and no projections on how much per member per month the new plans would be paid.

Although private insurers' MA plans in Massachusetts, including Dual SNP plans, have greater rather than reduced costs relative to Medicare FFS costs, the proposal does not explain in any detail how the costs in the new plans for Medicare dual beneficiaries would be equal to if not less than costs in Medicare FFS.

Beyond the calculation of payments, no details are provided on how plans would manage and control the costs of providing care to Medicare dual beneficiaries. There is no specific information on the extent that it is expected that the plans would reduce prices paid to providers, would reduce the quantity of services provided to enrollees, or reduce the intensity of new and high-tech services provide to enrollees from levels in the Medicare FFS system. There is no mention of the need for the program payments to plans to include the administrative costs of the private plans that are reported by the CMS Actuary to average 13 percent for MA plans.

The experience of the MA program is also that an extensive risk adjustment system is necessary to preclude plans with relatively healthier or less disabled enrollees from being overpaid and plans with sicker and more disable beneficiaries being underpaid.

In contrast to the detailed Federal MA payment risk adjustment system, the Massachusetts proposal does not describe in any detail how it would risk adjust payments to plans for the health and disability status of their enrollees. There is no discussion of how the demonstration would acquire and analyze extensive utilization encounter data from the new plans to adjust payments.

As noted above, the Massachusetts proposal would transfer a projected \$1.2 billion of Federal funds to Massachusetts in one year and over \$15 billion over 10 years. An inadequately designed and administered payment system in Massachusetts could lose millions of dollars of Federal funds though the inefficiently of plans or even perhaps through fraud and abuse. An increase of only 1 percent in Medicare costs in the demonstration would increase Federal spending by \$150 million over 10 years.

Improving, or Not Reducing, the Quality of Care. A proposal to transfer 109,000 totally and permanently disabled Medicare beneficiaries from Medicare FFS to state government selected private plans should provide specific details on how the program would assure that the quality of care provided these severely disabled individuals would improve, or at least not be reduced. Access to, and quality of, health care can literally be a matter of life and death for severely disabled Medicare beneficiaries.

There are reasons to be concerned that the private plans in the Massachusetts demonstration program would reduce the quality of care provided to Medicare dual beneficiaries.

The Massachusetts proposal does not require the new managed care plans to meet Federal standards to be fully qualified Medicare Advantage plans in general and Dual SNP plans in particular. In the absence of the Federal standards now met by all MA plans in the nation with over 10 million enrollees, and MA Dual SNP plans with over 1 million enrollees, the proposal does not describe an alternative quality program with clear and strong standards, detailed data reporting, active monitoring, and vigorous enforcement related to the quality of care.

The traditional Medicare FFS system, from which the Medicare dual beneficiaries in Massachusetts will be transferred, is an open system where Medicare beneficiaries, on their own initiative or with the help of their families and others, can seek out and receive high quality care. The financial incentives to physicians and other providers are to provide all necessary care.

In contrast to Medicare FFS, physicians in private plans paid monthly capitation payments have financial incentives to reduce the quantity and quality of care. If patients in closed panel HMOs find they are receiving inadequate care, they have little opportunity to use their own initiative to obtain care from non-plan physicians. The incentive for capitated health plans to reduce or “skimp” on care has been acknowledged for more than 40 years since the consideration of the Federal HMO Act of 1973.

Medicare has recognized, since the advent of prospective capitated payments to managed care plans as part of Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982, the need to balance incentives to private plans for efficiency from prospective capitation payments with protections for Medicare beneficiaries against inadequate quantity and quality of care.

Over the past 30 years, since TEFRA first provided prospective payments to Medicare private plans, Medicare has developed a comprehensive system to detect and respond to

plans that provide inadequate care. Many GAO, HHS Inspector General and other investigations and reports have documented different aspects of problems with the quality of care provided by Medicare plans since 1982.

Federally qualified Medicare plans are now required to meet explicit standards provided by Medicare Regulations and described in specific detail in the *Medicare Managed Care Manual in Chapter 5 – Quality Assessment* and other chapters. MA plans are required to submit specific data to CMS to document that they are meeting quality standards as specified in the *2011 Medicare Part C Plan Reporting Requirements: Technical Specifications Document*.

These requirements include data and information on benefit utilization, procedure frequency, serious reportable adverse events, provider network adequacy, and grievances. CMS has sophisticated data base management systems to analyze the data and identify plans that are outliers in the data. Experience and extensive CMS staff manage the data that deal with MA plans providing inadequate care.

The Massachusetts proposal provides little detailed information, mostly on pages 22 – 24 and 28, on how the program would address the quality of care provided to disabled Medicare beneficiaries. In contrast to the extensive Federal MA quality assurance system, the Massachusetts proposal describes only cursorily how it would monitor, assess and assure the quality of care provided to disabled Medicare beneficiaries by plans for the health and disability status of their enrollees.

Proposal to Test and Evaluate Fully Integrating Care for Dual Eligible Individuals.

The proposal to the CMMI for a "State Demonstration to Integrate Care for Dual Eligible Individuals" from Massachusetts described in the draft of the proposal of December 7, 2011 is a proposal to revise the Federal Medicare and State Medicaid programs for 109,000 Medicare low-income beneficiaries who live in Massachusetts.

This proposal does not, however, describe a "model" to "test and evaluate" fully integrating care for Medicare dual beneficiaries as required by the statutory authority for the CMMI programs.

There are two reasons for concern about the proposed Massachusetts demonstration program in this regard.

First, the proposal does not describe a "model" to be tested in sufficient detail that, if tested and evaluated with the result of positive or negative findings, there would be any way to

understand the specific features of the model that were responsible for the positive or negative outcomes. While there are some promising detailed models to reduce costs or improve the quality of care for specific categories of the disabled Medical dual beneficiaries under the age of 65 such as those with serious mentally illness or developmental disabilities, the Massachusetts proposal does not describe one or more models in any meaningful detail.

The demonstration as described would not provide findings sufficiently related to specific features of the program model so that other states might replicate the demonstrated program if the outcomes are positive or avoid the program if the outcomes are negative.

Second, the proposal does not describe a process to “test and evaluate” the proposed program in sufficient detail to conclude that the activities tested either: (1) reduced or at least did not increase spending under Medicare and Medicaid; and (2) improved or at least did not reduce the quality of care received by Medicare dual beneficiaries.

In this regard, the proposal does not include a description of the program evaluation that is methodologically sound and could lead with any confidence that the findings from the evaluation are valid. The demonstration evaluation as described, mostly on pages 28 – 31, does not meet standards for the evaluation of community intervention program that other Federal agencies such as CDC and NIH require.

The lack of a methodologically sound evaluation is remarkable for a program with projected costs of over \$1 billion in one year and \$15 billion over 10 years.

Conclusion and Recommendation

For the reasons described above, we recommend that the December 7, 2011 draft of the Massachusetts proposal should not be submitted to CMMI at this time.

Instead, the Massachusetts proposal for a demonstration should be substantially revised to become a methodologically sound “test and evaluation” of a “model”, with both the model and the design of the evaluation design described in much greater detail.

In a revised proposal, the model should be described in sufficient detail that the model could be replicated in other states if it is successful, whether in reducing Medicare costs without reducing Medicare beneficiaries’ quality of care or in improving beneficiaries’ quality of care without increasing Medicare costs.

The evaluation of the impact of the model on Medicare costs and on the quality of care for Medicare beneficiaries should be designed to fully meet current professional program evaluation standards so that any findings, either positive or negative, will have national credibility.

Such a demonstration should include the following features:

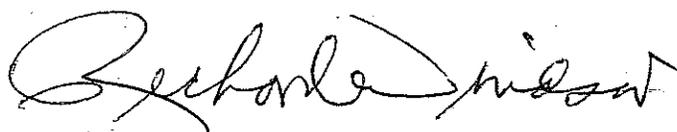
1. A limited number of under-65 Medicare dual beneficiaries, perhaps a representative sample of 20,000 beneficiaries;
2. A new model focused on a single disability condition, perhaps serious mental illness;
3. A well defined geographic area within the state, perhaps Boston or even some specific portion of Boston;
4. A specific time period for the length of the demonstration program evaluation, at least 3 to 5 years;
5. A requirement that all health plans that in the demonstration are fully Federally qualified MA plans meeting all MA plan standards and submit all MA plan required information to CMS for the life of the demonstration, including the specific standards and information for Dual SNP plans;
6. A payment system for the health plans that includes the submission by plans of all payment and risk-adjustment encounter information to CMS for the life of the demonstration;
7. A single, clearly described new service model, with core treatment components described in sufficient detail, including frequency, intensity, and duration so the associated costs would be well defined and could be replicated in other states if the demonstration is successful;
8. A model that builds and expands on promising models previously tested and evaluated on a smaller scale, perhaps in Massachusetts;
9. A rigorous program evaluation design that meets professional standards of Federal agencies such as NIH and will provide broad confidence that the results of the evaluation of the model are valid, reliable, and representative.

In the development of a revised proposal for a demonstration to test and evaluate a new model of financing and provide care to Medicare dual beneficiaries, Massachusetts might find it useful to consult with experts within the state on Medicare, Medicare managed care plans, serious mental illness or other major conditions of Medicare dual beneficiaries, and the program evaluation design and implementation. Massachusetts is privileged in this regard as there are a number of individuals who are recognized as national experts in these fields at Harvard, Brandeis, Tufts, Boston and other universities in the state.

Finally, Massachusetts might also consider developing a proposal for the testing and evaluation of a model in which a number of disabled Medicaid dual beneficiaries would be transferred to Medicare with enhanced benefits. Such a model might focus on a specific disability condition, such a serious mental illness, with Medicare adding new benefits, including perhaps a monthly patient management fee for care management of the disability related services by primary care medical home physicians and practitioners.



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¹ This projection is based on average Medicare per capita costs for Medicare beneficiaries in Massachusetts in 2009 adjusted by the risk score for Dual SNP enrollees increased by the CBO projected increase in Medicare costs over the next decade.

² These findings are the result of analysis of MA plan costs in 2009 reported to CMS in June of 2010. These plan costs are the annual amount of costs for providing Medicare benefits, and only Medicare benefits, adjusted to a uniform risk score of 1.0. They are certified to be accurate by the MA plans and are subject to Federal audit. Nationwide, 8 percent Medicare dual beneficiaries were enrolled in Dual SNP plans in 2009.

³ Only 3% of Massachusetts Medicare dual beneficiaries were enrolled in Dual SNP plans in 2009, the findings regarding Dual SNP plans costs related to FFS costs should be viewed as illustrative. In contrast, 21% of all Medicare beneficiaries in Massachusetts were enrolled in MA plans in 2009.



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January 10, 2012

Secretary JudyAnn Bigby
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Bigby:

Thank you for this opportunity to provide testimony on the draft proposal to the Center for Medicare and Medicaid Innovation for the Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals. Health Care For All is dedicated to making quality, affordable health care the right of all people, and supports a health care system that is universal, comprehensive and equitable. Health Care For All is proud to work closely with you, the Office of Medicaid and other agencies in EOHHS to successfully implement the access reforms initiated by chapter 58 in 2006, and we are strongly focused on supporting the payment and delivery system reforms being pushed by you and the Governor.

As a charter member of the Disability Advocates Advancing Our Healthcare Rights (DAAHR) coalition, we strongly support all of the concerns raised by the coalition throughout this process, along with the recommendations for amendments to the draft proposal put forth in DAAHR's written testimony.

Health Care For All recognizes the importance of securing quality and affordable health care coverage and improving coordination between Medicare and Medicaid. Integrating care for disabled dually eligible adults provides an opportunity to provide more services, to offer more patient-centered care, and to achieve some savings in the process. Thus we strongly support the Commonwealth's initiative to advance a maximally integrated care model and financial model.

However, this can only succeed if the plan engenders the confidence and support of the people who will be enrolled in the program. Without the strong support of the community of people with disabilities, the project will not be successful, and this will inhibit our ability to make progress in this area.

Thus, in addition to the issues raised by DAAHR and other commenters, we urge the Executive Office to keep in mind three overriding concerns which should guide your approach to the demonstration request.

First is the need to move our focus beyond the provision of medical care. The needs to be covered by the demonstration for adults with disabilities span a broad spectrum of services. As health-focused programs, both Medicare and Medicaid often are concerned foremost with doctors, hospitals and other medical services. This is appropriate, and medical care must not be ignored and pushed back. However, we know that in order for this demonstration to succeed in serving the unique and diverse needs of the dual eligibles population, the paradigm must lift up and protect the long term services and supports (LTSS) that are critical for people with disabilities. We urge the proposal to center around maximizing patient choice, self-direction and protection for LTSS access. That is the arena where the most critical improvements in overall quality of life can be achieved, and where the benefits of integration can pay off the most, if done well.

Second is the admonition to be extraordinarily careful of doing harm to people in the rush to quickly achieve scale in the program. While the opportunities are enormous, so are the risks. Because this demonstration acts on the most critical needs of the most vulnerable population in the state, we believe that the possibility of doing serious harm must always be taken into account. Thus we would counsel making changes step by step, with full transparency and opportunities for evaluation along the way. To implement a dramatic change in the care system for all 115,000 dually eligible people at once could very well be too much, too quick. We urge the proposal to provide for a gradual expansion of the integrated program, and that enrollment initially be through a voluntary opt-in system.

Third, we urge the State to continue the process of actively listening to the individuals who will be affected by this demonstration and engaging them in the ongoing negotiations with CMS in the months ahead. The process so far has been uniquely open and participatory, with multiple avenues for the affected groups to react to proposals and make their voices heard. The need for this open process will intensify during the next stage of the proposal. As the state begins its arduous process with CMS, we hope you will find ways to bring those most affected by the proposal squarely into the center of the policy process. This is the only way you can assure broad support and buy-in for the final program.

At the two listening sessions in Boston and Worcester, the office saw evidence of the extraordinary depth of feeling among people with disabilities about this proposal. Your challenge will be use that energy to fashion a proposal that wins the support of the community as well as meets state and federal requirements. HCFA will continue to work through the DAAHR coalition to assist in that goal.

Brian Rosman
Research Director
Health Care For All

From: Cliff Cohn [ccohn@seiu509.org]
Sent: Tuesday, January 10, 2012 1:35 PM
To: Duals (EHS)
Subject: Dual Testimony from SEIU Local 509

January 10, 2012

RE: SEIU Local 509 Position Statement on Integrating Medicaid/Medicare Dual Eligibles

Dear EOHHS,

Massachusetts has been a national leader regarding the diversity and quality of its 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. For that reason please accept our following comments.

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1) We want to maintain the current waivers and ask there be explicit language in the proposal to not include Waiver Services.

- Massachusetts must explicitly modify its initial Proposal to CMS to exempt CMS Waivers in all state operated programs in community and facility settings, including all public/private human services within DDS, DMH, MRC and services for blind/deaf individuals reimbursed through Medicaid/Medicare dollars.
- 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.

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Society's most vulnerable citizens deserve much better planning and thought regarding considered changes of this magnitude.

- 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.

- With the implementation in 2009 of Community Based Flexible Supports (CBFS), which merged DMH community based services, the state reportedly lost \$30 million in Rehab Option Medicaid dollars. We believe that the layoffs of 100 DMH Case Managers and the separation of CBFS clients from the remaining 300 Case Managers contributed greatly to system wide implementation problems in CBFS. Those layoffs are currently under litigation, however, legal issues aside, it is easy in hindsight to see the impact of those layoffs. Furthermore, DMH Case Managers currently bring in \$11 million in Medicaid Target Case Management funds and DDS Service Coordinators bring in \$14 million in Targeted Case Management funds. These public workers have extensive expertise and should be fully utilized to insure there are no further losses of valuable Medicaid dollars.

2) We want to ensure that state workers – specifically DDS Care Coordinators, DDS Residential Supervisors, and DMH Case Managers – are not laid off in the spirit of cost-effectiveness. We want to ensure that they have an integral role in the new system to ensure continuity of care and quality of care for consumers.

- Local 509 agrees with the need to address needless costs of medical procedures, tests abuse, billing and administrative redundancies, etc., but this is profoundly different then the care of human beings. Cost effective case management for human beings requires far more of a skill set then being ensconced in an office wearing head phones and gauging what is billable within the bottom line and what isn't.
- Including CMS waivers in the Dual Eligibles Proposal to CMS could result in many thousands of public/private layoffs for “cost efficiencies” and profits to managed care organizations (ICOs).

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Why would Massachusetts want to further risk unemployment 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 ICOs presents 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.
- 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.
- 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.

3) We want to ensure that valuable Medicaid/Medicare money be used for client services. ICOs should establish contracts with human service providers consistent with 808 CMR 1.05 (1-28) such that funds are spent solely on improving the lives of persons with disabilities and not on "non reimbursable" and inappropriate endeavors.

I look forward to our continued work together on this important project. Feel free to contact me with any questions.

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Sincerely,

Cliff Cohn, Chief of Staff

SEIU Local 509

100 Talcott Ave.

Watertown Ma 02472

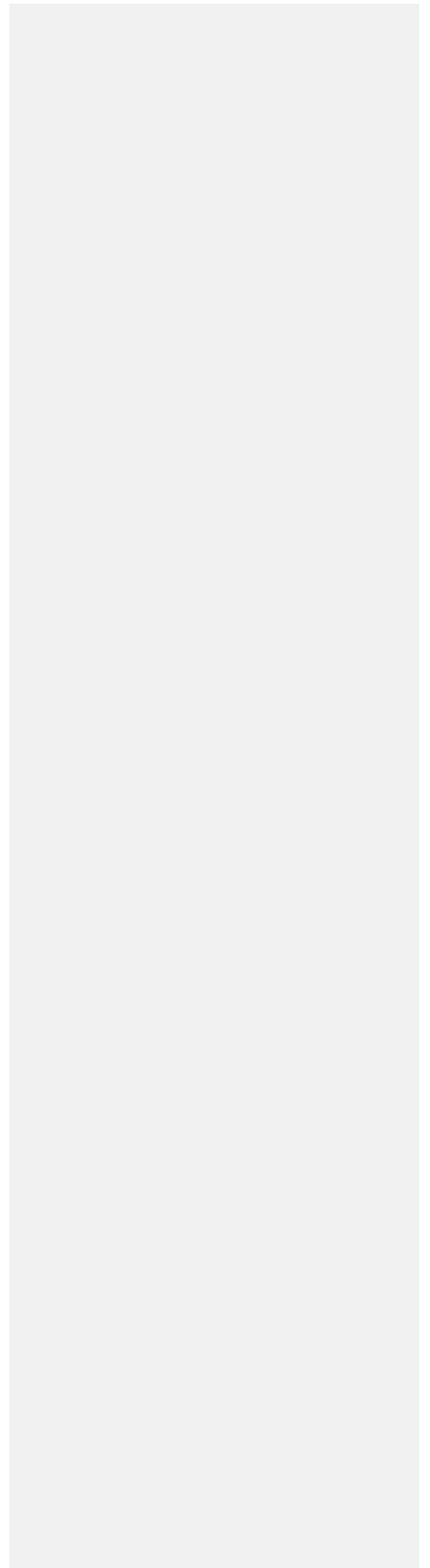
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To Whom It May Concern:

The National Empowerment Center (NEC) is a consumer/survivor/ex-patient-run organization dedicated to bringing the message that recovery is possible for people with lived experience of mental health issues, trauma, and extreme states.

