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DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

February 13, 2012

Ms. Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Mail Stop: Room 315-H
Washington, D.C. 20201

Dear Ms. Bella:

I am writing to express my full support for the *Integrating Medicare and Medicaid for Dual Eligible Individuals* draft demonstration proposal, submitted by the Commonwealth of Massachusetts Executive Office of Health and Human Services. This demonstration as proposed will significantly advance the shared goals of both the Commonwealth and the Centers for Medicare and Medicaid Services to expand access to care and improve the lives of dual eligibles, while streamlining the delivery of services.

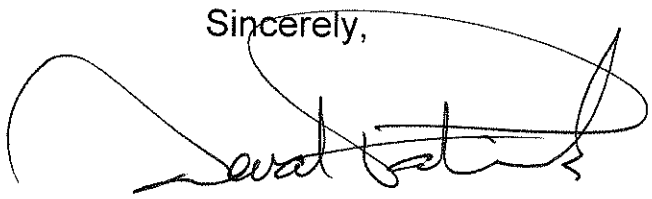
Dual eligible individuals under age 65 have among the most complex care needs of any MassHealth or Medicare members, including chronic illnesses, disabling conditions, and other health and wellness challenges. This Demonstration will provide comprehensive services beyond those currently covered by Medicare and Medicaid, addressing a complete range of care. Individuals will be able to choose an Integrated Care Organization (ICO) to provide Medicare and Medicaid benefits plus additional behavioral health diversionary and community support services. A multi-disciplinary

care team will work with members to plan each individual's primary care, behavioral health, acute, and long term services and supports needs. To measure success, ICOs' performance will be rigorously monitored to ensure the delivery of high quality care, and we will hold them accountable for improved outcomes for the population.

This Demonstration is a key component of the Commonwealth's strategic efforts to enhance the MassHealth program and achieve comprehensive delivery system and payment reform throughout our state. Through all of these initiatives, Massachusetts seeks to ensure access to appropriate services, integrate comprehensive services at the personal level, improve care coordination, and create payment systems that provide proper incentives, encourage flexible, responsive care, and hold providers accountable at the highest levels of quality.

We look forward to continued partnership with CMS on this Demonstration and all our health reform efforts.

Sincerely,



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Vicker V. DiGravio III PRESIDENT / CEO
Kevin P. Norton CHAIR

ASSOCIATION FOR BEHAVIORAL HEALTHCARE

February 13, 2012

Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Mail Stop: Room 315-H
Washington, D.C. 20201

Dear Ms. Bella:

On behalf of the Association for Behavioral Healthcare (ABH), it is my pleasure to submit this letter of support for the Commonwealth of Massachusetts' *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration proposal.

The Association for Behavioral Healthcare is a Massachusetts statewide association representing over eighty community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately eighty-one thousand Massachusetts residents daily and over three-quarters of a million residents annually.

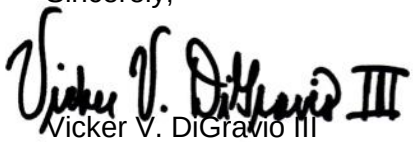
Our members believe this demonstration offers great potential to improve the health outcomes and quality of life of dually-eligible residents in Massachusetts by expanding access to enhanced behavioral health services and community supports while also ensuring improved coordination of medical and non-medical services.

We especially want to commend Massachusetts' Medicaid office, MassHealth, for their engagement with external stakeholders during the design of the demonstration proposal. ABH and our members are very pleased by MassHealth's decision to omit Medicaid-funded services currently provided through the Massachusetts Department of Mental Health (DMH) from inclusion in the demonstration proposal. MassHealth's decision means that dually-eligible clients of DMH will continue to maintain access to important long-term support services without interruption while also being able to have expanded access to vital community-based behavioral health services.

These efforts will promote timely, efficient and effective care without the added strain to consumers of navigating multiple systems and processes. This model of care delivery, moreover, should improve the health outcomes of dually-eligible members and reduce utilization of acute and facility-based care which in turn, should lead to a reduction in costs associated with serving this population.

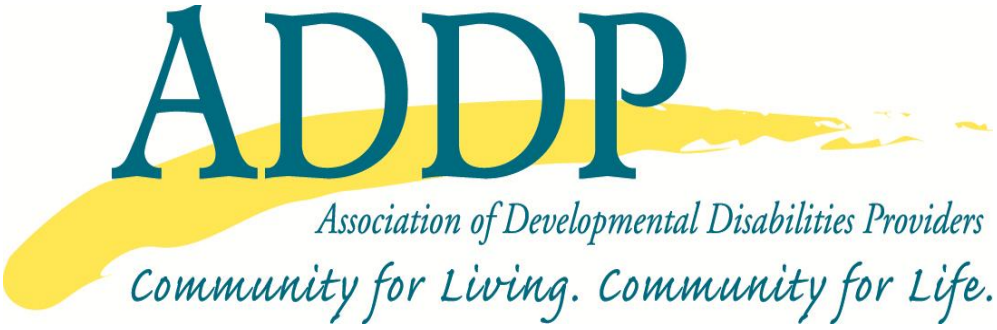
For all of these reasons, ABH and our members look forward to working with the Commonwealth of Massachusetts to implement this exciting demonstration.

Sincerely,



Vicker V. DiGravio III
President/CEO

Cc: JudyAnn Bigby, M.D., Secretary, Executive Office of Health and Human Services
Julian Harris, M.D., Director, MassHealth
Marcia Fowler, Commissioner, Department of Mental Health
Chris Counihan, Director, MassHealth Office of Behavioral Health



February 10, 2012

Melanie Bella
Centers for Medicare & Medicaid Services
Baltimore, Maryland 21244-1850

Dear Ms. Bella,

I am writing to you on behalf of the 128 member organizations that comprise our statewide provider association to express our support of the Commonwealth's *Integrating Medicare and Medicaid for Dual Eligible Individuals* grant proposal.

Our members provide a range of services and supports for people with develomental disabilities and brain injuries in local community settings. We have worked as an engaged stakeholder organization with the Commonwealth of Massachusetts in the continuing development of the state's demonstration proposal.

We respect the lengths the Patrick Administration and the MassHealth (Medicaid) office have gone to address our concerns in protecting the interests of people with developmental disabilities and other cognitive impairments who receive services through the HCBS Waiver. We stand strongly in support of the Demonstration Project's design in carving out an exemption in ICO direction for services delivered through the HCBS Waiver. We believe the inclusion of a Long Term Service and Supports Coordinator within the structure of this plan will further enhance the needed coordination between the acute health care needs and daily lives of our constituency. We appreciate the assurances that have been given to us by EOHHS that the structure of the demonstration will protect the access, authorizations and funding of community Medicaid services for individuals served in this system.

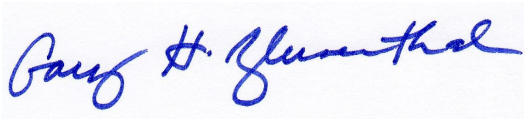
It is our belief that this demonstration will significantly improve the health outcomes and quality of life of dual eligible residents in Massachusetts by expanding access to services such as enhanced behavioral health services and community supports and by ensuring coordination of medical and non-medical services. Members will be empowered to participate in decision making through their central role within a care team that can include medical providers, providers of community support services, and other key individuals identified by the member as important contributors to his or her care, such as peers and family caregivers. This initiative will give the care team greater flexibility in developing a package of acute, behavioral health, long-term services and supports, and community support services to meet the needs of dual eligible individuals.

We believe that this demonstration will eliminate barriers to efficient, high quality care and positive health outcomes for dual eligibles adults by: 1) establishing coordinated, person-centered care; 2) increasing access to comprehensive, appropriate, and cost-effective services; and 3) integrating various administrative processes for beneficiaries and providers. These efforts will promote timely, efficient and effective care without the added strain of navigating multiple systems and processes.

We look forward to working with the Commonwealth of Massachusetts to implement this demonstration. We strongly believe that this model of care delivery will improve the health outcomes of dual eligible members and reduce costs associated with serving this population due to a decline in need for acute and facility-based care.