NEC respectfully submits these comments on the Dual Eligibles Demonstration Project draft proposal on the behalf of all Massachusetts citizens who struggle with mental health conditions. As stated in the EOHHS draft proposal, 34.9% of the dual eligible population in Massachusetts had a diagnosis of serious mental illness in 2008. NEC asserts that unless the long term support services (LTSS) of these consumers include robust community-based peer supports, the demonstration project will not succeed in its objectives of achieving comprehensive delivery system and payment reform in Massachusetts' health care system, nor will the care provided to these consumers be of sufficient value for them to achieve full recovery from mental health conditions.

We thus request that the following changes and/or additions be made to the proposal before its submission to CMS.

- 1) NEC proposes that passive enrollment into the proposed demonstration project be replaced with voluntary enrollment by consumers.
- 2) NEC proposes that consumers have the choice of providers, and that Integrated Care Organizations (ICOs) be required to adopt an open network policy with out-of-network providers that a consumer wishes to remain on their treatment team.
- 3) NEC proposes that ICO treatment teams be consumer-led and that the consumer makes the final decisions on all team recommendations.
- 4) NEC proposes that an independent Long Term Service and Support (LTSS) care coordinator be offered to every consumer as part of the treatment team. "Independent" means a care coordinator who is not employed by the ICO who can provide unbiased information, recommendations, and referrals to community based organizations (CBOs) that might be useful for the consumer as part of their recovery-based treatment.
- 5) NEC proposes that capacity-building money be available to independent CBOs (including Recovery Learning Communities and other peer-led organizations) in order to provide support services for the enormous number of new dual eligibles who will be

referred to CBOs by the independent LTSS care coordinators. This money might be raised by assigning a "tax" on each consumer enrolled in an ICO plan.

(6) NEC proposes the creation of an independent, non-profit disability (consumer-run) group to oversee ADA and Olmstead compliance by the ICOs. Further, we request that this consumer-led board include at least 33% of consumers with lived experience of mental health conditions, as is reflected in the statistics of the dual eligible population in Massachusetts (MMPI data, 2008).

7) NEC also proposes that Massachusetts Certified Peer Specialists (CPSs) are granted Medicaid-reimbursement in order to provide the integrated community services that dual eligible consumers with mental health conditions will need in order to achieve their full recovery.

Thank you for supporting the growth of person-centered care and independent living for consumers in Massachusetts. We believe that with the above noted changes, Massachusetts has the opportunity to be the leader of truly innovative healthcare reform and a beacon for the rest of the United States of America.

Sincerely,

A handwritten signature in black ink that reads "Daniel B. Fisher, MD, PhD". The signature is written in a cursive, flowing style.

Daniel B. Fisher, MD. PhD
Executive Director, NEC

The Transformation Center
Testimony to EOHHS
Regarding State Demonstration to
Integrate Care for Dual Eligible Individuals
January 10, 2012

Contact: Deborah Delman

Deborahd@transformation-center.org

Cell: 617-872-7768

DRAFT:

In general, we see the state's proposal as a step forward to achieving improved coordination for dual eligibles. However, we recommend the following in relation to the specific and complex needs of people with serious mental illnesses.

1) Consumer-run organizations, Certified Peer Specialists

On page 12 of your proposal it is stated that: *“Each ICO will be responsible for management of its network, including credentialing and re-credentialing providers, establishing and tracking quality improvement goals, and conducting site visits and medical record reviews. The ICO will be responsible for ensuring that a sufficient number of appropriate providers, including community-based LTSS providers, are available to deliver all covered services to the ICO’s anticipated enrollees.”*

Consumer operated organizations (COOs) play a critical role in efforts to achieving a coordinated care system, both with their special knowledge of community resources and peer support, and they are considered an evidence-based practice by SAMHSA.

We recommend a statement that experienced consumer-run organizations which specialize in these areas will be highly considered for leadership in quality improvement, credentialing, and designing appropriate recovery oriented services.

For example, the Transformation Center for 7 years has been authorized to credential Certified Peer Specialists. Peer specialists work with consumers to help them understand and support their recovery process. Peer specialists use their lived experience to inspire consumers, many of whom have not been encouraged and lost hope. They are vital members of treatment teams, educating staff on recovery principles. In Massachusetts, they serve as members of various types of mental health treatment teams, including Program for Assertive Community Treatment (PACT), day treatment, emergency services, in-patient care and Community Based Flexible Supports (CBFS). Emerging evidence supports the cost-effectiveness of peer support services as an adjunct to clinical mental health services and supports. Because of the skills required, we also recommend that peer specialists be certified through a consumer-run process.

Since 1988, MPower has advocated passionately for peers in Massachusetts providing a common voice for legislative and policy reform. This led to a DMH informed consent policy, reduction in restraint in seclusion and establishment of the 5 Fundamental rights in psychiatric hospitals among many other accomplishments. The mere fact that the Transformation Center and RLCs were started under its roof demonstrates a capacity to set up viable programs to benefit peers. Therefore, it is the correct CBO for the advocacy piece.

In addition, Consumer Quality Initiatives is a consumer-run quality improvement organization that has worked with MassHealth behavioral health and DMH to bring the consumer voice to Total Quality Management TQM or other quality improvement systems. For quality management, we recommend the inclusion of continuous quality improvement teams, which would include at least two consumer representatives, to identify where practices do not meet the standards and evidence base and to develop initiatives to close those gaps. DMH currently uses this practice in assessing PACT teams. (See CQI's Report "Crossing the Mental Health Quality Chasm in Massachusetts" - <http://www.cqi-mass.org/pdfs/crossingchasm.pdf>).

Thus, we believe that capacity-building money should be made available to independent CBOs (including the Transformation Center, Recovery Learning Communities and other mental health-specific peer-led organizations while advocacy be handled by MPower) in order to provide support services for the huge number of new dual eligible individuals who will be referred to CBOs by the independent LTSS care coordinators. (Capacity-building means having money to help grow the CBOs through hiring more peers, renting new or larger office space, access to more community services, etc.) **This money might be raised by assigning a "tax" on each consumer enrolled in an ICO plan (e.g. 50 cents per person per year to be set aside by ICOs to assist CBOs in capacity building).**

Specialty Medical Homes

Your proposal indicates that "Clinical case management" will deal with enrollees with more complex needs, presumably including people with serious mental illnesses. We believe that the number of people who need Clinical Care Management will be relatively high, perhaps more that you create capacity for.

We strongly suggest you revisit the idea of placing these people in specialty medical homes. A significant value of this approach is the creation of a continuum of necessary services. Without specialty homes, mental health providers will be less likely to develop innovative programs to meet such people's specific needs because there will be great uncertainty of sufficient consumer demand. It's a repeat of the private insurance model, which fails to pay for critical long-term and innovative behavioral health service. Through the carve-out, many innovative behavioral health programs have been developed. General medical homes will likely not have the knowledge or financial interest in connecting consumers to such programs. The MCO's have behaved in that fashion historically (until very recently).

. This is the trend, and at Appendix A is an example of how Missouri is setting up these health homes. For more support on this matter,

2) Training of PCPs in behavioral health care

Primary care staff is usually not familiar with clients who have a serious mental illness, their particular sensitivities and multiple needs, including with rehabilitation (employment, education, and housing). Mental health clients have often felt stigmatized in this system, where physical complaints are frequently, and mistakenly, seen as an emotional problem, and a key reason for the lower ages at which consumers die.

Thus, primary care will need training and coaching in these areas, as well as in identifying and addressing mental illness and addiction problems. Training in evidenced-based behavioral health practices must take place at all levels. Cross-training will also be important, e.g., for addictions treatment or primary care providers to become adept at identifying and

appropriately responding to mental illness. More general training is also indicated, such as mentoring to support medical providers to better understand people with behavioral health care needs and training for specialty providers to become ready for third party billing.

3) Supported employment (IPS)

We realize that there are financial barriers to offering this service. However, if we take a broader perspective of a government interested in cost savings, supportive employment makes sense. First, supported employment not only helps people get and keep jobs, but it also helps with their broader recovery in building self-esteem and with symptom reduction. Perhaps most importantly, helping people get jobs can take them off Social Security Disability and probably with access to insurance. That is, they will be able to access health insurance through their employment. This is the recovery process, where people move beyond their illness and take a meaningful role in society, along with community integration.

Supported employment, in the form of the evidence based practice Individualized Placements and Supports, is designed to integrate the vocational support specialist into the treatment team. With IPS, the employment specialist (ES) acts in concert with a multidisciplinary treatment team, which provides the ES with clinical information (such as medication side effects) that give him or her a more clear understanding of the reasons for the consumer's clinical needs in relation to job attainment and retention. When the ES has greater and more direct knowledge of the consumer's health condition, he or she is in a better position to provide more informed advice to the consumer getting and maintaining the job, and to the employer as the consumer permits.

4) Decision supports

Person-driven planning and treatment takes place when the client works with the treatment team to identify his/her desired treatment preferences and long-term hopes, and then to develop strategies to achieve those outcomes. The process assumes an active and informed role for the client to choose treatments, services, and supports. Shared decision-making—an interactive process in which providers and patients simultaneously participate in all phases of the decision-making process and negotiate a treatment plan—is one approach to patient-centered planning. Decision support mechanisms to help clients become more knowledgeable about treatment and clarify their values help them become more active participants.

In our view, there are at least 3 necessary baseline components to for consumers to determine (eg, choose) their own supports and services: 1) knowledge around both (a) the current service/support choices and (b) the most effective practices/services/supports; 2) literacy- there are significant amount of clients who are illiterate or have trouble reading, or are non-English speaking, and 3) effective and clear communication skills regarding consumer's values and choices. Also, Pat Deegan's computer driven CommonGround is worth exploration, as MBHP and DMH has already funded its use.

We have also learned that consumers want to share in decision making, but if there is disagreement they want to final call. This is "consumer directed shared decision making." The literature is clear that this kind of relationship leads to better outcomes in terms of optimal medication use (over a time period). This notion relates to the "dignity of risk" and recovery.

The concept of "transparency" is also important here, as it's difficult to have to direct services over one's choices without information. Thus, there should first be an updated database which people can review to see the services and supports can be obtained, as well as any data on

the effectiveness of those programs. This knowledge is about both the quality of existing services and the research on evidence-based and promising practices. For the former, some sort of report card format, assuming there is some sort of case mix model can make the grades comparable. Clients will only be able to use these report cards if they've received at least some training on "quality of care."

5) Outcomes Measurement

We suggest focusing on specific and tangible outcomes. In our view, the key mid-term outcome is self-efficacy/confidence. People often cannot move on the ultimate goals if they cannot develop their confidence and motivation to do certain things (eg., take care of health/wellness). Programs may appear to be doing a good job without achieving the major outcomes, and self-efficacy is a good intermediate measure for that.

In our view the key outcome for people living with mental illnesses is managing one's own life, including symptoms, money, and the daily challenges, without an substantial reliance on the mental health system. Four key components of that are 1) active participation in treatment decision making, 2) empowerment, 3) independence, and 4) community integration, and there are several validated measures of these outcomes.

7. Outreach to hard-to-reach populations is critical

People with serious mental illness and addictions often do not utilize health services due to their high rates of poverty, homelessness, imprisonment, immigrant status, and transportation barriers. Individuals in correctional facilities often receive minimal treatment and may have difficulty obtaining care when they re-enter the community. In general, these populations may have difficulty accessing primary care services, have major unmet medical and behavioral health needs, and are often very costly to treat. Veterans are another special population. Although veterans have access to the Veterans Health Administration (already an integrated health care system), many veterans seek care in other settings that do not address their specific issues, such as post-traumatic stress disorder. New health delivery systems will need to take these needs into account.

State funding has been available throughout the years to pay for outreach programs that provide appropriate health care for difficult-to-reach populations. We are concerned that an insurance-driven model may not effectively reach out to these groups, and special initiatives will continue to be needed.

8. Health reform implementation must take account of housing needs of people with behavioral health conditions

Massachusetts has a large system of residential treatment centers; many of the clients in these systems have nowhere else to go. Summit participants felt there has been little discussion about how the residential system fits with health care reform. An overarching concern is that if Medicaid starts to focus more narrowly on a medical care and stops funding housing, people who rely on residential programs and other housing supports will face an uncertain future. People with substance use disorders would benefit from a case management system to reach out to support homeless clients. DMH has a system in place to support their clients who become homeless, and that system should not be dismantled. It is important to adequately fund housing supports.

Appendix A

Missouri Health Homes Launched January 1, 2012

OPEN MINDS January 9, 2012

Beginning January 1, 2012, Missouri Medicaid will be providing “Health Homes” for Medicaid eligible children and adults with chronic illnesses, including those with serious mental illnesses (SMI). The Health Homes will use health information technology to link services; provide comprehensive care management; care coordination and health promotion; comprehensive transitional care between inpatient and other settings; patient and family support; and referrals to community and support services. Medicaid beneficiaries enrolled in managed care (MO HealthNet) and beneficiaries that are dually enrolled in Medicaid and Medicare are also eligible for Health Home services.

The Missouri Department of Social Services and the Department of Mental Health is providing two types of Health Homes—Community Mental Health Center (CMHC) Homes and Primary Care Chronic Conditions Healthcare Homes. The Health Home provider organizations were selected following an application review. At least 25% of each Health Home provider organizations’ patient base must consist of Medicaid patients and/or uninsured patients. More than 30,000 eligible consumers have already been auto-enrolled based on their history of receiving services at a Health Home provider organization for a qualifying condition. Individuals with qualifying conditions who are not currently receiving services from a Health Home provider organization may request to join a Health Home. Additionally, potentially eligible individuals receiving services in a hospital emergency department or as an inpatient will be notified about eligible Health Homes and referred to one based on their choice of provider organization.

Community Mental Health Center (CMHC) Homes

The CMHC Health homes are provided by 27 CMHCs and CMHC affiliates. In order to participate in the program, the selected CMHCs will be required to obtain Health Home certification through nationally recognized Health Home accrediting organizations. Medicaid individuals that have been diagnosed with a serious mental illness or addiction disorder will be auto-enrolled in a CMHC Healthcare Home. The CMHC Healthcare Homes will be the state’s designated provider organization for an estimated 6,757 individuals of any age with the following conditions:

- Serious and persistent mental health condition
- Serious and persistent mental health condition and one of the targeted chronic health conditions
- Addiction disorder
- Co-morbid mental health condition and addiction disorder
- Addiction disorder and one of the targeted chronic health conditions
- A mental health or addiction disorder and tobacco use, which is considered as an at-risk behavior for chronic health conditions such as asthma and cardiovascular disease

Additional details about the CMHC Health Homes are as follows:

- **How staffed**—The CMHC Healthcare Homes will be physician led; the health teams will include a Health Home director, a primary care physician consultant, a nurse care manager, and an administrative support staff member. Optional health team members can include the individual’s treating primary care physician, psychiatrist, and mental health case manager, as well as a nutritionist/dietitian, pharmacist, peer recovery specialist, grade school personnel, and other educational, employment, or housing representatives.
- **How paid**—The CMHC Healthcare Homes will receive \$78.74 per member per month (PMPM) to provide all needed care coordination services specified by the individual’s person-centered plan; the PMPM reimbursement is not intended to cover the cost of services covered by Medicaid. The PMPM reimbursement is calculated as a sub-PMPM for each team member that assumes specific tasks will be provided for a pre-specified number of patients. For example, the \$78.74 total PMPM includes \$35.00 for a nurse care manager who coordinates care via 12 tasks for up to 250 enrollees, \$12.50 for a primary care physician consultant who devotes one hour per enrollee per year to provide four services, \$19.17 for a Health Home director who oversees care for 500 enrollees through five activities, and \$12.07 for one administrative support staff person who handles seven administration

tasks related to 500 enrollees. All Health Home payments, including those for beneficiaries enrolled in managed care will be made directly from MO HealthNet, the state Medicaid plan, to the Health Home provider organization.

- Anticipated savings to state—16% reduction in PMPM health care costs within three years as compared to usual care. Usual care PMPM costs are expected to reach \$1,815.81 PMPM based on existing cost trends.
- Bonus payments—Not specified in the SPA, but DMH staff indicated in a June 2011 presentation about the Health Home implementation titled "Paving the Way," that CMHC Health Homes will receive additional funding based on their improvement on performance measure outcomes.
- Performance measures—The SPA lists specific goal-based performance measures intended to measure improvements in health care quality, patient outcomes, and care coordination. In July 2011, each CMHC was given its benchmark data for certain measures; the SPA lists the goals for each measure. Performance measure outcomes will be derived from Medicaid claims data, pharmacy claims data, required reports filed by the Health Home provider organizations, patient surveys, and patient engagement with Missouri's Cyber Access personal health record, disease registry data.

Primary Care Chronic Conditions Healthcare Homes

The Primary Care Chronic Conditions Healthcare Homes are comprised of federally qualified health centers (FQHC's), rural health centers (RHC's), and physician practices. Primary care practices will be required to obtain NCQA (National Committee for Quality Assurance) Health Home certification. Enrollment for primary care practices are targeted at persons with two chronic health conditions; or those diagnosed with one chronic condition who are at risk of developing another. An estimated 25,372 individuals eligible for Healthcare Home services will be auto-assigned to a Health Home provider organization based on their qualifying conditions. The following chronic conditions are targeted for Primary Care Chronic Conditions Healthcare Homes services:

- Asthma
- Diabetes
- Cardiovascular disease, including hypertension
- Overweight, defined as a body mass index of 25 or more
- Developmental disabilities
- Smoking or diabetes qualifies a person with one qualifying condition as being at-risk of having a second chronic condition.

Additional details about the Primary Care Chronic Condition Health Homes are as follows:

- How staffed—The Primary Care Chronic Conditions Healthcare Homes will also be physician led; the health teams will include a primary care physician or nurse practitioner, a licensed nurse or medical assistant, behavioral health consultant, a nurse care manager, and the practice administrator or office manager. Optional health team members can include a nutritionist, diabetes educator, public school personnel, and others as appropriate and available.
- How paid—The Primary Care Chronic Conditions Healthcare Homes will receive \$58.87 PMPM. The PMPM reimbursement for each team member assumes specific tasks and a target workload, similar to the tasks and targets for the CMHC Health Home team members. All Health Home payments, including those for beneficiaries enrolled in managed care will be made directly from MO HealthNet, the state Medicaid plan, to the Health Home provider organization
- Anticipated savings to state—1.89% net savings in annual aggregate enrollee health care costs as compared to pre-Health Home estimated costs of \$136 million
- Bonus payments—Not specified in the SPA
- Performance measures—The SPA lists specific goal-based performance measures intended to measure improvements in health care quality, patient outcomes, and care coordination for this population. The SPA lists goals for each measure. Performance measure outcomes will be derived from Medicaid claims data, pharmacy claims data, required reports filed by the Health Home provider organizations, patient surveys, patient engagement with Missouri's Cyber Access personal health record, disease registry data,

A link to the full text of “Missouri Medicaid CMHC Health Homes State Plan Amendment” may be found in *The OPEN MINDS Circle Library* at www.openminds.com/library/102111mhcdmocomhchealthhomesspa.htm.

A link to the full text of “Missouri Medicaid Health Homes State Plan Amendment” for primary care settings may be found in *The OPEN MINDS Circle Library* at www.openminds.com/library/110311mhcdmoprimcarehealthhomesspa.htm.

The “Paving the Way for Healthcare Home” presentation was also part of the documents discussed at the Missouri Coalition of Community Mental Health Centers 2011 Annual Meeting. The meeting topics covered multiple aspects of the Health Home implementation. A link to the full text of the annual meeting documents may be found in *The OPEN MINDS Circle Library* at www.openminds.com/library/062811mhcdmohcpresmddmhc.htm

For more information, contact: Bob Bax, Missouri Department of Mental Health, 1706 E. Elm Street, Post Office Box 687, Jefferson City, Missouri 65102; 573-751-4122; Fax: 573-751-8224; E-mail: bob.bax@dmh.mo.gov; Web site: <http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm>; or Seth Bundy, Missouri Department of Social Services, Broadway State Office Building, Post Office Box 1527, Jefferson City, Missouri 65102-1527; 573-751-4815; Fax: 573-751-3203; E-mail: Seth.D.Bundy@dss.mo.gov; Web site: <http://dss.mo.gov>

Position Statement on the PCA program within the Massachusetts Duals Initiative

January 10, 2012

To: Dr. Julian Harris, Assistant Secretary Christine Griffin, Robin Callahan, Rosalie Edes

The state's Personal Care Attendant program enables approximately 20,000 people with disabilities of all ages to live more independent lives in the community. It is critical to keeping children out of pediatric institutions and elders out of nursing homes. It helps working-age adults to hold a job and raise a family. Critical to the program's success are its hallmark features, consumer control and a complete embracing of independent living philosophy.

While nothing has yet been finalized, it has been suggested that the PCA program under the state's duals initiative will follow the model currently used by Senior Care Organizations (SCOs), where eligibility evaluations are performed and approved by SCO staff independent of MassHealth and Personal Care Management agencies, with skills training provided by PCM agencies under contract to a SCO. The advantages of this arrangement, in which PCA rates are part of a provider's capitation, are the SCO's ability to quickly adjust a consumer's PCA hours as needed and more closely link services to healthcare and independent living needs. Such prudent use of PCA services can be a gigantic part of enhancing individuals' wellness and continued integration in the community. There would, however, be major risk associated with such arrangements with Integrated Care Organizations (ICOs), and it is because of this that we urge the state to adopt alternative arrangements for the PCA program under the duals initiative. Specifically, our concerns are as follows:

1. Serious lack of understanding of the PCA program as a vital component of wellness and independence.

The state's duals initiative envisions a fair number of ICOs serving as the key providers of services to people with disabilities. It is likely that only a few, at most, will have any significant experience with the program. To expect medically-oriented healthcare providers, with most if not all of their experience in the provision of primary care, to comprehend and prescribe PCA hours is not realistic. PCMs have a long history of evaluating consumers, and the agencies' governing bodies and missions are distinctly reflective of the population served. Independent living is typically part of a PCMs operational DNA— in many agencies, in fact, PCA consumers also serve as PCA staff.

2. Variability in standards, operating procedures, and consumer hours under an ICO.

There undoubtedly would be a troubling variance in standards and procedures for the program's operation with it being undertaken by ICOs with no prior experience running a PCA program. Notably, in the past three years, staff from MassHealth and the Office of Long Term Care have worked closely with advocates from the Statewide Personal Assistance Coalition and providers from PCMs to bring

uniformity, and many would argue a level of sanity, to the evaluation process. There had been use of differing forms, and even amongst MassHealth nurses and offices there were wide variations in interpretation of regulations. The diligent work to keep PCMs and state officials speaking the same language continues, driven by a desire to ensure efficient delivery of services to consumers, and this is essentially a continuous process. Having written standards alone would not be sufficient to ensure that consumers receive adequate PCA coverage, and while critical, an appeals process is nonetheless a tool that many people would not use. In many respects the current relationship between MassHealth and PCMs is a check-and-balances system. Notably, MassHealth has resisted suggestions by advocates that the licensed RNs working for PCMs be the sole determiners of consumer eligibility and hours. Thus, to move to a PCA system where there is no advocacy check on PCA hours prescribed through a medical home from an ICO— an entity which may have no experience whatsoever in the provision of PCA services— while non-duals still would be required to go through the Prior Authorization process— seems both nonsensical and a major disregard of the independent living imperative. And compounding this are the serious possibilities of an ICO reducing PCA services to stay within their capitation because of financial pressures accelerated by increased primary care costs, misunderstanding of the role of the PCA program for a consumer, and the lack of a formal and significant community advocacy role in the eligibility determination process.

There are three potential arrangements for the duals that can address these concerns. One would be to keep the program out of the ICOs' capitation, with consumers obtaining services as they currently do from PCMs and going through MassHealth, with the consumer's primary care physician from his or her medical home signing off on hours. A second option would be to have the program fall within the capitation, but have the ICO contract with PCMs for evaluations and skills training with the consumer's primary care physician or a designated RN from his or her medical home approving hours. All basic rules and regulations for the program, including, though not exclusively, standards to be a PCM, pay rates and benefits for PCAs, surrogacy requirements, skills training requirements, evaluation criteria, and the right of consumers to hire, train, supervise, schedule, and dismiss attendants, would remain. This model would ensure greater integration of LTSS in a consumer's care plan, a more flexible and expedited approval process than currently exists when consumers must go through MassHealth Prior Approval, and the involvement of a PCM steeped in independent living, consumer control, and the ability to promote services that fit the unique needs of each consumer. A third option would be for there to be an opt-in feature attendant to either of the models just mentioned, whereby a consumer, if he or she wishes, could have their medical home within an ICO perform evaluations, with skills training still provided by PCM agencies, with all current standards for skills training remaining. For all of these models, we strongly support the addition of prompting and cuing as part of services that can be performed by PCAs and the guarantee of an appeals process with consumer rights at or greater than currently exist for those on the MassHealth PCA program.

We appreciate your attention to our recommendations.

Sincerely,

Paul Spooner, executive director, Metrowest Center for Independent Living

Jim Kruidenier, executive director, Stavros Center for Independent Living

Coreen Brinckerhoff, executive director, Cape Organization for Rights of the Disabled

Ann Ruder, executive director, Center for Living and Working

Mary Margaret Moore, executive director, Independent Living Center of the North Shore and Cape Ann

Derrick Dominique, executive director, Multicultural Independent Living Center of Boston

Joe Castellani, executive director, Ad Lib

June Cowen, executive director, Northeast Independent Living Program

Bill Henning, executive director, Boston Center for Independent Living



Community-Based Organizations in the Dual-Eligibles Initiative

What is a Community-Based Organization (CBO)?

Community-based organizations (CBOs) are defined as organizations independent of any ICO or MassHealth or Medicare provider organizations, with expertise in LTSS. Generally, over 50% of the CBO's governing body shall come from the population it serves. The CBOs discussed in this document may include, but are not limited to: Independent Living Centers (ILCs), Recovery Learning Communities (RLCs), Deaf and Hard of Hearing Independent Living Services programs (DHILS), ASAPs, and chapters of The Arc. EOHHS, in consultation with other stakeholders, will further identify the characteristics of such CBOs, and the qualifications and duties of such LTSS Coordinators.

Coordinating Long-Term Services and Supports

Long-term supports and services (LTSS) are to be coordinated by community-based organizations. ICOs will contract with CBOs to provide staff trained specifically to serve as independent LTSS Coordinators. The LTSS Coordinator is independent in that he or she is not directly employed by an ICO, PCMH, or other provider organization, to help ensure that coordination is “conflict-free.”¹ However, he or she is expected to act in cooperation with the rest of the care team, and at the direction of the beneficiary. There will be one coordinator per care team, and ideally that coordinator will come from a CBO whose expertise is most reflective of a consumer's particular needs, including CBOs with

¹ Community-based organizations which provide only referral, training, and assessment services shall not be considered “provider organizations” for the purpose of determining eligibility to provide independent LTSS Coordinator services.

whom the individual had a relationship prior to enrollment into the ICO. (For instance, a consumer with deep and persistent mental illness may wish to choose a coordinator affiliated with an RLC.)

The independent long-term service coordinator is a full member of the beneficiary's care team, serving at the discretion of the beneficiary. The consumer may decline to have an LTSS coordinator and seek other people to serve in this role or not have someone fulfill this role, while retaining the option to have this position filled at any time as needed.

The coordinator will assess the long-term support service needs of beneficiaries, working in coordination with the beneficiary and the rest of his or her care team to develop an appropriate service and care plan for community-based services, equipment and other home and community needs. This shall include both covered community-based services and other available community resources, as appropriate to the beneficiary's needs. If, after initial assessment, an individual has no LTSS needs, the LTSS Coordinator need not continue as member of team; however, an LTSS Coordinator shall be added to the team at any time at the request of the individual and in the event of any contemplated nursing facility, psychiatric hospital or other institutional admission.

Once LTSS needs have been identified, the coordinator will also assist in referrals and procurement of services, including those from other organizations as appropriate. If the LTSS requires medical expertise, the LTSS coordinator shall work with the necessary medical professional(s) and the beneficiary to ensure the beneficiary receives the appropriate LTSS.

EOHHS, in consultation with other stakeholders, will identify further qualifications and duties of LTSS Coordinators.

Example 1: A care team has decided a beneficiary requires an air conditioner to reduce the incidences of heat exhaustion suffered by the beneficiary in the summer months. The LTSS service coordinator on the care team shall be required to assess the air-conditioner options in collaboration with the beneficiary and appropriate parties (i.e. building management). These

options shall be presented to the rest of the care team for final determination of the product to be purchased.

Example 2: A care team has decided that a beneficiary who previously had no LTSS needs (and thus had no active LTSS coordinator) now requires peer respite. A member of the care team shall be designated to contact the appropriate CBO contracted LTSS service coordinator, who will then re-join the team. The LTSS service coordinator shall be responsible for taking the necessary steps for the beneficiary to enter the peer respite.

Ensuring Culturally-Competent, Barrier-Free Care

In addition to using an independent LTSS Coordinator from a CBO, an ICO or EOHHS shall contract with designated CBOs, as determined by EOHHS, to ensure that it provides culturally-competent care suited to a diverse population of people with disabilities. Culturally competent care includes, but is not limited to, the ability to demonstrate compliance with the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS), Massachusetts CLAS standards, and the Americans with Disabilities Act.

An ICO, in order to demonstrate CLAS compliance, must contract with a CBO to complete a CLAS assessment every 3 years, or more frequently as appropriate, and to monitor the implementation of any recommendations resulting from the assessment process. ICOs must also contract with CBOs to provide ongoing training for staff at all levels on issues of cultural competence pertaining specifically to people with disabilities. These trainings shall include information about the intersections of disability, health status, and social determinants of health (such as race, ethnicity, socioeconomic status, gender, sexual orientation, and geographic location). Staff attendance at such trainings shall be required in order to demonstrate ongoing CLAS compliance.

Example: An ICO requires staff to receive quarterly training on cultural competency in provision of care to people with disabilities. One quarter, the training is on unique attributes of Deaf culture. The next quarter, training may be on different views of mental illness within different ethnic minority populations.

In order to demonstrate compliance with the ADA, an ICO must contract with a designated CBO to complete an ADA assessment tool required by the Department of Public Health. Previous completion of any assessment tools shall not be understood as fulfilling the ADA obligation. The ICO ADA coordinator will work with the CBO ADA trainer to assess compliance with the ADA, develop a transition plan and create a training program that meets the needs of the ICO. Trainings should be geared to address concerns specific to any ICO target populations or beneficiaries.

Example: An ICO in Franklin Massachusetts contracts with an ILC in Worcester to conduct an ADA assessment. As part of the assessment the ILC discovers that the examination rooms in a provider's office are not accessible. The ILC will work with the provider to develop a transition plan that includes programmatic access. The ILC will work with the provider and track progress of the transition plan.

Overseeing Service Provision

Oversight of the dual-eligibles initiative shall be provided through a collaborative arrangement between EOHHS, ICOs, and those CBOs identified by EOHHS to fulfill this role. The consumer oversight entity formed by this arrangement shall be independent of any ICO or LTSS provider, and shall not be subject to legislative appropriation. It shall be an independent advocate for members of the program to provide quality assurance, performance monitoring, and ombudsman services to ICO members.

The responsibilities of the entity may include, but not be limited to: reviewing transition plans to ensure ICOs meet requirements of the Americans with Disabilities Act and CLAS standards; reviewing quality and performance data; reviewing eligibility and enrollment coverage policies; and reviewing medical necessity criteria and protocols.

The oversight entity shall also provide trained staff to assist consumers who have concerns or questions regarding the program. As part of this consumer-assistance role, the oversight-entity staff members may serve consumers who are going through the complaint process, in the role of third-party advocates. (The consumer may also elect to choose an advocate outside of the oversight structure.) The oversight organization shall receive notification of all complaints filed, tracking and reviewing them to assess any patterns or practices by ICOs that negatively impact the provision of care and services to consumers.

Example 1: A dual eligible is denied access to personal care attendant services by an ICO, despite the service being recommended by the care team. The dual eligible shall have the option of getting support from the oversight entity in the form of direct advocacy. This advocacy may include, but is not limited to, providing direct assistance to the dual eligible in the internal ICO grievance procedure and/or filing a complaint against the ICO.

Example 2: The oversight entity will track ADA compliance of ICOs at the statewide level, reporting back progress to the Assistant Secretary for Disability and other stakeholders, for the purpose of determining strategies for improving ADA access by ICOs as needed, rewarding ICOs achieving compliance, and developing best practices that go beyond mere letter-of-the-law ADA compliance.

Geographic Considerations

To ensure the highest quality of services and conflict free case management, ICOs shall not be limited to contracting with CBOs by geographic regions. An ICO may contract with a variety of CBOs, without geographic limitations, in order to ensure its beneficiaries receive expert LTSS coordination particular to their primary needs, and in order to receive training and assessment to comply with CLAS and ADA obligations.

Example: An ICO in a rural region of the state may not be geographically proximate to an ILC or be proximate to an ILC seeking contracts with an ICO, making it necessary for the ICO to contract with an ILC from another region.

From: James Zweber [JZweber@grow-associates.org]
Sent: Tuesday, January 10, 2012 2:31 PM
To: Duals (EHS)
Subject: Duel Eligibles Medicare/Medicaid Proposal

To Whom It May Concern;

I am writing today to express my concern regarding the proposed demonstration project the Commonwealth is entering into with the federal government, specifically the plan to place all services within the Managed care entity (ICO).

Although appreciative of the spirit in which the Commonwealth is attempting to manage the overall care of people with disabilities and to provide a better overall coordination of services, I am deeply troubled by the placement of all care including long-term support/services (LTSS) in this demonstration until the cost saving and system of medical services is determined to have sufficiently demonstrated their ability to do so. The fact that many individuals and families rely on services that the ICO may not have a good understanding of troubles me.

My concern is that the control is taken away and may indeed impact the quality of services now received if healthcare cost escalate for an individual, what safe guards are going to be in place to make sure the ICO do not stop funding the LTSS? I also am concerned that the rates of the ICO have not yet been established that will manage these services.

I would hope that MassHealth will work to insure that the changes proposed DO NOT negatively impact people with disabilities and limit access to LTSS and the way that the disabilities services are currently delivered.

Thank you for your consideration.

Jim Zweber
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**Comments on Massachusetts' Proposed Demonstration to
Integrate Care for Dual Eligible Individuals**

January 10, 2012

The Biotechnology Industry Organization (“BIO”) respectfully submits for your consideration the following comments on The Commonwealth’s Executive Office of Health and Humans Services Office of Medicaid Proposal to Integrate Care for Dual Eligible Individuals. BIO applauds the Commonwealth’s efforts to work through the many problems facing this extremely vulnerable population, and we recognize the difficulties faced for any state attempting to overhaul a portion of the vast and complex healthcare marketplace. Further, we hope to work with the Commonwealth as this program is implemented to ensure the most appropriate and effective care is delivered to the target population over the course of this demonstration and beyond. We do, however, have some comments regarding specific points outlined in the draft proposal for which we hope the Medicaid Office will consider in finalizing it for review by the Center for Medicare and Medicaid Innovation.

BIO is a national trade organization, based in Washington, D.C., representing more than 1,100 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and 31 other nations. BIO members are involved in the research and development of innovative healthcare, agricultural, industrial and environmental biotechnology products. Massachusetts is a bright spot for our organization and the biotechnology community. Along with our close partner – The Massachusetts Biotechnology Council – we represent a robust biotechnology cluster in the Commonwealth that is responsible for discovering and producing some of the most innovative and impactful medicines to treat some of the rarest and most intractable illnesses that we face today. We are happy that Massachusetts is a leader not only in the healthcare delivery space but also in the biotechnology community and we hope to see continued strengthening of this great reputation through innovative programs like the proposal at hand.

At the outset, we want to recognize the difficulty the Commonwealth must have faced in crafting a proposal to deal with the traditionally disjointed care available to this small but incredibly vulnerable patient population. In that spirit we hope that you will agree that our comments are meant to help strengthen the program and further protect the availability of quality care for these patients. To that end, our initial suggestion is to ensure robust and open access to new and innovative therapies as they become available. More specifically, while the proposal does not yet specifically deal with formulary design and therapy access standards, when dealing with a population that is likely to be managing various prescription and non-prescription medications in order to appropriately function in society, the rapid availability of breakthrough therapies may be crucial to minimizing the compliance and daily burden for some of these patients.