Sincerely,

Sincerely,



Gary H. Blumenthal, President & CEO
Association of Developmental Disabilities Providers
Framingham, Massachusetts

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February 13, 2012

Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Mail Stop: Room 315-H
Washington, D.C. 20201

Dear Melanie:

I am writing regarding the development of Massachusetts's *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration proposal, and wish to convey support for the general goals of the initiative. There is much promise in the future integration of services for duals, who endure documented barriers to care and services that both hurt them and significantly increase costs. EOHHS and MassHealth leadership have embraced the need to make major improvements to systems of care and service for persons with disabilities.

The role of the Boston Center for Independent Living (BCIL) in this effort has been substantial. Perhaps most noteworthy has been our leadership role with Disability Advocates Advancing Our Healthcare Rights (DAAHR), which has addressed the initiative with EOHHS and MassHealth, a variety of healthcare providers, and people with disabilities who have a major personal stake in this initiative. We have identified nearly four hundred people receiving our services as duals, and fundamentally the healthcare concerns of thousands of others we serve— including the 1,300 people on our consumer-directed Personal Care Attendant (PCA) program—are those of duals. Our consumers and members spoke loud and strong on their concerns at the state's public hearings on the initiative in Worcester and Boston.

Of note about this proposal has been the state's willingness, perhaps unprecedented, to engage stakeholders, including members of DAAHR. We expect this vital working relationship with DAAHR to continue, including in the development of procurement standards and the actual RFP for the demonstration. The creation of an innovative program involving highly medically-involved people with disabilities—people often with significant medical needs, high use of long-term services and supports (LTSS), and multiple disabilities—requires, without exception, the serious input of advocates and consumers.

We are pleased that the submission will include provision for coordinators of LTSS, who will come from community-based organizations such as independent living centers, recovery learning centers, and Aging Service Access Points. EOHHS heard our concerns, though we expect more precise details will need to be worked out. We likewise applaud the role that should exist for certified peer

specialists who will serve consumers with behavioral health needs. This can be a huge step forward in serving those with mental illness. The acknowledgement that homeless populations will need devoted attention also is important.

We also are pleased with the expansion of benefits proposed by EOHHS. The expanded package, including use of PCAs for people whose primary disability is mental illness, is a huge and long overdue step. The idea that Integrated Care Organizations (ICOs) can move outside of the limitations of standard medical benefits to offer non-traditional services, giving greater emphasis to independence and wellness, is a positive step forward. Other program components deserving favorable mention include the no-lock-in provision for enrollees, the guarantee of continuity of care, and the mandate for comprehensive consumer assessments prior to services being provided. The state's intention to require compliance by ICOs with the Americans with Disabilities Act also is a most necessary requirement. Nationwide, health facilities are some of the worst offenders when it comes to providing equal access to services and care. Specific areas to be addressed—and this will need to be stated clearly in the procurement effort—include, though not exclusively, access to exam tables, scales, rest rooms, the provision of information in accessible formats, accommodations in scheduling procedures and appointments, general understanding of disability, and the provision of interpreters and equal communication access for all disability populations.

Among areas of concern that we will be watching and providing further comment on in the near future include the state's plans for enrollment. We remain firmly committed to an opt-in mechanism, as opposed to an opt-out. The state is working to mitigate some of the concerns we've raised about their proposed opt-out arrangement, but BCIL remains concerned that people may end up in a program without full understanding of what it entails and a risk of losing fragile networks of care and service that they have carefully crafted over many years. We also will need to see more in-depth information on these program elements: consumer choice and provider networks; quality measures; the forms of risk adjustment that are developed for providers; and the geographic mandates providers must abide by and potential restrictions on programs that serve so-called special populations, something that can stifle innovation in serving those who are, in practice, the biggest drivers of costs, most who are unlikely to be adequately served in traditional programs of care. These are not concerns typically addressed by independent living centers in our healthcare advocacy, but we have come to deeply comprehend that questions that still remain in these areas can make or break the successful delivery of quality healthcare to our consumers. And this speaks pointedly to another need, that being the creation of a strong, oversight entity with deep ties to disability organizations to monitor implementation and then ongoing operation of the demonstration.