As the science that fuels biotech development continues to evolve, we are finding new and less burdensome methods to treat many chronic conditions. As these products are approved many stand to significantly impact the quality of life for affected patient populations. It is in this spirit that we urge the Commonwealth to ensure that patients in this program are provided every opportunity to receive new therapies that become available to help manage – or even potentially cure – the conditions they face. Similar to the 90 day review period for plans established under the Medicare Part D rule, we would urge the Commonwealth to likewise provide guidance to the ICO's to evaluate and decide on the appropriateness of new therapies as timely as possible. It is important that all dual eligible Medicare beneficiaries in Massachusetts have at least as much access to innovative therapies, many of which may be developed or manufactured in the Commonwealth, as those beneficiaries outside of the State.

Along the same lines of evaluation of new therapies, we would also like to comment on the evidence-based medical care protocols set forth in the proposal. BIO supports appropriate use of evidence-based decision making in treatment plans and we are happy to see that the Commonwealth has recognized the need to also support provider flexibility in the context of evidence-based medical care; reflecting the reality that unique needs of each individual patient may call for more than current evidence-based practice envisions. We also believe, however, that any application of evidence-based medicine be wholly transparent as to the inclusion or exclusion of clinical information and practices, describe the analytical methods used in developing and approving these protocols, and we urge the Commonwealth to establish a process to discuss and evaluate limitations on the quality of the evidence and methods used in adopting these protocols.

Where evidence generation requirements are specified and pursued, it is paramount that such studies be done in a manner that is consistent with prevailing standards for comparative effectiveness and outcomes-based research using widely adopted and well-regarded guidance. Further, there needs to be a high degree of clarity for specific metrics that will be examined, as well as the appropriate weighting for them; particularly in the case of subjective elements dealing with quality-of-life issues and related items. We believe that a transparent process in this case will provide all aspects of the medical community with a way to better evaluate the appropriateness and effectiveness of the evidence-based standards being proposed, and will therefore provide the optimal scenario for ensuring patients are given the best care possible.

In addition, we would like to address a more technical aspect of the proposal that we hope the Commonwealth will consider: that is the interconnectivity of the Medicare Part D program into the coordinated demonstration. Medicare Part D is a bright-spot in the overall Medicare program; consistently garnering high praise from beneficiaries and at a cost far below original Congressional Budget Office projections. Because this program is so historically successful we hope that the Commonwealth will not abandon its traditional place in the care delivery for the dually eligible population. While we recognize the need to better coordinate care and think outside the normal policy construct in order to make a difference to this patient population, we also hesitate to see any changes made that would impact the very workable framework already established under the Part D program. Not only could this impact the dual eligible population at issue, but reaching into the Part D program with any type of regulatory or

legislative changes could very well impact the program as a whole in Massachusetts. For instance, taking a core group of beneficiaries out of the Part D equation could impact the ability of private payers to develop actuarially sound and competitive bids to provide services to the remaining Part D beneficiaries – since the patient pool will have shrunk and the health status mix changed. This could inadvertently create inefficiencies in the Part D process and impact care across the spectrum. Accordingly, we urge the Commonwealth to seek an innovative option to provide flexibility to the ICO's in managing the medical care for this population while leaving in place the traditional Part D program that these beneficiaries already enjoy.

Finally, as more specific practice guidelines, ICO selection criteria, and other important aspects of this demonstration are introduced, we hope that the Commonwealth will provide stakeholders with the opportunity to comment on these crucial development steps. We recognize that a fair amount of detail remains to be specified with respect to the day-to-day operation of this program: from formulary standards, access protocols, ICO make-up and selection, beneficiary enrollment, to program integrity and payment standards; there is clearly more to do. During this process we hope that we will have further opportunity to comment on many of these aspects. Establishing a thoroughly vetted and appropriately regulated program is likely to lead to a model standard of care for this patient population and hopefully serve as a model for other localities to emulate. We appreciate the opportunity to provide comments on this initial proposal and we look forward to working with the Commonwealth going forward. We would like to be of continued assistance to the Commonwealth on this and other programs going forward and we hope that you will contact us if you have any further questions.

Regards,



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Leslie N. Wood
Senior Director
State Advocacy



January 10, 2012

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

VIA ELECTRONIC SUBMISSION

Re: Draft Demonstration Proposal to Integrate Care for Dual Eligible Individuals

Dear Ms. Wong:

The Pharmaceutical Research and Manufacturers of America (“PhRMA”) is pleased to submit comments regarding the Massachusetts Draft State Demonstration to Integrate Care for Dual Eligible Individuals. PhRMA is a voluntary nonprofit organization representing the country’s leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA supports efforts to better improve care coordination for dual eligible beneficiaries. Increased care coordination offers the potential to achieve both higher quality of care as well as to realize savings. PhRMA is concerned, however, that this proposal represents a step away from Medicare’s long standing principal of universality—that is, all Medicare beneficiaries, regardless of income, are covered through the same program and are entitled to the same benefits and protections even if the services are delivered through different types of plans. In this proposal, that would no longer be the case.

This proposed program would segregate certain low income beneficiaries into a new program effectively outside of Medicare. Over time, we believe this could open the door to different levels of treatment, and risk access to care for these lowest-income Medicare beneficiaries. Sub-regulatory protections were specifically put into place to protect dual eligible and other Medicare Beneficiaries from these potentially discriminatory practices. Although erosion of the Medicare program’s protections may not be the intention, certain phrases used in the document can be read as “substituting” Medicaid services for Medicare services, or more explicitly as substituting other services

Pharmaceutical Research and Manufacturers of America

for traditional Medicare and Medicaid service options. If erosion of Medicare protections is not intended, we think it is important for this to be clearly stated as a program requirement.

Furthermore, PhRMA and its members are concerned that the proposal unnecessarily eliminates coverage through Medicare Part D in a manner that may significantly disrupt care for both dual eligible individuals as well as other Medicare beneficiaries in Massachusetts. We urge the Commonwealth to revise the proposed demonstration model to incorporate the full protections available to consumers in Medicare, specifically including coverage through Medicare Part D, in order to ensure that Massachusetts residents continue to have access to the full range of benefits and protections currently available to them.

Part D Is an Established and Effective Method of Prescription Drug Delivery

Dual eligible beneficiaries currently account for a significantly disproportionate share of Medicare and Medicaid spending, and the use of Integrated Care Organizations (“ICOs”) has the potential to benefit patients by improving care coordination while at the same time reducing costs. Nevertheless, PhRMA is concerned that prescription drug coverage may be inadvertently, but significantly, disrupted if Part D participation is eliminated for dual eligibles.

The Medicare Part D drug benefit effectively provides access to robust prescription drug coverage for all Medicare beneficiaries in Massachusetts, including dual eligible individuals. The Massachusetts demonstration should not abandon those aspects of the health care delivery system that are already working – such as Part D – in order to build an entirely new system from the ground up. For example, information systems and real-time claims adjudication that minimize delay for the patient at the point-of-dispensing are already in place and working well in the Part D program. It would be a considerable waste of federal and state tax dollars, as well as the Commonwealth’s time and effort, to redesign these systems and establish an untested outpatient prescription drug delivery program, especially when the Part D program has proven to provide effective drug coverage.

Furthermore, the Medicare Part D program has resulted in substantial savings for the Medicare program. A recent study in the Journal of the American Medical Association (“JAMA”) found annual savings of \$1,200 on other Medicare costs for seniors who previously had no drug coverage or limited drug coverage prior to Part D.¹ Such savings may be at risk if dual eligibles are moved out of Part D. Approaches to care coordination for dual eligibles can work with the Part D program; for example, both Medicare Special Needs Plans (SNPs) and the PACE program have successfully administered Part D benefits since 2006.

¹ J.M. McWilliams, “Implementation of Medicare Part D and Non-drug Medical Spending for Elderly Adults with Limited Prior Drug Coverage,” Journal of the American Medical Association, July 27, 2011.

ICOs Should Participate Fully in Part D Coverage

Dual eligibles often have varied and complex healthcare needs, including the management of multiple prescription medications. Any disruption in care for this population has the potential to exacerbate their existing conditions. Transferring accountability on a massive scale for the care of dual eligible beneficiaries to new and untested ICOs² risks disrupting established patient-provider relationships and current treatment plans. Continuity of care could be lost, and patients may risk ill-advised substitutions in medications if coverage is changed at the time they are seeking refills of maintenance medications or if robust drug coverage is no longer available. Consistency and predictability in prescription drug delivery should be paramount in serving the dual eligible population, and this is best achieved by structuring the demonstration in a manner that takes advantage of Part D coverage for dual eligibles under the demonstration.

PhRMA recommends amending the draft demonstration proposal to require that an ICO, when operating as a managed care plan that has its own prescription drug benefit, participate fully in the Part D program (as is done by PACE and SNP plans) to ensure that the demonstration obtains the benefit of the competitive bidding process and the beneficiary receives protections that are available to all other Medicare beneficiaries in the Commonwealth. Alternatively, ICOs (such as those that are provider based) could contract with current Part D plans in Massachusetts, as the Centers for Medicare and Medicaid Services ("CMS") will permit subcontractors in the dual demonstration context. In that event, the Commonwealth could more usefully channel its resources into assisting with the intelligent assignment of dual eligible beneficiaries into Part D plans. This type of assignment, which has been utilized in states like Pennsylvania and Maine, could help reduce program costs by enrolling beneficiaries into plans that best meet their medical needs (for example, by enrolling a beneficiary in a plan with a formulary that includes the beneficiary's established maintenance prescriptions). Following such a model would help to ensure quality integrated care and high beneficiary satisfaction, while minimizing unintended negative consequences.

Incorporating Part D coverage in the demonstration will enable the Commonwealth, the federal government, and the newly-formed ICOs to capitalize on the successes and efficiencies of the current Medicare Part D program. This will allow seamless continuation of prescription drug coverage for beneficiaries while avoiding higher program costs and the risk of jeopardizing patient care.

² While framed as a "demonstration" in fact this initiative would be a very quick, large scale and fundamental restructuring of Medicare for over 100,000 Massachusetts beneficiaries, not a demonstration or test. Notably, this would be done with a population that faces extensive, complex clinical and other issues and for which there is little precedent of intensively managed care. In fact, this population has not previously been included in such programs on a large-scale basis specifically because of the many questions about the programs' ability to appropriately serve these beneficiaries' needs.

Part D Bidding and Plan Participation May Be Adversely Affected Under the Proposal as Currently Drafted

Removing dual eligible beneficiaries in Massachusetts from their current Part D coverage as proposed by the Commonwealth, could fundamentally alter the program for other Medicare beneficiaries. CMS has noted that the Part D bidding process is designed to incentivize plan sponsors to bid as low as possible in order to garner as many beneficiaries as possible.³ The Commonwealth's proposal, which will remove as many as 110,000 duals from the Part D system, has the potential to reduce these incentives by limiting the potential enrollee base in Massachusetts. It could also undermine the bidding process in Part D by invalidating actuarial assumptions on which Part D plans have based their 2012 premium bids.

These changes to market dynamics could lead to disruption and unpredictability for all Medicare beneficiaries who depend on Part D. If plans were to withdraw from the market, the result is likely to be higher costs for the Commonwealth's Medicare beneficiaries.⁴ Maintaining health plan participation in the Part D program, by ensuring that ICOs are full participants in the Part D program, is crucial to sustained competition and assuring that non-dual eligible Medicare beneficiaries in the Commonwealth continue to have access to robust and affordable prescription drug benefits.

Enrollment in the Demonstration Should Use an Opt-In Mechanism

Given the scale of the proposed changes, PhRMA recommends that, at least initially, patients should be given the choice of whether to enroll in the demonstration—following sufficient education and consultation with their providers—rather than being automatically removed from their current care system. While the Massachusetts proposal would permit beneficiaries the ability to opt out of the demonstration at any time, PhRMA urges the Commonwealth to instead give beneficiaries the opportunity to choose a new coverage model *in the first instance*, rather than being faced with the undesirable alternative of potentially going back and forth between the traditional dual model and the proposed demonstration model.

Considering that the Commonwealth's proposal will affect approximately 110,000 beneficiaries, a third of whom are severely mentally ill, and the fact that the newly-constituted ICOs will not have experience in coordinating Medicare, Medicaid, and the additional services, PhRMA believes that patient choice should be a paramount concern in the development of the demonstration. In the early days of getting the new organizations operational and transitioning 100,000 people, the patient, in consultation with key providers and caregivers is in the best position to judge readiness of the new

³ 73 Fed. Reg. 18,176, 18,179 (Apr. 3, 2008).

⁴ CMS has frequently commented on the importance of competition in the Part D bidding process, noting that the process is designed to "pass on the savings to beneficiaries resulting from competition." 70 Fed. Reg. 4,194, 4,298 (Jan. 28, 2005).

ICOs to meet the patient's needs. Perhaps at least in the first year of the demonstration, the Commonwealth could permit an ongoing opt-in opportunity for patients as the organizations mature and gain experience and provider and patient confidence.

Ambiguous Statements Create Concern That the Demonstration Proposal May Limit Services for Dual Eligible Beneficiaries

In addition to the general concern that this proposal represents a step away from Medicare's long standing universality principal, it is important when making such a significant modification of patients' health care arrangements that the program not lose provider and patient trust through ambiguous language. For example, the proposal suggests that Massachusetts will integrate all Medicare-covered and Medicaid-covered services, but it also refers to providing certain services "as substitution services for high cost traditional Medicare and Medicaid service options." Does this mean that the coverage package for the demonstration may not include certain services covered by Medicare or Medicaid? This is a matter of great concern to patients and their providers.

* * * *

We thank you for your consideration of these comments on the Massachusetts Draft Demonstration Proposal. We urge the Commonwealth to finalize the proposal in a manner that enhances coordinated care without unnecessarily disrupting care for the Commonwealth's most vulnerable beneficiaries or undermining Medicare prescription drug benefits for all Massachusetts Medicare beneficiaries. We look forward to the opportunity to continue working with the Commonwealth as it develops the demonstration. Please contact me if you have any questions regarding these comments. Thank you for your attention to these important issues.

Respectfully Submitted,



Leslie N. Wood

From: Michelle Dickson [Michelle.Dickson@nmss.org]
Sent: Tuesday, January 10, 2012 5:49 PM
To: Duals (EHS)
Subject: Public comment on the proposed state dual eligibles

Dear Dual Eligible Administrator:

Please accept these brief public comments due today regarding the proposed state demonstration to integrate care for "Dual Eligibles" -please respond that these comments were received and accepted. Thank you

Our organization has submitted comments previously at the request of EOHHS, but these comments relate directly to the proposal at hand.

Overall, the proposal appears thorough in its approach, inclusive and patient centered as the demo all appears to be.

- For duals with MS, a chronic progressive neurological condition- access to regular neurological care, especially MS trained neurologists and related specialists as needed is essential. Access must be preserved, especially to patients with long-time relationships with clinicians
- We fully support the use of network providers when necessary
- Duals living in rural areas must be given consideration for they have fewer options than those living in less rural areas. Rural areas were not mentioned specially and the lack of access
- We are concerned that there was no mention about how differences in coverage between Medicare & Medicaid will be handled. Mass Health currently provides more generous durable medical benefits and Medicare is far more restrictive. We advocate that the policy(either Medicare or Medicaid that provides the greater coverage be the one utilized)
- We support the use of Care Coordinators and Clinical care Mgmt when necessary and would be interested in exploring collaborating with the state on the Home LINKS model for MS care management in use now.
- We support the ICO providing certain community support systems such as respite care (not currently available to many duals such as younger physically disabled adults with disabilities like MS) home modification & medication mgmt

Finally, we remain concerned about the Commonwealth's commitment to providing HCBS waiver options to disabled adults under age 65 who do not have a brain injury or DD condition. Our organization has long advocated for a 1915 c waiver for physically disabled adults under age 65 which was to be included in the *Community First*. The proposal does cite Mass Health's willingness to explore with CMS the need for additional waiver services- we would strongly urge the administration to do so to ensure dual eligible's can remain safely in the community and out of a nursing facility and be assured access to other long-term supports that fellow dual eligible's will continue to have under this demo.

Michelle Dickson
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GREATER BOSTON
LEGAL SERVICES
...and justice for all

January 10, 2012

Dr. JudyAnn Bigby
Dr. Julian Harris
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02108

Re: Comments on MassHealth's draft Demonstration Proposal on Integrating Medicare and Medicaid for Dual Eligible Individuals

Dear Dr. Bigby and Dr. Harris:

Thank you for the opportunity to comment on this important initiative. We very much appreciate the steps that MassHealth has taken to include consumers and consumer advocates in the development of this proposal. We look forward to a continuing involvement in the development of this initiative that has the potential to provide improved health care to dual eligibles and to improve access to services needed for independent community living. While we have concerns about some aspects of your proposal, we are hopeful that these concerns will be addressed and that a program will be developed which we can fully support and which can be used as a national model.

We join in the comments of DAAHR, which address many of the larger conceptual and philosophical concerns with your proposal, and we will not reiterate all of the concerns that DAAHR raises. Rather, as lawyers with many years of experience representing Medicare beneficiaries, MassHealth members and dual eligibles we will focus on some specific aspects of the proposal that could detrimentally impact services to our clients. Our comments are not intended to be as comprehensive as the DAAHR comments, and are instead intended to address some of the more technical aspects of the proposal where differences between Medicare and Medicaid rules may cause unintended adverse consequences. We also raise concerns about the potential for loss of consumer control in community long term services and supports such as the personal care attendant (PCA) program. In addition, we urge you to take this opportunity to mandate specific requirements with enforcement mechanisms to ensure that the integrated care organizations (ICOs) comply with the ADA and that they provide all services necessary to support community integration.

1. Passive Enrollment Issues

You are proposing a “voluntary opt-out enrollment process.” While your proposal contains protections intended to prevent harm to dual eligibles through passive enrollment, we do not think that it is possible for passive enrollment to be truly voluntary or risk free.

Our concerns are informed by our experience with dual eligibles during the implementation of the Medicare Part D program in January 2006, when prescription drug coverage for dual eligibles changed from MassHealth to a Medicare Part D plan. Prior to Part D implementation, there was widespread outreach, public advertising, and written notification to dual eligibles concerning the impending changes. Despite this outreach program, countless dual eligibles ended up at pharmacy counters unable to fill necessary prescriptions during 2006. We encountered dual eligibles who had not been assigned to plans, who had been assigned to plans other than the one they chose, and who had been assigned to plans which did not cover their medications. There were also many dual eligibles who, despite all the outreach and advertising, had no idea that their pharmacy coverage was changing or that Part D existed. Several of our clients suffered adverse health consequences and ended up in emergency rooms. More extensive harm was only avoided because the Commonwealth provided MassHealth drug coverage to dual eligibles on an emergency basis throughout 2006.

Our experience with Part D tells us that despite your best efforts, despite advance written notice, and despite the involvement of community organizations, passive enrollment will inevitably result in some dual eligibles who will be unaware that they have been enrolled in an ICO until they are unable to obtain the medical care or the long term support services on which they depend. We are certain that some of these members will suffer adverse health and wellbeing consequences.