The placement of the PCA program within the ICOs remains a question of highest concern. We are fully expecting to have discussions with state officials on this topic. A detailed suggestion on how the PCA program would operate was submitted to EOHHS by the state’s independent living centers but is not represented in their proposal. We would emphasize that for people with physical disabilities, consumer-controlled personal assistance services are arguably the most important independent living service. Their placement within the ICO must be considered—and as we just said, expect it will be—through further discussion between advocates, consumers, and EOHHS/MassHealth staff.

I hope you will understand that if this letter does not reflect, upon review, unqualified support for the state's submission, it would be impossible to provide this for a proposal that, despite being a profound prescription to make tremendous positive change in so many ways, remains a gigantic work in progress. Developing systems of service and care not yet existing on the scale envisioned— along with

the extremely serious deadlines hanging over the entire submission— speak to an astounding need for continued advocate scrutiny and input.

Thank you for your continued close involvement with this process. I would emphasize that one oft-discussed feature of the demonstration projects is the three-way funding mechanism. What also must continue to exist, whether or not it receives a specific labeling, is extensive three-way discussions on program components between the disability community, EOHHS, and CMS.

Sincerely,

Bill Henning

BCIL Director

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

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February 13, 2012

Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Mail Stop: Room 315-H
Washington, D.C. 20201

Dear Ms. Bella,

We are writing in support of the Commonwealth of Massachusetts' *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration proposal. As an engaged stakeholder, we believe that this initiative will lead to better overall health outcomes for our patient population, the homeless men and women in the Boston area.

Massachusetts has a long-held commitment to enrolling eligible homeless men and women in MassHealth benefits and assuring that the unique health and health care complications caused by a lack of safe and stable housing needs are fully reflected in the MassHealth Program. They conducted a focus group with homeless individuals as part of their earlier due diligence in designing the duals plan, and their proposed plan requires the integrated care organizations have the capacities needed to address the special needs of homeless people. The proposal that resulted from this careful process has been responsive to our requests and suggestions.

This demonstration creates a well considered package of acute care, behavioral health, long-term services, and community support services to meet the needs of dual eligible individuals. By combining these services into one integrated and comprehensive package, we are hopeful that all dually eligible individuals will receive the attention and care that can lead to improved overall health. The Commonwealth has been diligent in working with all stakeholders, including homeless men and women, to ensure that their focus remains on the dual eligible person, enabling them to remain in control of their care.

We look forward to working with the Commonwealth to implement this initiative, and we are hopeful of realizing improved health outcomes and cost savings as our dual eligible patient population gains greater control of their care and utilizes the resources made available.

Sincerely,

Robert L. Taube, PhD, MPH
Executive Director

February 13, 2012

Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Mail Stop: Room 315-H
Washington, D.C. 20201

Dear Ms. Bella,

The Boston Public Health Commission is an engaged stakeholder organization that was involved in the development of the Commonwealth's *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration proposal. We are writing to express our strong support of the state's grant proposal.

This demonstration will significantly improve the health outcomes and quality of life of dual eligible residents in Massachusetts by expanding access to services such as enhanced behavioral health services and community supports and by ensuring coordination of medical and non-medical services. Clients we serve through programs like our Mayor's Health Line will be empowered to participate in decision making through their central role within a care team that can include medical providers, providers of community support services, and other key individuals identified by the member as important contributors to his or her care, such as peers and family caregivers. This initiative will give the care team greater flexibility in developing a package of acute, behavioral health, long-term services and supports, and community support services to meet the needs of dual eligible individuals.

We believe that this demonstration will eliminate barriers to efficient, high quality care and positive health outcomes for dual eligibles adults by: 1) establishing coordinated, person-centered care; 2) increasing access to comprehensive, appropriate, and cost-effective services; and 3) integrating various administrative processes for beneficiaries and providers. These efforts will promote timely, efficient and effective care without the added strain of navigating multiple systems and processes.

We look forward to working with the Commonwealth of Massachusetts to implement this demonstration. We strongly believe that this model of care delivery will improve the health outcomes of dual eligible members and reduce costs associated with serving this population due to a decline in need for acute and facility-based care.