Your proposal states that there will be “no lock-in period” and that dual eligibles will be able to change ICOs or select the fee-for-service (FFS) option at any time. We do not know if this means that ICOs will operate like MassHealth managed care organizations (MCOs) where someone can request a transfer which becomes effective within 24 hours. We do not know if this is even possible within the context of Medicare. Medicare eligibility and enrollment always operates on a monthly basis, with changes effective on the first of a month. Thus, we fear that passive enrollment will lock people into an ICO that they have not chosen for at least a full calendar month or will leave people who opt out without Medicare coverage for the remainder of the month, interrupting treatment relationships and perhaps access to supplies, durable medical equipment (DME) or prescriptions. Passive enrollment could also have a detrimental impact on individuals who are actively using their Medicare coverage to obtain treatment out of state that is not available in Massachusetts.

We have an additional concern for “new dual eligibles,” a population that is not mentioned in your proposal. Approximately 1500 – 2000¹ MassHealth members become dual eligibles every month. We hope that it is not your intent to passively enroll them into ICOs with

¹ This figure was given to us by MassHealth in 2006 and includes both seniors and people with disabilities.

minimal or no advance notice. We strongly oppose any computerized system that would automatically enroll new dual eligibles into ICOs, as these members often have no warning that they are about to become Medicare eligible.

Your enrollment goals for the ICOs should be met through the provision of improved benefits and quality services. You propose to offer, among other enhancements, expanded dental care, enhanced behavioral health services and PCA services for cuing and prompting. These expanded services will undoubtedly attract members. In addition, we suggest that you could attract CommonHealth members through payment of the Medicare B premium. Waiving any claim for estate recovery would also appeal to prospective members. Finally, eliminating the prospect of passive enrollment will lessen the fear that many duals have concerning this proposal and will lead to increased support from the dual eligible community.

2. Eligibility Issues

While Medicare eligibility tends to be stable, MassHealth eligibility can be volatile. Your proposal does not explain what effect this will have on an individual's ICO enrollment. If MassHealth coverage is lost in the middle of the month, does the individual immediately revert to FFS Medicare? As discussed above, it may not be possible to transition to FFS Medicare in the middle of a month. A better option would be the Part D model, where an individual who has a low income subsidy at the beginning of the year will maintain it throughout the calendar year, despite loss of MassHealth. Guaranteed coverage for the calendar year would attract members and providers and would help prevent enrollment volatility into and out of an ICO.

Medicare B presents another eligibility issue. Your proposal does not state whether CommonHealth members who have Medicare A, but not Medicare B, will be allowed to join an ICO.

3. Areas of Concern Due to Differences between Medicare and Medicaid

Medical Necessity Definition

All ICOs must operate with a uniform medical necessity standard broad enough to include coverage for the care and long term services and supports (LTSS) a member needs to live as independently as possible in the least restrictive community setting preferred by the member.

The Medicare definition is too narrow to achieve this goal. Medicare limits coverage to services considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part. 42 U.S.C. 1395y(a)(1)(A). Medicare uses lists of services that are covered or not covered, with virtually no ability to obtain coverage for a medically necessary item or service on the non-covered list.

The MassHealth medical necessity definition, while broader, is still inadequate as a standard to meet what we understand is the purpose of ICO coverage. We therefore propose the following definition

An item or service reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions or limitations of daily activity functions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, result in illness, impairment or infirmity, or inhibit integration into the community; or that is reasonably calculated to promote habilitation, wellness, recovery or integration into the community.

DME and Supplies

Currently, neither Medicare nor MassHealth adequately meets the DME needs of members for full community integration. Medicare limits the scope of DME covered services to equipment that is needed for use in the home. Medicare will not pay for a wheelchair if the individual can manage household distances with a crutch or walker. Medicare will not cover the add-on that prevents tipping on uneven surfaces unless the individual has uneven surfaces in his/her home. Medicare will cover a power chair that the individual needs for in-home use, but will not cover a more rugged or powerful chair that the individual may need for use in his/her community, e.g., a hilly community. These limitations have the effect of confining the individual to the home and limiting independent community activities like shopping and working. Such limitations must not be part of the ICO model.

Through the prior approval process MassHealth provides broader coverage for DME. However, MassHealth relies on private DME providers as the gateway to access and prior approval and it is up to members to shop the few remaining DME providers and convince one of them to submit a request for prior approval for the item. Some members have access to information about the DME possibilities and have medical providers who know their needs and who are willing to document them. However, many do not, often resulting in long waits for needed DME or inadequate access to needed DME. Waits for repairs, parts and even batteries can be lengthy and many members do not have adequate backup equipment or do not receive loaners, stranding them in their homes or leaving them at the mercy of unsafe equipment. Many people must resort to the MassHealth appeal process, with its attendant delays, clogging up the system with many appeals that would have been unnecessary with better initial needs assessments. In addition, because MassHealth limits DME coverage to items that are “fabricated primarily and customarily to fulfill a medical purpose” and are “generally not useful in the absence of illness or injury,” equipment necessary for the community integration of some members is simply not covered, such as air conditioners, other environmental controls, and personal data assistants (PDAs).

The ICO care teams, if done right, include the possibility of member choice and involvement, transparency, and a complete needs assessment. However to do this, the care teams must be steeped in the independent living philosophy, through involvement with community based organizations, and must have the ability to work with the member to do a meaningful assessment of the member's DME needs for independent community living - not just the ability to get around at home.

Similarly, members must have seamless and timely access to medically necessary supplies in sufficient quantities to meet their needs for independent community living, e.g., absorbent products, and catheters.

Nursing Facilities and Home Health Services

The differences between MassHealth and Medicare coverage of skilled nursing facilities are dramatic and raise several issues. Distinct rules of eligibility, duration, and cost govern the two programs. For example, once a MassHealth member meets certain clinical and financial standards, she may be covered for both skilled care and custodial care so long as those standards are maintained. Original Medicare coverage, on the other hand, requires a beneficiary to have a three-day acute hospital stay within thirty days of admission to the nursing facility and be receiving daily skilled care up to a maximum of 100 days per spell of illness. While MassHealth calculates a patient paid amount based on income and community spousal needs, Medicare, at best, will pay in full for twenty days and with a current co-pay of \$144.50 for the next eighty days. Medicare coverage then stops until such time as the beneficiary enjoys a sixty-day period without need of skilled care. The ICO benefit must be designed with an awareness of these differences so as to maximize services to duals and, where possible, assist in a return to community living.

Likewise, sharp differences between MassHealth home health care benefits and those offered by Medicare raise the question of how they should be melded and modified to best serve dual eligibles. For example, Medicare requires its beneficiaries to be home-bound in order to qualify for home health services while people who go out into the community can use the MassHealth benefit. Likewise, the broader definition of medical necessity used by MassHealth may make home health services more available than they would be under Medicare's narrower definition.

Estate Recovery

With some exceptions, MassHealth regulations provide for the recovery from the estate of a deceased member of "all services provided while the member was aged 55 or older." However as of January 1, 2010, estate recovery is not permitted for Medicare cost sharing for MassHealth members receiving Medicare Buy-In benefits. Medicare, itself, does not have estate recovery provisions. Your proposal does not address estate recovery and we do not understand how estate recovery would be implemented in the context of a capitated payment to an ICO. It would be unjust to attempt to recover a capitation payment for a member who has not used services and problematic to distinguish Qualified Medicare Beneficiary (QMB)-in benefits as a portion of a capitation rate. The QMB and Medicare estate recovery rules should be adopted and there should be no estate recovery for ICO members.

Coverage for Out-of-State services

Your proposal does not address the issue of out of state coverage. If the ICO benefit were to adopt the MassHealth rules for out of state coverage, this could discourage some dual

eligibles from joining an ICO. There is a significant difference between coverage away from one's home state under MassHealth, which largely restricts payment to emergency services and that under FFS Medicare, a federal program serving beneficiaries throughout the country which covers services without regard to state boundaries. Even Medicare Advantage plans, with limited service areas, provide coverage outside of those service areas for urgent care.

Moreover, the more expansive coverage can be, at least to the extent of not requiring dual eligibles to forego their coverage under Medicare, the more attractive it can be. Dual eligibles under age 65 are a diverse population in Massachusetts. While some rarely leave their homes, others, with CommonHealth or 1619(b) eligibility, regularly travel outside of the state for business and need coverage that works across state lines.

Appeals

We appreciate that your list of what should be included in grievances, complaints and appeals is so complete and exhaustive and commend you for including so many important Medicare and due process protections. We agree that there should be a single external appeals process that meets all required Medicare Advantage and Medicaid managed care rules. It must also meet Medicare Part D appeal rules as these continue to apply to pharmacy appeals in Medicare Advantage plans.

Unfortunately, we are aware that the devil is in the details and that the details are yet to be determined. Thus, we request that you include us, along with CMS, as you develop the complaints, grievances and appeals processes. We would like to be provided with the opportunity to have meaningful input as the detailed proposal is developed, and not be put in the position of merely reacting to the details of the unified set of requirements after their development.

4. Maintenance of Existing Community Supports

Enhanced LTSS services will be vital to the success of the demonstration in promoting wellness, recovery, independence, and community integration, whether the LTSS involves peer services, PCA services, or any of the other LTSS services. Many LTSS services are already provided through existing programs and community based organizations, e.g., independent living centers, recovery learning centers, home and community based waivers, aging services access point (ASAP) home care services, Options Counseling, Money Follows the Person, Community Choices. *Great care must be taken to do no harm*, i.e., ICO members must be able to access at least the type and amount of services currently available, and must be able to opt to retain access to LTSS services that work for them, as well as having options for additional services delivered in accordance with independent living, wellness and recovery principles.

In the PCA context, this requires preserving the consumer control and independent living philosophy of the Massachusetts PCA program. This program enables members with disabilities to live independent lives, fully integrated into the community. Preservation of consumer control and the independent living philosophy can be accomplished through:

- * Continuing to fund PCA services through the MassHealth fee-for service system [as is done with MassHealth MCOs and Boston's Community Medical Group (BCMG),] with services expanded to cover cueing and prompting;
- * Including PCA services, expanded to cover cueing and prompting, within the ICO capitation and requiring the ICO to contract with the MassHealth approved personal care management (PCM) agencies for all evaluations and skills training, with services to be authorized by the members' medical homes. All policies, standards and criteria of the MassHealth PCA program would apply; or
- * Adding an "opt-in" feature to either model, where the consumer can choose to have the medical home perform both evaluations and authorizations, with skills training provided by PCM agencies and all current standards for skills training remaining.

5. Beneficiary Protections

DAAHR's comments set forth a more comprehensive list of elements that must be in place to protect beneficiaries than is set forth here. Once again, that is because our comments are not meant to be exhaustive, but rather to focus on some areas that raise legal issues that are of particular importance to community integration mandates. Inclusion of these protections will promote the health and independence of dual eligibles, a very diverse population with a variety of medical and non-medical needs.

Guardianship Avoidance

In order to ensure autonomy, independence, and maximum self-determination for dual eligibles, MassHealth should require the ICO and all participating service providers to document that they will offer facilitation with advance planning directives such as Health Care Proxies and Durable Powers of Attorney documents, and that they have measures in place to avoid or limit petitions for court-ordered guardianship/conservatorship.

ADA Compliance

ADA access requirements must be included in the request for response (RFR) and any contracts that are entered into with ICOs, including mechanism for enforcement of these requirements. ADA compliance is integral to the success of an integrated care model.

Person centered care requires physical access to buildings, services and equipment plus flexibility in scheduling and processes. Full access promotes better wellness outcomes and comports with the principles of independent living, recovery and self-determination. Full access will also make ICOs a more attractive option for people with disabilities. Requirements for ICOs should be guided by the ADA, 42 U.S.C. 12101 et seq. Full physical access requires at least: accessible entry doors; accessible parking and entry pathways; accessible pathway signage; clear floor space and turning space in examination rooms; accessible examination tables, radiology

and mammography equipment; patient lifts; transfer assistance; accessible changing areas for medical testing; and accessible scales.

Full access also requires effective communication access. The type of service or equipment necessary will vary with member choice and need, as well as with the length and complexity of the communication involved. Members must have the choice whenever possible as to the type of auxiliary aid needed to ensure effective communication. In some cases, more than one type of auxiliary aid or service may be needed for effective communication. The individual with the disability is in the best position to determine what is needed and effective.

Flexible scheduling and processes also promote full access. For example, scheduling longer appointment times may be necessary to accommodate mobility access, communication access, and where more time is needed to provide information and explain options and procedures, e.g., for some individuals with traumatic brain injury (TBI) or developmental disabilities. ICOs should have voluntary procedures for allowing members, if they so choose, to designate an appropriate person to attend appointments and receive information.

Finally, staff training on full access and the independent living and recovery and wellness philosophies is critical.

Meaningful Access for those with Limited English Proficiency

The Commonwealth, in its draft proposal, pledges to require ICO customer service departments(CSD) to make oral interpretation services available free -of -charge to enrollees, and to ensure that the CSD make available to enrollees information on how to access oral interpretation services and written materials in prevalent languages. MassHealth will also work on developing materials, including notices, that are understood by LEP speakers, and will translate materials into prevalent languages as determined by the Commonwealth. (Draft Proposal, pp. 23-25) It is critical that the Commonwealth actually develop these policies, put them into operation, and monitor their implementation. These language access guidelines are an integral part of ensuring meaningful access to the all the promised services, and that members understand what their choices are in this project. These policies should be developed as the details of the demonstration are worked out, and not simply added on afterwards.

Protection of Member Eligibility

In order for the dual eligibles demonstration to succeed, ICO responsibilities must include member assistance with maintaining eligibility and avoiding unnecessary eligibility volatility. Currently MassHealth members can lose eligibility for non-substantive administrative reasons or mistakes, losing coverage, incurring debt and facing procedural delays to regaining eligibility. This volatility is commonly referred to as "churning". Enrollment volatility occurs in the eligibility redetermination process when MassHealth receives paperwork late or without needed information or when the system makes an error. Even temporary loss of health coverage can be extensive, significant and detrimental. Massachusetts Medicaid Policy Institute, April 2010. Such volatility must be avoided to achieve community integration and avoid acute

hospitalization or other types of institutional care. Members and ICO teams must have the ability to prevent loss of coverage for bureaucratic, rather than substantive reasons.

In addition, MassHealth must consider how to allow for seamless transitions for members who may need periods of acute care or nursing home or other institutional rehabilitative care. Even with maximum effectiveness of member driven care teams, some members with complex needs may still need a period of acute care, nursing home or other institutional care. However, MassHealth eligibility for nursing home care is more restrictive than that for community care - even for short stays. Similar transitions or eligibility changes will be needed for those who opt in while under age 65 and who want to remain in after attaining age 65.

Individuals who receive supplemental security income (SSI) are automatically eligible for MassHealth, but those who reside in a public institution for 30 days lose SSI eligibility and may lose MassHealth coverage. <https://secure.ssa.gov/apps10/poms.nsf/lnx/0500520001> They can regain SSI without filing a new application if they return to community living within 12 consecutive months (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301205>) but may need assistance making that happen and retaining or regaining MassHealth coverage quickly to ensure that community living needs are met.

An additional SSI related problem is benefit reduction in certain circumstances that can trap an individual in a nursing home or other institution. As stated above, individuals residing a public institution for 30 days or more lose SSI payment eligibility. SSI recipients who reside in medical care facilities (hospitals, nursing homes) for 30 days or more are eligible for only \$72.80 per month. <https://secure.ssa.gov/apps10/poms.nsf/lnx/0500520001>. This is insufficient to pay the rent to maintain a home to which to return. Once individuals lose their community living arrangements, they may have great difficulty returning to the community without significant delay. However, a little-known SSI rule allows SSI recipients to retain full SSI benefits if: they demonstrate they need their full SSI benefit to maintain a community living arrangement; and their doctors provide the Social Security Administration (SSA) with a statement that they are likely to remain in the public institution, medical care facility or nursing home for less than 90 days. This showing must be made before the 90 days has run. [tps://secure.ssa.gov/apps10/poms.nsf/lnx/0500520140](https://secure.ssa.gov/apps10/poms.nsf/lnx/0500520140). ICO care teams must be familiar with these complex rules, and must have the training and capacity to provide assistance to members who want to maintain their community residence and who qualify to retain full SSI under SSA's rules. The care teams must also be familiar with the MassHealth rule which allows a deduction for maintenance of a home for the first six months of a nursing home stay, enabling a member to continue to pay rent so that there is a home to return to.

Finally, members who receive SSDI or SSI (or both) and who work can take advantage of SSA's work incentive rules to maximize benefits for a time and to retain related Medicare and Medicaid eligibility. These rules are very complex, and many benefit recipients could benefit from counseling to avoid unnecessary benefit and health coverage terminations. ICO care teams must also be trained to be aware of these issues and must be able to refer members for counseling about their benefit options.

Dr. JudyAnn Bigby
Dr. Julian Harris
January 10, 2012
Page 10

Again, we appreciate the opportunity to submit these comments. We accept that there are many details still to be determined and we offer to assist you in the development of a program that will improve health care quality, promote wellness and recovery, and do no harm to dual eligibles. We look forward to continuing to work with you on the design and implementation of integrated care for dual eligibles under age 65.

Sincerely,

/s/

Nancy Lorenz, Senior Attorney
Donna McCormick, Managing Attorney
Diane Paulson, Senior Attorney
Deborah Filler, Senior Attorney
Wynn Gerhard, Managing Attorney
Greater Boston Legal Services

Linda Landry, Senior Attorney,
Disability Law Center



the northeast **independent living** program, inc.

January 10, 2012

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

Dear Ms. Wong,

I am writing today to provide testimony to the Draft Demonstration Proposal for Integrating Medicare and Medicaid for Dual Eligible Individuals.

As I person with a disability and the Assistant Director of an Independent Living Center, I know firsthand importance of good health care particularly for people with disabilities. People with disabilities are among the most vulnerable and even the most articulate, knowledgeable person, when faced with an acute medical situation, can be rendered helpless without the proper supports and resources.

Several years ago, I had the unfortunate experience of breaking my leg. After a week in the hospital for surgery to repair the break, the discharge planner came to me and said "we need to transfer you, where do you want to go"? I told her I wanted to go to a nearby rehab hospital that was well known to me where I could get the appropriate therapy to get me back to the level of functioning prior to my accident. She later came back to me and said "you insurance won't pay to send you there". Their logic behind their decision was "you came in using a wheelchair and will be leaving using a wheelchair so what's the point"!!!! Although, I have experience in these matters, I did not have any resources at my disposal nor did I have the strength to put up a fight. Therefore, I ended up in a nursing home for a week where I got minimal therapy, they tried to force me to take pain medication when I had no pain, and I couldn't even ask for a bedpan at a time other than the time they were given out !!!!!!! Needless to say, this was the worst week of my life!