Sincerely,

Steven Belec

Director, Mayor's Health Line, Boston Public Health Commission

Cape Organization for Rights of the Disabled
106 Bassett Lane, Hyannis, MA 02601

(508) 775-8300 / 1-800-541-0282 (both numbers Voice and TTY) **Fax (508)775-7022** **www.cilcapecod.org**

February 10, 2012

Ms. Melanie Bella
Centers for Medicare & Medicaid Services
Baltimore, Maryland 21244-1850

Dear Ms. Bella:

I am writing as an engaged stakeholder involved in the development of the Commonwealth's *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration proposal, and wish to convey support for the goals of the initiative. There is much promise in the future integration of services for duals, who endure documented barriers to care and services that both hurt them and significantly increase costs.

Of note about this proposal has been the state's willingness to engage stakeholders, including members of Disability Rights Advancing Our Healthcare Rights (DAAHR). We expect this vital working relationship with DAAHR to continue, including in the development of procurement standards and the actual RFP for the demonstration. The creation of an innovative program involving highly medically-involved people with disabilities—people often with significant medical needs, high use of long-term services and supports (LTSS), and multiple disabilities—requires, without exception, the serious input of advocates and consumers.
We are pleased that the submission will include provision for coordinators of LTSS, who will come from community-based organizations such as independent living centers, recovery learning centers, and Aging Service Access Points. EOHHS heard our concerns, though we expect more precise details will need to be worked out.

We also are pleased with the expansion of benefits proposed by EOHHS. The expanded package, including use of Personal Care Attendants (PCAs) for people whose primary disability is mental illness, is a huge and long overdue step. The idea that Integrated Care Organizations (ICOs) can move outside of the limitations of standard medical benefits to offer non-traditional services, giving greater emphasis to independence and wellness, is a positive step forward. Other program components deserving favorable mention include the no-lock-in provision for enrollees, the guarantee of continuity of care, and the mandate for comprehensive consumer assessments prior to services being provided. The state's intention to require compliance by ICOs with the Americans with Disabilities Act also is a most necessary requirement. Nationwide, health facilities are some of the worst offenders when it comes to providing equal access to services and care. Specific areas to be addressed—and this will need to be stated clearly in the procurement effort—include, though not exclusively, access to exam tables, scales, rest rooms, the provision of information in accessible formats, accommodations in scheduling procedures and appointments, general understanding of disability, and the provision of interpreters and equal communication access for a disability populations.

Among areas of concern that we will be watching and providing further comment on in the near future include the state's plans for enrollment. We remain firmly committed to an opt-in mechanism, as opposed to an opt-out. The placement of the PCA program within the ICOs remains a question of highest concern. We are fully expecting to have discussions on this topic. A detailed suggestion on how the PCA program would operate was submitted to EOHHS but is not represented in their proposal. We would emphasize that for people with disabilities, consumer-controlled personal assistance services are arguably the most important independent living service. Their placement within the ICO must be considered through further discussion with advocates.

We appreciate you taking these comments into consideration to best serve the needs of dual eligible individuals in the Commonwealth.

Thank you.

Sincerely,

Coreen S. Brinckerhoff

Coreen S. Brinckerhoff
Executive Director

CENTER FOR LIVING & WORKING, INC.

484 Main St. Suite 345, Denholm Building, Worcester, MA 01608
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Website: www.centerlw.org

Independent Living Services
Personal Care Management Services
Deaf & Hard of Hearing Independent Living Services

February 13, 2012

Melanie Bella
Centers for Medicare & Medicaid Services
Baltimore, Maryland 21244-1850

Dear Ms. Bella:

As an invested and involved stakeholder, I'm writing to express CLW's support for the goals of the Commonwealth's *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration proposal. The future integration of services for those whom are dually eligible, is critical to those who endure the barriers to care which ultimately affect quality of care and incur the potential high cost.

As the development of the procurement standards and RFR move forward, it is vital Disability Rights Advancing Our Healthcare Rights (DAAHR) continue to be at the table for input and consideration. The development of an innovative program involving highly medically-involved people with disabilities—people often with significant medical needs, high use of long-term services and supports (LTSS), and multiple disabilities—requires the serious input of advocates and consumers.