This is just one example of what can happen if this demonstration proposal is not implemented properly.

- We need to include people with disabilities in the planning and implementation of this plan
- We need to ensure that the Americans with Disabilities Act is enforced
- We need to enforce contractual relationships with ICOs and ILCs and RLCs
- We need to preserve the Independent Living philosophy and model of consumer control
- We need to ensure that there is consumer choice of enrollment and opting out
- We need to ensure that there is consumer choice of health care facilities, physicians, durable medical suppliers and other health care providers
- We need to ensure that there is an independent long term supports coordinator on a person's care team

*Full community participation
through education, training
and advocacy by and for
people with disabilities*

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January 10, 2012

pg 2

Dual eligibles testimony

- We need to be able to receive services from providers who have the knowledge and experience of treating people with disabilities-the ability for us to maintain the relationships we have fostered with our service providers is imperative.
- We need to ensure communication access for people who are Deaf, hard of hearing, or Deaf/Blind

People with disabilities have fought long and hard for their civil rights. Let's not jeopardize this by implementing a plan where the focus is on saving money rather than saving lives, the results could have devastating effects.

I thank you for the opportunity to provide input to this important demonstration proposal.

Sincerely,

Nanette Goodwin

Nanette Goodwin
Assistant Director

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January 10, 2012

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

Delivered via e-mail to duals@state.ma.us

Re: Commonwealth of Massachusetts Proposal to the Center for Medicare and Medicaid Innovation: State Demonstration to Integrate Care for Dual Eligible Individuals

Dear Ms. Wong:

The Center for Medicare Advocacy offers the following comments on the Commonwealth of Massachusetts' proposed "State Demonstration to Integrate Care for Dual Eligible Individuals."

The Center is a twenty-five year old national advocacy organization promoting fair access to Medicare and Medicaid services for older people and people with disabilities. Through direct client services, including legal representation, education and policy advocacy, we seek to ensure that Medicare and Medicaid beneficiaries receive the services to which they are entitled and that the programs are maintained and strengthened to promote the health and well-being of their beneficiaries.

The Center neither endorses nor opposes this proposal; we believe it is not yet sufficiently developed and wish to highlight areas where we believe the Commonwealth needs to provide more thought and information before submitting the proposal to the Center for Medicare and Medicaid Innovation. In particular, we find the proposal has given little consideration to the Medicare aspects of dual eligibility and we believe the Medicare rights of individuals affected by the proposal may be compromised.

Our comments are not comprehensive; they are intended to point the state in the direction of particular areas of focus. Our failure to comment on any given aspect of the proposal should be taken as neither endorsement nor repudiation of that aspect.

Comments

Overarching. The proposal is vague and includes hardly any references to Medicare, although Medicare will provide approximately one-half of the financing and the federal government will provide approximately three-quarters of all the money (including its share of the Medicaid costs) for the program. The proposal should clearly state that all Medicare and Medicaid requirements apply except for those explicitly waived and should identify those specific requirements for which the Commonwealth will seek waivers. It should also describe a rigorous state and federal level of oversight as well as a more clearly defined and described evaluation, since the project will be supported through authorities in the Affordable Care Act relating to testing and evaluating new financing and delivery systems.

Structure of Integrated Care Organizations (ICOs). According to the proposal, an ICO could be either an insurance entity or a provider group, but no specific standards are identified that would govern either structure. Standards for both Medicaid and Medicare managed care organizations have been developed through statute, regulation and guidance over decades, including decades of advocacy to improve them. We propose that any ICO that relies on an insurance/plan model should be governed by existing Medicare and Medicaid regulations except where individual requirements are explicitly waived for purposes of better aligning the programs or to provide expanded benefits. We propose that the Medicare regulations be those governing Medicare Advantage Dual Eligible Special Needs Plans.

Provider certification. The proposal states, on page nine, that the ICO is responsible for credentialing and re-credentialing its providers, but it is unclear exactly what this means. All providers in the program should be certified by Medicare and by Medicaid as Medicare and Medicaid providers, in addition to whatever criteria the ICO might require. The proposal should explicitly state this; Massachusetts should require ICOs to include only those providers willing to participate in both programs, otherwise, integration is not real for the beneficiary as she or he may be denied access to Medicare services because the Medicare provider is not also certified for Medicaid, a common occurrence in the existing system.

Cost-sharing and Qualified Medicare Beneficiary enrollment. The proposal makes no mention of cost-sharing, even though widespread mis-information about cost-sharing responsibilities are one of the issues that make access to care difficult for dual eligibles. (The federal Centers for Medicare & Medicaid (CMS) reports receiving a high volume of calls about this issue.) As a general matter, dual eligibles should not have cost-sharing since Medicaid should pay most of their Medicare cost-sharing and the state is only permitted to charge dual eligibles nominal co-pays. But more specifically, most

individuals who are dually eligible are also eligible for (even if not enrolled in) the Qualified Medicare Beneficiary (QMB) program and QMBs are excused from all Medicare cost-sharing. States do not necessarily enroll all those who are eligible for it into their QMB programs. The Commonwealth should make clear in this proposal that it will ensure that all full benefit dual eligibles who are eligible for QMB are enrolled in the program. In addition, it should require ICOs to provide clear instructions to all participating providers concerning cost-sharing obligations. We wish to see discussion of these issues by Massachusetts in its proposal.

Care Coordination. Care coordination is a central element of this proposal. The proposal should make clear that ICOs and their providers *must* offer care coordination either to all participants or to all who request it, regardless of whether they fit a "profile" for care coordination. Our experience with private Medicare plans that are designated as coordinated care plans is that they deny care coordination to all but those they specifically identify as needing it. We know from focus groups, including those reported on in a report released recently by AARP, that most people who have care coordinators are happier with their health care than those who do not; such an important feature should be easily accessible by anyone who has enrolled in the program.

Transparency. Because the private ICOs through which care will be delivered will be conduits for an enormous amount of public money and will be, in essence, performing a public function, all participating ICOs and all of their participating providers should be required to agree to be bound by state and federal Freedom of Information Act requirements as if they were public entities.

Estate Recovery and maximizing Medicare coverage. The proposal talks, on page 26, about ICOs receiving money from both Medicare and Medicaid but "these contributions will not be directly aligned with payment for particular services"; this arrangement gives the ICOs flexibility to offer services that are outside those required by Medicare and Medicaid. However, beneficiaries who are subject to mandatory Medicaid estate recovery will suffer if there is not a specific accounting of services they received from Medicaid, because their estates will be liable for such amounts but *only for such amount* (not for Medicare services or "extra services" that are available due to waivers). It is, therefore, beneficial for those participating to get as much of their care "covered" by (and attributable to) Medicare as possible, as well as to be able to receive a proper and accurate accounting of services for which the state seeks recovery from their estate. Massachusetts should address this issue in its proposal.

Enrollment. The proposal is based on the assumption that all those eligible will be passively enrolled into an ICO participating in the program if they do not make an active choice either in or out during the enrollment period. It asserts that they could opt out at any time but does not clarify what that means, especially if a person opted out mid-month. But more importantly, mandatory enrollment into private plans, even with an option to change at any time, is not required of any other Medicare beneficiary and thus this proposed method discriminates, among all Medicare beneficiaries, against dual eligibles, who are the poorest, sickest and greatest users of health care services. Those

who have complex medical and health care situations may also have care regimens carefully worked out over time with their providers and disruptions could be dangerous. While the proposal talks about rigorous requirements for transitions and about ways to encourage the retention of existing provider arrangements, these are not assured. A beneficiary may first discover his/her enrollment into the ICO at the first appointment with a (non-ICO participating) provider after enrollment, at which juncture she or he would be faced with complexities of disenrolling, or trying to get the provider to join the ICO or paying privately. We do not favor this opt out approach, which discriminates against dual eligibles and could cause them harm. To the extent that ICOs are offering services unavailable to the target population -- care coordination, clinical care management and diversionary behavioral health services, as well as expanded dental and vision services are those that are most apparent from the proposal -- beneficiaries should find them attractive and choose to enroll.

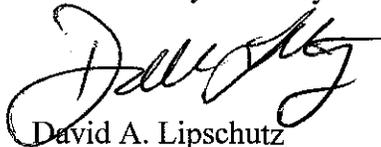
Due Process and Appeals. The proposal states that appeals processes will be developed relying on current requirements for Medicare Advantage organizations and Medicaid managed care organizations. The existing regulations should remain intact except to the extent that waivers are necessary to improve beneficiary access to due process. Notable in the Medicare Advantage world is a requirement for expedited appeals where the need for same is demonstrated; a constitutional requirement for Medicaid has always been that assistance is continued pending appeal. These are essential protections.

We appreciate this opportunity to comment and welcome conversation with those in Massachusetts who are developing this proposal.

Sincerely,



Patricia B. Nemore
Senior Policy Attorney



David A. Lipschutz
Policy Attorney

Position Statement on the PCA program within the Massachusetts Duals Initiative

January 10, 2012

To: Dr. Julian Harris, Assistant Secretary Christine Griffin, Robin Callahan, Rosalie Edes

The state's Personal Care Attendant program enables approximately 20,000 people with disabilities of all ages to live more independent lives in the community. It is critical to keeping children out of pediatric institutions and elders out of nursing homes. It helps working-age adults to hold a job and raise a family. Critical to the program's success are its hallmark features, consumer control and a complete embracing of independent living philosophy.

While nothing has yet been finalized, it has been suggested that the PCA program under the state's duals initiative will follow the model currently used by Senior Care Organizations (SCOs), where eligibility evaluations are performed and approved by SCO staff independent of MassHealth and Personal Care Management agencies, with skills training provided by PCM agencies under contract to a SCO. The advantages of this arrangement, in which PCA rates are part of a provider's capitation, are the SCO's ability to quickly adjust a consumer's PCA hours as needed and more closely link services to healthcare and independent living needs. Such prudent use of PCA services can be a gigantic part of enhancing individuals' wellness and continued integration in the community. There would, however, be major risk associated with such arrangements with Integrated Care Organizations (ICOs), and it is because of this that we urge the state to adopt alternative arrangements for the PCA program under the duals initiative. Specifically, our concerns are as follows:

1. Serious lack of understanding of the PCA program as a vital component of wellness and independence.

The state's duals initiative envisions a fair number of ICOs serving as the key providers of services to people with disabilities. It is likely that only a few, at most, will have any significant experience with the program. To expect medically-oriented healthcare providers, with most if not all of their experience in the provision of primary care, to comprehend and prescribe PCA hours is not realistic. PCMs have a long history of evaluating consumers, and the agencies' governing bodies and missions are distinctly reflective of the population served. Independent living is typically part of a PCMs operational DNA— in many agencies, in fact, PCA consumers also serve as PCA staff.

2. Variability in standards, operating procedures, and consumer hours under an ICO.

There undoubtedly would be a troubling variance in standards and procedures for the program's operation with it being undertaken by ICOs with no prior experience running a PCA program. Notably, in the past three years, staff from MassHealth and the Office of Long Term Care have worked closely with advocates from the Statewide Personal Assistance Coalition and providers from PCMs to bring

uniformity, and many would argue a level of sanity, to the evaluation process. There had been use of differing forms, and even amongst MassHealth nurses and offices there were wide variations in interpretation of regulations. The diligent work to keep PCMs and state officials speaking the same language continues, driven by a desire to ensure efficient delivery of services to consumers, and this is essentially a continuous process. Having written standards alone would not be sufficient to ensure that consumers receive adequate PCA coverage, and while critical, an appeals process is nonetheless a tool that many people would not use. In many respects the current relationship between MassHealth and PCMs is a check-and-balances system. Notably, MassHealth has resisted suggestions by advocates that the licensed RNs working for PCMs be the sole determiners of consumer eligibility and hours. Thus, to move to a PCA system where there is no advocacy check on PCA hours prescribed through a medical home from an ICO— an entity which may have no experience whatsoever in the provision of PCA services— while non-duals still would be required to go through the Prior Authorization process— seems both nonsensical and a major disregard of the independent living imperative. And compounding this are the serious possibilities of an ICO reducing PCA services to stay within their capitation because of financial pressures accelerated by increased primary care costs, misunderstanding of the role of the PCA program for a consumer, and the lack of a formal and significant community advocacy role in the eligibility determination process.

There are three potential arrangements for the duals that can address these concerns. One would be to keep the program out of the ICOs' capitation, with consumers obtaining services as they currently do from PCMs and going through MassHealth, with the consumer's primary care physician from his or her medical home signing off on hours. A second option would be to have the program fall within the capitation, but have the ICO contract with PCMs for evaluations and skills training with the consumer's primary care physician or a designated RN from his or her medical home approving hours. All basic rules and regulations for the program, including, though not exclusively, standards to be a PCM, pay rates and benefits for PCAs, surrogacy requirements, skills training requirements, evaluation criteria, and the right of consumers to hire, train, supervise, schedule, and dismiss attendants, would remain. This model would ensure greater integration of LTSS in a consumer's care plan, a more flexible and expedited approval process than currently exists when consumers must go through MassHealth Prior Approval, and the involvement of a PCM steeped in independent living, consumer control, and the ability to promote services that fit the unique needs of each consumer. A third option would be for there to be an opt-in feature attendant to either of the models just mentioned, whereby a consumer, if he or she wishes, could have their medical home within an ICO perform evaluations, with skills training still provided by PCM agencies, with all current standards for skills training remaining. For all of these models, we strongly support the addition of prompting and cuing as part of services that can be performed by PCAs and the guarantee of an appeals process with consumer rights at or greater than currently exist for those on the MassHealth PCA program.

We appreciate your attention to our recommendations.

Sincerely,

Paul Spooner, executive director, Metrowest Center for Independent Living

Jim Kruidenier, executive director, Stavros Center for Independent Living

Coreen Brinckerhoff, executive director, Cape Organization for Rights of the Disabled

Ann Ruder, executive director, Center for Living and Working

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Massachusetts Biotechnology Council
Ninth Floor, One Cambridge Center
Cambridge, MA 02142

January 10, 2012

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

Dear Secretary Bigby,

On behalf of MassBio and its 600+ member organizations, please accept these comments concerning the Executive Office of Health and Human Services Office of Medicaid Proposal to Integrate Care for Dual Eligible Individuals.

MassBio has been and continues to be support of the Commonwealth's efforts to expand access to all residents, most especially the vulnerable population that is dual eligible. We do, however, have some comments regarding specific points outlined in the draft proposal for which we hope the Medicaid Office will consider in finalizing it for review by the Center for Medicare and Medicaid Innovation.

The Massachusetts Biotechnology Council (MassBio) is a non-profit organization representing over 600 members companies and organizations such as teaching hospitals and academic institutions. MassBio promotes the social and economic benefits of biotechnology. The majority of our members are engaged in research, development and manufacturing that not only represent a significant amount of jobs across the Commonwealth, but also result in the creation of new, innovative products that improve the lives of people in the Commonwealth and all around the world. We are committed to ensuring patients around the globe have access to the life-saving therapies and cures they need.

To that end, our first suggestion is that any policy should ensure robust and open access to new and innovative therapies as they become available. More specifically, while the proposal does not yet specifically deal with formulary design and therapy access standards, when dealing with a population that is likely to be managing various prescription and non-prescription medications in order to appropriately function in society, the rapid availability of breakthrough therapies may be crucial to minimizing the compliance and daily burden for some of these patients.

As the science that fuels biotech development continues to evolve, we are finding new and less burdensome methods to treat many chronic conditions. As these products are approved many stand to significantly impact the quality of life for affected patient populations. It is in this spirit that we urge you to ensure that patients in this program are provided every opportunity to receive new therapies that become available to help manage – or even potentially cure – the conditions they face. Similar to the 90 day review period for plans established under the Medicare Part D rule, we would urge you to provide guidance to the ICO's to evaluate and decide on the appropriateness of new therapies as timely as possible. It is important that all dual eligible Medicare beneficiaries in Massachusetts have at least as much access to innovative therapies, many of which may be developed or manufactured in the Commonwealth, as those beneficiaries outside of the state.

We would also like to comment on the evidence-based medical care protocols set forth in the proposal. We support appropriate use of evidence-based decision making in treatment plans and we are happy to see that the proposal recognizes the need to also support provider flexibility in the context of evidence-based medical care.

We also believe, however, that any application of evidence-based medicine be wholly transparent as to the inclusion or exclusion of clinical information and practices, describe the analytical methods used in developing and approving these protocols, and we urge the Commonwealth to establish a process to discuss and evaluate limitations on the quality of the evidence and methods used in adopting these protocols.

Where evidence generation requirements are specified and pursued, it is paramount that such studies be done in a manner that is consistent with prevailing standards for comparative effectiveness and outcomes-based research using widely adopted and well-regarded guidance. Further, there needs to be a high degree of clarity for specific metrics that will be examined, as well as the appropriate weighting for them; particularly in the case of subjective elements dealing with quality-of-life issues and related items. We believe that a transparent process in this case will provide all aspects of the medical community with a way to better evaluate the appropriateness and effectiveness of the evidence-based standards being proposed, and will therefore provide the optimal scenario for ensuring patients are given the best care possible.

In addition, we would like to address a more technical aspect of the proposal that we hope you will consider: the interconnectivity of the Medicare Part D program into the coordinated demonstration. Medicare Part D is a bright-spot in the overall Medicare program; consistently garnering high praise from beneficiaries and at a cost far below original Congressional Budget Office projections. Because this program is so historically successful we hope that the Commonwealth will not abandon its traditional place in the care delivery for the dually eligible population. While we recognize the need to better coordinate care and think outside the normal policy construct in order to make a difference to this patient population, we also hesitate to see any changes made that would impact the very workable framework already established under the Part D program. Not only could this impact the dual eligible population at issue, but reaching into the Part D program with any type of regulatory or legislative changes could very well impact the program as a whole in Massachusetts. For instance, taking a core group of beneficiaries out of the Part D equation could impact the ability of private payers to develop actuarially sound and competitive bids to provide services to the remaining Part D beneficiaries – since the patient pool will have shrunk and the health status mix changed. This could inadvertently create inefficiencies in the Part D process and impact care across the spectrum. Accordingly, we urge you to seek an innovative option to provide flexibility to the ICO's in managing the medical care for this population while leaving in place the traditional Part D program that these beneficiaries already enjoy.

Finally, as more specific practice guidelines, ICO selection criteria, and other important aspects of this demonstration are introduced, we hope that the Commonwealth will provide stakeholders with the opportunity to comment on these crucial development steps. We recognize that a fair amount of detail remains to be specified with respect to the day-to-day operation of this program: from formulary standards, access protocols, ICO make-up and selection, beneficiary enrollment, to program integrity and payment standards; there is clearly more to do. During this process we hope that we will have further opportunity to comment on many of these aspects. Establishing a thoroughly vetted and appropriately regulated program is likely to lead to a model standard of care for this patient population and hopefully serve as a model for other localities to emulate.