CLW is pleased that the submission will include provision for coordinators of LTSS, who will come from community-based organizations such as Independent Living Centers, Recovery Learning Centers, and Aging Service Access Points. CLW supports the role of certified peer specialists, who will enhance the needed service to consumers with behavioral health needs. The option for Personal Care Attendants (PCAs) for persons whose primary disability is mental illness, is a positive step. Having Integrated Care Organizations (ICOs) able to move outside of the limitations of standard medical benefits to offer non-traditional services, the promise of continuity of care, and the mandate for comprehensive consumer assessments prior to services being provided is noteworthy. Further, we agree that ICOs need to be compliant with the Americans with Disabilities Act.

We ask for reconsideration with regard to, the enrollment process, specifically the proposed opt-out and feel strongly that an opt-in approach is more inclusive, much more manageable with less negative consequences to the consumer's ongoing healthcare. Consumer choice throughout the process is critical to accessing appropriate healthcare and the successful delivery of quality healthcare to our consumers.

CENTER FOR LIVING & WORKING, INC.

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Website: www.centerlw.org

Independent Living Services
Personal Care Management Services
Deaf & Hard of Hearing Independent Living Services

Consumer-controlled PCA services for individuals with physical disabilities, is singlehandedly the most important independent living service. We request that consumer's and advocates have an opportunity to express the importance of PCA services and how it enhances one's independence.

The State's continued willingness to engage stakeholders, specifically DAAHR, is very much appreciated and in our opinion will result in a more inclusive quality end product. We look forward to continued participation and dialogue with regard to consumer choice, resulting in equal access to quality health care.

Sincerely,

Ann Ruder
Executive Director

CQI
Consumer
Quality Initiatives

January 24, 2012

Melanie Bella
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Bella,

As an engaged stakeholder organization involved in the development of the Commonwealth's *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration proposal, we are writing to express our support of our state's grant application.

This demonstration project is designed to significantly improve the health outcomes and quality of life of dual eligible residents in Massachusetts by expanding access to services, such as enhanced behavioral health services and community supports, and by ensuring coordination of medical and non-medical services. In CQI's work as a consumer-run research and evaluation organization, we see significant benefits for members empowered to participate in decision making with a care team that includes providers of medical and community support services, in addition to other key individuals identified by the member, such as peers and family caregivers. This initiative offers the care team greater flexibility to develop a package of acute, long-term behavioral health services and supports, as well as community support services, to better meet the needs of dual eligible individuals.

CQI believes that this demonstration project will eliminate barriers to efficient, high quality care and positive health outcomes for dual eligible adults by: 1) establishing coordinated, person-centered care; 2) increasing access to comprehensive, appropriate, and cost-effective services; and 3) integrating various administrative processes for beneficiaries and providers. These efforts will promote timely, efficient and effective care without the added strain of navigating multiple systems and processes.

We very much look forward to working with the Commonwealth of Massachusetts to implement this demonstration project. CQI strongly believes that this model of care delivery will improve the health outcomes of dual eligible members and reduce costs associated with serving this population due to a decline in need for acute and facility-based care.

Sincerely,

Laurie Ansorge Ball
CQI Board President

February 12, 2012

Melanie Bella
Centers for Medicare & Medicaid Services
Baltimore, MD 21244-1850

Dear Ms. Bella:

While I serve as healthcare policy analyst for the Disability Policy Consortium and Co-chair of Disability Advocate Advancing Our Healthcare Rights (DAAHR), the comments in this letter are my own, and do not represent those of any particular organization or stakeholder entity. I am writing to you solely as a dual eligible directly affected by the Dual Eligibles Demonstration Project in Massachusetts and as a public health practitioner who believes in the vision of the Project.

The Massachusetts Executive Office of Health and Human Services (EOHHS) has taken great strides toward developing a person-centered integrated healthcare delivery system for dual eligibles in the Commonwealth. Much of this success is owed to the ongoing and increasingly transparent communication between EOHHS and stakeholders, as evidenced by the regular meetings with DAAHR representatives, EOHHS participation in a Recovery Learning Community event, two public listening sessions and other informational forums.