Thank you for your attention and please let me know if you have any questions. We look forward to continuing to work with you on this very important issue.

Sincerely,

A handwritten signature in black ink, appearing to read "RKC", followed by a vertical red line.

Robert K. Coughlin
President & CEO



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January 10, 2012

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

Dear Ms. Wong,

The Boston Health Care for the Homeless Program (BHCHP) appreciates the opportunity to provide feedback comments on the Dual Eligibles draft dated December 7th, 2011. As the provider of health care services to approximately 1200 under 65 dually eligible currently homeless and recently homeless men and women in Boston, we bear witness to the morbidity and mortality that this group of Boston's poorest and sometimes most complex patients face in their struggle for daily survival. We will begin our comments at the larger policy level and then at a level of more specific details.

Policy Issues

The approach that has emerged from this past year of planning is thoughtful on the policy level, and is cognizant of the needs of disabled persons who live without stable housing.

Integration

Aiming for integrated care organizations that are overtly mandated to accomplish integration of medical and behavioral health care is absolutely the right approach for this initiative and for the population that BHCHP serves.

Patient Choice

Providing a patient-centered service and finance model where patients remain in charge of their choices is essential, I believe that the draft proposal accomplishes that. Opting out rather than opting in as an initial enrollment strategy seems fine as long as enrollees can easily opt out of bad situations. The key is leaving the door open so that enrollees can reverse assignments that do not fit their needs at the outset or when their needs later change. While avoiding lock-in of patients complicates life for providers and insurers, it is a core protection for consumers and we applaud its inclusion in the draft plan.

Easing into Provider Risk

We know from our years of serving chronically homeless individuals and from some key research in Boston and other cities that the morbidity, mortality, and health care cost of people living without safe and stable homes is literally orders of magnitude higher than for stably housed cohorts. Unfortunately, at this time the language in the proposal on risk adjustment is largely aspirational, not clearly achievable. The information basis for

adjusting for social risk is not yet well developed. Until such time as risk adjustment for social factors is possible, risk mitigation must be supplemented in other ways (risk corridors or carve outs are two) in order to avoid unintended perverse incentives and consequences.

Some Specific Details

Homelessness as an Identified Risk Factor and Special Need

The identification of persons who are homeless as an identified “population with unique needs” (pg 7) is an encouraging aspect of this draft proposal. The requirement that ICO’s maintain relationships with organizations expert in serving the needs of homeless persons is a useful and clear statement that homeless dual eligibles are not to be avoided and that they are expected to be served resourcefully. We applaud the inclusion of that language in the draft proposal.

Another opportunity to assure attentiveness to the special needs and circumstances of people who live without stable housing occurs on page 36 (Section H, part i. subpart d.) in the section that begins with “Aligning provider capacity and competencies... where the proposal speaks to “...encouraging shared learning through methods such as a learning collaborative model. Specific mention of persons who are homeless or newly and fragiley in permanent supportive housing as an enumerated complex need in this section would also serve to raise the visibility of homelessness as a condition that requires special focus. We would ask that you consider inserting this language.

Community Health Workers

We also are encouraged by the specific requirement for CHWs to support PCMH practices to implement care plans (pg 15), but this would be strengthened if it more clearly places CHWs as an integrated part of the PCMH care team. CHWs whose practice is disconnected from the PCMH seem less likely to play an effective role.

Extension of Existing Specialty Health Plans to Dual Eligibles

Section C, iv, c – Existing specialty behavioral health plans describes as a benefit the fact that ICO enrollees will be able to access the broad array of behavioral health diversionary services that are currently offered only to non-dual eligible members through other programs. We agree that this is an important benefit and one which duals currently miss out in receiving. We would go further and encourage the specific inclusion in Appendix C (page ix) of “CSPECH (Community Support for Persons Experiencing Chronic Homelessness)” alongside Community Support Program (CSP) so that it reads: CSP/CSPECH. CSPECH, which focuses specifically on community support for persons who have been chronically homeless has been found to be both effective in ending homelessness and in lowering Medicaid cost for individuals fortunate enough to receive the housing and the steady support. It needs to be better advertised and specifically encouraged.

Pre-Duals

Section G, iii, a. describes the desirability to expand this program to Medicaid-only members with disabilities under age 65. We agree. Among the chronically homeless, persons in this category disabled individuals with Medicaid only are often functionally indistinguishable from duals. They are sadly sometimes too disorganized or impaired to successfully navigate the SSI or SSDI disability determination process and they lose out

on the cash assistance that dual eligibles can use to resolve their homelessness and improve their situations. We would encourage some pilot efforts to support and incentivize PCMH providers to assist pre-duals to achieve dual status.

Risk Adjustment

Section E, ii., c. and d. speak to the critical importance of risk adjustment that "...is sensitive enough to appropriately account for costs for the highest cost, highest need enrollees". We could not agree more strongly, but have been discouraged to see so little visible activity directed to understanding the social risk factors attendant to chronic homelessness. We believe that with data from MassHealth and CMS, we and our partners have the ability to do some useful analysis of this high-risk group whose overall risk is only partially captured by clinical diagnoses. We would like to work directly with MassHealth to do that.

Thank you for the opportunity to comment. We are excited to be a part of this process.

Yours truly,



Robert L. Taube, PhD, MPH
Executive Director

From: Roseann Martoccia [rmartoccia@fchcc.org]
Sent: Tuesday, January 10, 2012 4:58 PM
To: Duals (EHS)
Subject: ICO Plan Comments from FCHCC

Dear EOHHS Officials,

As you know, Mass Home Care (MHC) has submitted testimony on the proposed ICO plan. As a member of MHC working in a rural area of Massachusetts with many elders and persons with disabilities on Mass Health and many more on a fixed and limited income, Franklin County Home Care Corporation supports efforts to integrate long term care supports. We offer the following summary comments on the ICO plan:

Build on the existing system of long term care supports and increase capacity to offer options to consumers rather than start all over in this economic climate. The service system for elders and persons with disabilities is complex enough. In this way, consumers can be afforded their choices and all Medicare, Medicaid and other federal (Older Americans Act), state and local services are built in. These choices will be comprehensive and include home, community based and care in nursing facilities if and when needed.

As in the existing SCO model, require that each consumer who is enrolled voluntarily have a independent (conflict free) care manager to help them navigate the system. This will serve as a safeguard, especially for those consumers with complex needs, cognitive impairment or mental health issues. This also helps to balance medical needs with day to day functional needs which are critical to a person's stability and continuity of care at home and in the community.

Thank you for this opportunity to comment on the ICO plan and work to support consumers with long term support needs and their caregivers in our Commonwealth.

Roseann Martoccia
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Comments of
MENTAL HEALTH LEGAL ADVISORS COMMITTEE
on the proposal to the
CENTER FOR MEDICARE AND MEDICAID INNOVATION
of the
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID
for a
STATE DEMONSTRATION TO INTEGRATE CARE FOR
DUAL ELIGIBLE INDIVIDUALS

January 10, 2012

Mental Health Legal Advisors Committee (MHLAC), an agency within the Supreme Judicial Court, is mandated to represent low-income persons with mental illness. In this capacity, we have been actively involved in the efforts of Disability Advocates Advancing Our Healthcare Rights (DAAHR) to assist the Commonwealth in formulating a demonstration project for persons eligible for both Medicare and Medicaid (dual eligibles) that will provide these persons quality, person-centered health care in a cost efficient manner. MHLAC joins DAAHR in its proposal comments and is submitting comments separately because we would like to emphasize certain points relevant to low-income persons with mental illness, as well as others.

Our comments, to a large extent, will focus on **the foundation for a successful state demonstration project: protecting the choices of dual eligibles**. Given that private parties, many of which will be for-profit entities, will be vying to participate in the demonstration, freedom of choice is essential to provide instantaneous quality control and to prevent the

repetition of the harms that resulted from the managed care fiascos of the 1990s.¹ Another issue of prime importance is that EOHHS establish a definition of necessity for service authorization and not leave it up to the individual ICOs.² This definition must recognize the wellness and recovery model of care that includes services which do not fall within the traditional medical model of treating the illness and not the person.

As a preliminary matter, we would like to voice our appreciation of the positive elements of the proposal. The elimination of conflicting coverage rules *in conjunction with* the expansion of benefits to include, e.g., a broader range of dental services, cueing and monitoring by personal care assistants, durable medical equipment repairs and environmental aids, vision services, and non-medical transportation. We are also pleased to see that the importance of community health workers and peer support are recognized (p. 15-16), although we believe that it is important to ensure their delivery through an independent, conflict-free long-term care coordinator.³ We are glad to see that EOHHS recognizes the need for enrollee assistance with access to services, grievances and appeals by an entity that has no financial interest in service denial or utilization. (p. 24) We appreciate the outlined opportunities for ongoing input (p. 25), but it is important that it is specified that dual eligibles and their representatives will have meaningful input at every phase in the design, implementation and monitoring of the dual eligible initiative. Recognition that the use of functional status would be valuable to risk adjustment, as well as the need to protect against under and overpayments, which in turn protects enrollees from financial incentives to deny needed care, and the stated intent to link savings to care improvement and not limitations of service are also positive points in the proposal. (p. 27-28)

CHOICE

The success of the dual eligibles initiative will be dependent upon providing dual eligibles meaningful choice in every aspect of the program. This includes:

¹ “To date, capitated systems (principally capitated primary care practices) have achieved savings largely by blocking specialist referrals and hospital admissions altogether.” Robert Kuttner, *Must Good HMOs Go Bad?—The Commercialization of Prepaid Group Health Care*, 338 *New Eng. J. Med.* 1559 (1998).

² DAAHR has recommended the following definition be used to establish the necessity of services:

A service reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions or daily activity functioning in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, result in illnesses, impairment, or infirmity, or inhibit integration into the community; or that is reasonably calculated to promote habilitation, wellness, recovery, or integration into the community.

³ Community-based services should not be limited to “substitution services.” (p. 16) For example, insurers typically limit home care for persons with mental illness to persons who are already “high cost” insureds and are on the brink of entering a hospital. This is the medical model of service provision, not one that recognizes wellness as a goal of the health care system. We hope that EOHHS modifies the language in the proposal that implies community services be rendered pursuant to a medical model of care.

- Opt-in enrollment
- Choice of in- and out-of-network providers
- Choice of treatment team
- Choice of mode of treatment/service
- Choice of which records to share

While we understand that EOHHS's proposal to CMS will lack many details, the proposal should at a minimum be modified where it conflicts with the following tenets.

Voluntary enrollment

Dual eligibles should affirmatively choose to participate in an ICO. Opt-out enrollment does not provide sufficient incentive to ICOs to provide services of appropriate breadth in the most enrollee-friendly manner possible. While it is commendable that there are no lock-in and lock-out periods, this fact alone will not ensure services are not unduly disrupted by mandatory assignment.

To allow prospective enrollees to make sound choices with respect to ICOs, basic information concerning the ICOs must be transparent and available to the public: medical necessity protocols, up-to-date network lists, details of financial arrangements with providers (e.g., capitation, shared savings arrangements, withholding/bonus amounts and criteria), prior authorization procedures, provider turnover,⁴ and, when such data is available, consumer satisfaction rates.

Choice of providers

At both the Worcester and Boston EOHHS listening sessions, persons testified as to the importance of maintaining relationships with providers who knew them. They testified to the difficulty of finding providers who were qualified to treat them and their particular disabilities and with whom they could establish a therapeutic relationship. The success of mental health treatment is reliant on the existence of a therapeutic relationship.⁵ Licensure or experience treating people with a particular diagnosis does not guarantee that a therapeutic relationship can be established with any person with that diagnosis. Therefore, dual eligibles must be able to maintain existing therapeutic relationships or seek such clinicians whether those clinicians are in or out of network.

⁴ This is particularly important to mental health consumers who experience high clinician turnover at mental health clinics.

⁵ Carla A. Green, Michael R. Polen, Shannon L. Janoff, David K. Castleton, Jennifer P. Wisdom, Nancy Vuckovic, Nancy A. Perrin, Robert I. Paulson & Stuart L. Oken, *Understanding How Clinician-Patient Relationships and Relational Continuity of Care Affect Recovery from Serious Mental Illness: STARS Results*, *Psychiatric Rehabilitation Journal*, Vol. 31, No. 1, 9, 19. (2008).

Continuity of care will suffer if the means to ensure that continuity are restricted. Requiring dual eligibles to prove that their request for a single case agreement meets “certain defined circumstances,” places an unnecessary burden on dual eligibles, one which may be beyond their means. While we are pleased that the ICOs would be required to accept into their networks providers with whom enrollees have a relationship (p. 9), some providers may not wish to become part of an ICO for any number of reasons, including terms of ICO membership unrelated to quality of care. Therefore, single-case agreements should be mandated by EOHHS where the provider is willing to accept rates comparable to those paid in-network providers and is willing to comply with reasonable terms of service, including care coordination. As Dr. Robert Masters testified at the Boston EOHHS listening session, networks should be built around the beneficiaries, not the insurer or, in this case, the ICO.

Dual eligibles also should be free to choose out-of-network providers for prospective care as well. Again, these out-of-network providers operating under a single-case agreement must agree to reasonable ICO terms and payment schedules. Enrollee freedom of choice will help to ensure quality of care and real-time quality management. Enrollees who are satisfied with in-network care will not look elsewhere. However, if the ICO network is inadequate⁶ or of poor quality, dual eligibles will provide immediate feedback to the ICO and EOHHS/CMS by seeking care elsewhere. It is unfair to dual eligibles in need of immediate assistance to wait for the results of quality measurements and corrective actions that may take months, if not years, to come to fruition.

Such freedom of choice is operationally feasible. As noted above, the providers must accept rates comparable to in-network providers. Likewise, the providers must agree to comply with reasonable operational procedures. Care management need not suffer. Contrary to the mythical picture of doctors of varying specialties popping into one another’s offices, most care coordination is done electronically or by telephone. Co-location of providers is rare and usually unnecessary.⁷

⁶ Specialists are often blamed for the high cost of health care. Insurers, including ICOs, have a financial incentive to limit access to specialists. Unfortunately, the risk of deterioration in enrollees’ conditions are insufficient to moderate this incentive in all cases. For example, a person may be in physical pain for an extended period of time while waiting for an appointment with a specialist, yet their underlying condition may not change. Likewise, persons who suffer from major depression may not end up in the hospital although their access to care is limited. Rather those persons may suffer silently, isolating themselves in their individual apartments.

⁷ If an ICO offers the convenience of all providers in one physical location – and if this important to the dual eligible – it is likely that the dual eligible will choose only in-network providers. MHLAC has more often found that the co-location requirement is more for the convenience of the large provider. Some clinics have told their clients to choose between obtaining a psychiatrist and their long-standing therapist who is not an employee of the clinic.

Choice of treatment team

Person centered care is driven by the enrollee, and requires full and meaningful participation of the enrollee (surrogate/guardian) and other persons of his or her choice within the care team.⁸ During the EOHHS listening sessions in Boston and Worcester, dual eligibles relayed reports of providers who refused to listen to their needs and of some providers who recommended intrusive, unwanted, and ultimately unnecessary interventions. If the care team includes persons with whom the enrollee has a fundamental disagreement, the process and likely the resulting care plan will not be person centered and will not meet the needs of the enrollee.

Choice of mode of treatment/service

Choice also means choice of treatment modalities, which happily, at least in the mental health field, may often lead to the use of less expensive modalities like peer respite and peer counseling. Choice of treatment is integral to person-centered care and should include:

- Personal care attendants and other supports for psychiatric illness
- Money follows the person
- No rigid use of protocols⁹
- Medically needed/empowering services, not just medically necessary services.

Alternative modalities of treatment should not be limited to substitutions for high cost traditional services (p. 16).¹⁰ MHLAC has seen private insurers refuse to provide services that support recovery and well-being, only to cover those self-same services when the insured is on the doorstep of the hospital. MHLAC also has seen insurers and providers deny treatment if the insured is not “compliant” with the providers’ recommendations. Rather than being person-centered care, the care is provider- or insurer-centered. Consumers who can choose their services are more likely to participate in their recovery and wellness. Consumer choice of service, obviously as part of a recovery and wellness plan developed by a care team led by the enrollee, is ultimately cost effective.

⁸ Person centered care also includes full participation in meetings and access to all medical records pertaining to the dual eligible, both of which are vital to making an informed decision about one’s own health care. Records, including care plans, must be available in accessible formats, including electronically, in a timely manner.

⁹ For example, formularies must include the broadest array of medications with emphasis on high quality outcomes for the individual over cost-cutting. Decisions about which drugs to include in formularies should be based on rigorous review of scientific evidence, recognizing, however, that persons with disabilities are often excluded from the clinical trials used to produce this evidence and that the effect of psychiatric medication is quite dependent upon the individual. Consumer choice should supersede considerations of drug cost and rigid adherence to step therapy protocols, which is why “medication adjustment by protocol” (p. 14) causes us concern.

¹⁰ An independent, conflict-free long term support services coordinator on the care team will help to ensure appropriate access to such services. Requirements for contractual arrangements with community-based organizations and other roles for community-based organizations, as well as independent LTSS coordinators, are discussed more fully in the comments of DAAHR.

To protect this consumer choice, EOHHS should establish internal and external appeal procedures that adopt the best protections of Medicaid (e.g., aid pending appeal) and Medicare (e.g., late filing provisions) as well as a requirement that ICOs cover a free and independent second opinion to potentially support the enrollee's appeal. This requirement is crucial to due process because the providers are essentially the insurers and have a direct financial conflict of interest.¹¹

Choice of which records to share

MHLAC supports the proposal's provision that states MassHealth "will implement other beneficiary protections that ensure privacy of records." (p. 24) A large portion of the dual eligible population has a behavioral health diagnosis. We know that persons with serious mental illness receive poor medical care and live shorter lives. Part of the reason for this is the stigma associated with behavioral health diagnoses even within the medical profession. Clients seek help from MHLAC on a regular basis because physical health care providers wrongly attribute the clients' complaints about physical illnesses to psychiatric disorders. Dual eligibles may have a legitimate fear of sharing their psychiatric records and histories with physical health practitioners. The privacy of dual eligibles should be respected and enrollees should have a choice about with whom and which information will be shared.

Some persons may object that this negates the benefits of electronic medical records. However, person-centered care upholds the "dignity of risk" – that is, the right of persons with disabilities to accept risks in their lives. If care is to be genuinely patient driven, participants must have the explicit right to grow and experience setbacks in their development of independence and personal decision-making. Massachusetts and federal law already recognize the basic premise that medical records are private and subject to release only with the consent of the subject of those records. Dual eligibles should be accorded the same respect for their privacy as others.

MHLAC looks forward to working with EOHHS and CMS to develop a person-centered, high quality program for dual eligibles that ties monetary savings to improvements in recovery and wellness. If the choices of dual eligibles are protected, we believe that the demonstration project will be beneficial to all parties involved.

Respectfully submitted,

Susan Fendell
Senior Attorney

¹¹ We are glad that EOHHS recognizes the need for some type of independent ombudsman. (p. 24) MHLAC encourages EOHHS/CMS to develop an oversight entity independent of state and federal appropriations that is funded by a subscription fee paid by each ICE proportional to its participant enrollment. The oversight agency should be comprised of representatives of the disability community and have responsibilities that include, but are not limited to, pursuing appeals and grievances on behalf of enrollees, quality oversight, and development of the ICO procurement standards, risk adjustment, and ADA compliance standards and implementation.



January 10, 2012

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

500 Boylston Street
Suite 640
Boston, MA 02116

t . 617 456 3758
f . 617 236 7777

Dear Ms. Wong:

We are pleased to offer comments on the Executive Office of Health and Human Services' (EOHHS) Draft Proposal to the Center for Medicare & Medicaid Innovation for a State Demonstration to Integrate Care for Dual Eligible Individuals (Draft Proposal). We appreciate the process that EOHHS and CMMI have used to ensure that the MassHealth members impacted by this initiative, and the organizations that support those members, have an opportunity to contribute to the development of this important initiative.

Seniorlink™, from its offices in Boston, Massachusetts, has expertise that is directly relevant to the Draft Proposal: working with dually eligible members and their informal and formal caregivers; leading care coordination activities that bridge long-term care domains and facilitate communication across medical and behavioral domains; collaborating with community-based organizations; and, managing long-term services and supports (LTSS). Through a subsidiary, Caregiver Homes™ of Massachusetts, we are proud to be a provider of Medicaid-covered Adult Foster Care Services to MassHealth members of all ages. We administer the program statewide, and currently serve more than 1,500 members, approximately 45% of whom are under the age of 65 and would be impacted by this initiative. As a caregiver testified at the most recent public hearing, Adult Foster Care supports medically and behaviorally complex MassHealth members to live in their communities, with person-centered supports provided by caregivers of the members' choosing, and with timely and structured care management and nursing oversight provided by AFC provider agencies.

We would first like to address a specific issue regarding the covered benefits that will be made available to members enrolled with ICOs, specifically the list identified as "MassHealth Direct Coverage Benefits" in Appendix C, Table A. *We ask that EOHHS amend Table A to clarify that Adult Foster Care (AFC) is an important covered benefit distinct from the service of Group Adult Foster Care (GAFC).*

Members using AFC are much more medically complex than members using GAFC. The nature and extent of the services that members using AFC receive from their caregivers, and from the staff of AFC provider agencies, are substantially different from the services that members using GAFC receive. Unlike GAFC, AFC is managed by MassHealth through a comprehensive set of program regulations that specifies provider qualifications and performance standards, professional staffing configurations, and credentialing and training requirements of caregivers and professional staff.



For the entities that will be bidding to be ICOs, it will be important that EOHHS make available service descriptions and data that clearly demonstrate the existing coverage requirements and utilization of services historically used by Massachusetts Duals. *We ask that any data released by EOHHS clearly distinguish between AFC and GAFC services. We would welcome the opportunity to make data available, to the extent permissible, regarding the utilization of services by members currently enrolled with Caregiver Homes™ of Massachusetts.*

We are pleased that EOHHS has recognized that organizations interested in supporting the Massachusetts Duals initiative must be able to demonstrate a willingness to deliver person-centered services, and to operate with an administrative infrastructure and provider network that is responsive to the needs of enrolled members. We understand that EOHHS is proposing that each selected ICO establish its own service authorization requirements. We would like to emphasize that such requirements must be consistent with EOHHS' goal to ensure that services are available without unnecessary delays. *While we are prepared to work with ICOs with differentiated service authorization processes, we recommend that EOHHS implement procedures to ensure that ICO-administered processes accommodate providing all members will timely, predictable, and consistent access to covered benefits.*

As very few organizations have demonstrated expertise across medical, behavioral health, LTSS, and insurance domains, we are also pleased that EOHHS will require ICOs to demonstrate an ability to partner with organizations that bring complementary strengths. *We encourage EOHHS to continue to make available the input that it receives regarding the Draft Proposal, including, for example, by publicly posting the testimony and written comments received.* This will help to ensure that potential ICOs, providers, community-based organizations, and others can identify potential partnerships, and develop services, supports, and administrative infrastructures that are responsive to the needs of the members to be served.

Finally, we recommend that the following two issues be clarified in the Draft Proposal and/or be included on an agenda for discussion at a future public meeting. Regarding the discussion of Demonstration enrollees who are enrolled in existing HCBS Waivers, it is unclear how the model that EOHHS intends to explore would incorporate the management of Direct Coverage (State Plan) LTSS in addition to HCBS Waiver LTSS. Regarding covered benefits, we would like to better understand what flexibility ICOs will have to design and deliver services that are different than the current MassHealth definitions of those services. For example, will the ICOs have the flexibility to offer additional tiers of service beyond those appearing in current MassHealth regulations?

Thank you again for the opportunity to comment on the Draft Proposal. We look forward to continuing to engage with EOHHS and CMMI, members, consumer and professional advocacy organizations, and bidding ICOs who are involved in this extremely important initiative.

Sincerely,

Janice Masi
Executive Director, Caregiver Homes™

Thomas P. Riley
President, Seniorlink™

MLRI Comments on Draft Demonstration Proposal To Integrate Care for Dual Eligible Individuals

January 10, 2012

Transmitted by email to duals@state.ma.us

These comments are submitted by the Massachusetts Law Reform Institute, a state-wide nonprofit advocacy organization whose mission is to promote economic, racial and social justice for low-income people including individuals with disabilities. MLRI fully endorses the comments submitted by the Disability Advocates Advancing Our Healthcare Rights (DAAHR) coalition. These additional comments are intended to be fully consistent with those comments while providing more detail in certain areas within the expertise of MLRI.

The proposal holds great promise for improving the lives of individuals with disabilities by providing expanded services, better coordinating care, and eliminating the misalignment between Medicare and Medicaid coverage rules. At the same time it holds great risk that capitated payments and limited networks may restrict access to necessary care for a highly vulnerable population. While we understand that the proposal represents an overview of the state's approach with many features to be negotiated with CMS and many details to be determined at a later date, certain essential consumer protections are missing from the proposal and should be included.

In its proposed legislation, the DAAHR Coalition has provided a structure for extensive consumer participation in outreach, enrollment, coordination of long term services and supports, ADA compliance monitoring, review of utilization review criteria, quality monitoring and consumer assistance. The state's proposal only acknowledges the need for an external consumer ombudsman role, and ongoing consultation with stakeholders in public meetings. We urge the state to include in its proposal a stronger commitment to consumer engagement as recommended by DAAHR.

Enrollment –Assure seamless transitions

The proposal should include a commitment to achieve seamless transition for both individuals opting into the new ICO model and those opting out. For individuals enrolling into an ICO with approved MassHealth services, such as personal care attendant hours or favorable Medicare Part D authorizations, a seamless transition must assure that all approved services will be honored by the ICO and that any reauthorization of expiring services will be treated as continued benefits for purposes of appeal. Similarly, when an ICO enrollee chooses to return to the fee for services systems, he or she must be able to do so without any gap in services with Medicare and Medicaid fee for service honoring prior unexpired authorizations of the ICO.

Also, we encourage the state to extend the demonstration to pre-duals, those RSDI recipients in the 24 month waiting period for Medicare who are enrolled in MassHealth, on an opt-in basis. For these individuals the opportunity to avoid the confusing transition from MassHealth coverage to dual coverage and the need to enroll in a Part D plan for continued drug coverage would be a valuable benefit and strong

incentive to enroll. The SCO plan has successfully offered coverage to Medicaid only seniors in addition to duals for many years.

Communications –Assure accessibility

The proposal promises that communications will be accessible to individuals with disabilities that affect the ability to read, hear, or process information as well as to dually eligible individuals with limited English proficiency (LEP). However, more specific protections to achieve both of these results should be addressed with respect to communications from the Office of Medicaid and its vendors, the ICOs, and the providers in the ICO networks. Accessible communication should extend to telephonic, web-based, mail and in-person information. Unfortunately, clear communication has been challenging for both MassHealth and Medicare for even English speaking enrollees with no communication-related disabilities.

Section 1557 of the Affordable Care Act expressly extends the protections of Title VI of the Civil Rights Act to any health program receiving federal financial assistance.

While both MassHealth and Medicare acknowledge the obligation to provide interpreters to communicate with non-LEP individuals, Medicare has more materials translated into more languages than MassHealth. The proposal should acknowledge the need to identify vital documents and translate them into languages spoken by at least 500-1000 people in the relevant service area or 5 % of the population. Further, MassHealth's current practice of including tag lines in multiple languages informing individuals to call the customer service line to have a notice translated, is not meaningful. The automated attendant on the Customer Service line is only available in English and Spanish and the tag line provides no information about how the individual should communicate what their language is in the unlikely event that they stay on the telephone line listening to the auto-attendant long enough to eventually default to a person.

Further, the proposal does not address reimbursement for interpreter services. MassHealth takes the position now that the costs of interpreters are included in its provider rates, but since these rates do not vary depending on whether a service area requires extensive interpreter services or very few, this approach does not meaningfully address the need for interpreters.

The proposal should identify its communication strategy as an area where the agency will work with stakeholder groups to assure the information is communicated adequately.

Consumer engagement-Independent external source of consumer assistance/ombudsman

Cost sharing –eliminate cost-sharing

The proposal does not address cost-sharing at all, and it should. Cost sharing for dual eligible is a source of widespread misinformation and confusion among beneficiaries as well as providers. The proposal should take the opportunity to eliminate cost sharing in order to both create an enrollment incentive and to improve access to care. The literature clearly establishes the adverse affects of even nominal cost sharing on a low income populations.

Medicare imposes significant costs on beneficiaries that MassHealth does not. Dually eligible individuals who are enrolled in MassHealth Standard or with income under 135% of the federal poverty level enrolled in CommonHealth are treated like Qualified Medicare Beneficiaries (QMB) and have their Medicare

premiums and cost sharing assumed by MassHealth. However, dually eligible individuals still have problems with cost sharing when Medicare providers are not also MassHealth providers and must go through MassHealth credentialing procedures to be paid for Medicare cost-sharing. The proposal should exempt all dually eligible individuals from Part B premiums and Medicare cost-sharing in Parts A and B.

In the Medicare Part D program, on the other hand, MassHealth often charges higher drug copayments than Medicare. Also annual drug caps in Medicaid and Medicare are calculated differently, some duals may reach one annual cap sooner than the other. For example, Medicare charges a copayment of only \$1.10 for generic drugs for those under the poverty level compared to a copayment of \$3.65 in MassHealth, and at least one Massachusetts Part D plan, Wellcare, charges no copayment for generic drugs.

Currently, PACE plans and SCOs prohibit all cost sharing including drug copayments. Starting January 1, 2012, dually eligible individuals enrolled in home and community based waiver programs are also exempt from copayments in order to equalize treatment of dually eligible individuals in nursing facilities who have long been exempt from copayments.

The proposal should explicitly seek to exempt enrollees from all forms of cost sharing.

Medical necessity –include a broad definition

The proposal leaves to the ICOs the definition of medical necessity and utilization review criteria subject to approval by CMS and the state agency. This approach eliminates any opportunity for individuals with disabilities to participate in the process, leaves open the possibility of varying definitions among ICOs, and omits a key protection to assure appropriate access to services. Existing definitions of medical necessity in MassHealth and Medicare differ. The proposal should include a common definition not leave it to the ICOs.

DAAHR has developed a medical necessity definition that is designed to address medical as well as long term support needs for individuals with disabilities and includes the important protections of a second opinion in the case of disputes that we urge the agency to include in its proposal.

Estate recovery –should be addressed & limited

MassHealth has elected the option of requiring estate recovery for medical expenditures for individuals age 55 and older as well as federally required estate recovery for nursing facility expenditures for individuals at any age. Medicare, on the other hand, has no estate recovery. This creates an obvious problem when Medicaid and Medicare funding streams are joined and not directly aligned with payments for particular services in an integrated system. The proposal should address estate recovery. We strongly urge the state to eliminate optional estate recovery for those age 55 and older who enroll in an ICO, and seek waiver authority from CMS to also eliminate recovery for nursing facilities. If the state does not follow this recommendation, the proposal should at least address the agency's method for fairly allocating expenses subject to estate recovery from those that are not.

Independent external ombudsman/consumer assistance

We strongly endorse the need for an external body to assist individual who have disputes related to the integrated care program related to enrollment, disenrollment, authorization of services, accessibility of services and communications, or any other issue. We support the proposal of DAAHR that this role be assumed by a consumer led CBO like the proposed Health Equity Alliance.

This specific advocacy/ombudsman function could also be contracted out to one of more nonprofit organizations with experience in individual advocacy and/or legal assistance. One model to consider has operated in Wisconsin for the benefit of individuals with disabilities required to enroll in managed care. The state has contracted out with the Disability Rights | Wisconsin to provide individual assistance and serve as ombudsman to individuals 18-59 in its Family Care and IRIS program.

Include improvements in MassHealth eligibility procedures

The proposal should address MassHealth volatility. By incorporating improvements in eligibility procedures, the agency can both create added incentives for voluntary enrollment and assure continuity of coverage. We recommend including the following improvements in the proposal:

1. Adopt stream-lined renewal/administrative review procedures for all integrated care enrollees to minimize eligible individuals losing coverage for not returning forms.
2. Pay Medicare Part B premium for enrollees in CommonHealth who are otherwise over-income for Medicare buy-in assistance (135% of poverty or more)
3. Do not impose an asset test on ICO enrollees who are temporarily receiving nursing facility services if they have a reasonable expectation of returning home. This reform addresses the confusion around when an individual is “institutionalized” within the meaning of 130 CMR 519.006, provides a strong enrollment incentive, and dove-tails with other state and federal initiatives to provide care in the most integrated setting. Loss of housing is a major barrier to successful return to the community after a nursing facility stay.
4. Eliminate MassHealth optional estate recovery for individuals age 55 -64 in ICOs as discussed above.

Protect Self-Directed Personal Care Attendant Services

The structure of PCA services that has been developed over the years in MassHealth in concert with the disability community should be preserved. Currently, PCA services are carved out of MassHealth managed care contracts. Only the SCO provides PCA services as a managed care benefit. The proposal should include specific protections for the existing PCA service in the proposal.

Choice of providers-include single case agreements

The proposal should specifically endorse single case agreements to assure enrollees continuity of care and access to trusted providers.

Appeals-specify essential protections

All members of an ICO shall have the right to advance notice of any adverse action denying, reducing, modifying or terminating a requested service and the right to a due process hearing to appeal from any such adverse action or failure to act including the right to appeal from the provisions of the member's care plan. Each ICO shall develop an internal grievance and appeal process, including procedures for expedited decisions, and members may file a grievance or appeal regarding any adverse action or other dispute with the ICO to be reviewed at the ICO by individuals not involved in the original decision. The decision of an ICO on any such internal grievance or appeal shall be in writing and shall notify the member of the right to file a further appeal with the MassHealth Board of Hearings. Any member aggrieved by an action of the ICO shall have the right to a due process hearing before the Board of Hearings of the Office of Medicaid, including the right to have benefits continued pending appeal which right shall extend to benefits that the individual was receiving prior to enrollment into an integrated care entity. All procedural rules applicable to timely and adequate notice and fair hearings with respect to MassHealth Standard shall apply to all disputes regarding eligibility for an ICO, enrollment into or disenrollment from an ICO and services provided by an ICO provided that such procedures shall be modified to the extent needed to provide additional procedural protections identified by the Executive Office in consultation with consumers and consumer advocates that are available in Medicare. Such additional protections shall include but not be limited to the rights to: file an appeal within 60 days of an adverse action, establish good cause for a late appeal, have pharmacy appeals heard on an expedited basis, and to appeal from a non-coverage determination or other decision by an integrated care entity not to pay a provider for a service on the grounds that the service is not covered or is not necessary. In any appeal regarding the medical necessity of a requested service, the individual appealing the decision shall have the right to obtain an independent second opinion of medical necessity at no cost to the individual. All communications related to notices of adverse action and appeals shall be in an appropriate format for individuals with disabilities and translated for individuals with limited English proficiency.

There should be specific protocols for members to make requests for ADA accommodation or lodge complaints of discrimination on the basis of disability

While MassHealth regulations recite that no one will be discriminated against on the basis of disability, they contain no protocol for members to lodge complaints related to disability discrimination or to request modification of program rules as a reasonable accommodation. This is in contrast to other EOHHS agencies like DTA that do have written procedures for handling requests for ADA compliance and make the existence of such procedures known to affected individuals. The proposal should include a provision to develop such protocols as part of its overall commitment to compliance with the ADA by both the ICOs and the agency.

Evaluation

The evaluation component of the demonstration should begin with a baseline measure of the costs and access to care of dually eligible individuals in the fee for service system. Alternatively, a control group might be developed of pre-duals enrolled in the PCC Plan. The premise of the demonstration is that it can

improve care and save money. An evaluation component should be designed to answer the question of whether an integrated global payment model can do either.

Questions about the proposal

1. Are individuals with third party coverage like employer sponsored insurance ineligible for the ICO?
2. Long term services and supports are defined in a functional way in the glossary rather than by specific services. Table B-1 lists certain specific services for LTSS. If LTSS are carved out of ICOs for those enrolled in HCBS waivers as the proposal suggests, which LTSS will be affected? Aren't all the HCBS waiver services defined as different from those services now included as covered benefits without a HCBS waiver even if name is the same, like PCA & Home Health –how would this be addressed in a carve-out?
3. The reference to “less costly alternatives” to state plan services is confusing. It raises the troubling prospect that someone could be issued a cell phone instead of a PCA for example. In meetings with the state agency, it was clear this was not the intended meaning. Nor did it appear that the proposal contemplated a list of enhanced benefits that would require some sort of “less costly alternative” threshold showing. We recommend that references to cost savings and less costly alternatives be revised so that these unintended meanings are clearly foreclosed.

We acknowledge the exemplary efforts of the Office of Medicaid to give individuals with disabilities an opportunity to learn about the duals project and to make their views known. We look forward to continuing to work with you as the project continues to evolve. Please let us know if we can supply any further information about any of these comments.

Yours truly,

Vicky Pulos and Neil Cronin