This communication with stakeholders has had a direct impact on policy, leading to the inclusion of Independent Long-Term Service Coordinators on care teams, increased emphasis on the ADA and great understanding of the need for independent oversight of ICOs.

While there are a number of positive aspects to the proposal as put forward by EOHHS beyond those already mentioned, I have a number of concerns, specifically those listed in Appendix I. In addition, I have one overriding concern, and that is the failure of EOHHS to communicate a clear philosophy for providing care to people with disabilities that reflects contemporary frameworks of disability as a dynamic interface between the personal, social and environmental. Most healthcare practitioners view disability as a phenomenon residing in the individual, with the treatment that ensues reflecting this narrow view of disability. The focus becomes the disability and not the person. It is not surprising that studies show that women with physical disabilities are less likely to receive Pap smears than their counterparts in the general population.

In this regard, one of my greatest concerns about the EOHHS proposal is that it provides pieces vision of healthcare delivery, rather than a vision that calls for true systems change. Implementing policies, practices and procedures may bring about some positive outcomes, but will not get to the core issues that result in health disparities experienced by people with disabilities. For instance, while providing an independent LTSS coordinator is extremely positive, it will not transform how healthcare is delivered to people with disabilities. I believe what is needed from EOHHS is an unambiguous statement of purpose that goes beyond improved health outcomes and cost savings, a statement that captures the once in a generation opportunity contained in the Project.

Below is an example of a mission statement that speaks to the change needed as the Project moves forward.

"The mission of the Dual Eligibles Demonstration Project is to achieve equity in health care access and health outcomes for dual eligibles, as compared to their peers in the general population. This includes

fully implementing Olmstead and increasing the opportunity for dual eligibles to be as fully engaged in the social and civic life of the Commonwealth as they so choose. To achieve this goal, people with disabilities will be engaged in every aspect of the project. All policies, practices and procedures in the Demonstration Project will be developed in a manner that advances the principles of the Independent Living and the Recovery Model of mental health, codifying their direct application as fundamental to the success of the Duals Demonstration Project. Further, the Project will achieve this goal by incorporating, in measurable ways, contemporary frameworks of disability as put forward by the Institute of Medicine, Centers for Disease Control and Prevention, National Institute of Health and World Health Organization.

In addition to achieving equity between dual eligibles and the general population, the purpose of the Dual Eligibles Demonstration Project will be to achieve equity in health care access and health outcomes within the dual eligible population for those groups who experience health disparities that result from racism and broader discrimination, as well as those disparities that are gender-based."

While this mission statement is long, it contains all the elements necessary for the success of the Project. With the mission, goals and methodology in alignment, all other components of the Demonstration Project can be developed in a manner that meets the **Triple Aim of CMS**, population health, improved individual care/healthcare experience and controlled costs. And though the goals of this mission statement cannot be achieved in three years, it sends a clear message to health care providers and the disability community, that a paradigm shift is taking place in the Commonwealth.

This paradigm shift has already taken place in the health care services provided by Boston Community Medical Group. A patient of BCMG for 25 years I know the potential contained within the Dual Eligibles Demonstration Project. As a dual eligible who has, because of my insurance status, not been eligible for many of the capitated services provided by BCMG, I look forward to the possibility of expanded benefits that might become available through the Project. *I also worry, **however**, that if EOHHS is unable to recognize the value of **population specific programs** such as BCMG that the program will collapse, leaving me and all dual eligibles with complex medical, behavioral, and intellectual needs to receive services through a large system of one-size-fits-all Managed-Care Organizations which rather than providing innovation, will continue providing the status quo with limited LTSS benefits.*

At this point in the development of the Dual Eligibles Demonstration Project, my hope would have been to give EOHHS unequivocal endorsement to move the Project forward, but I cannot. As a person with complex medical needs and user of PCA services, I remain concerned about too many issues to do so. My hope is that CMS will provide a clear directive to EOHHS, to commit to continued partnership with DAAHR, increased opportunity for stakeholder input and creation of a specific strategy to address concerns raised in this letter as well as those raised by disability advocates.

In closing, I want to thank you and your staff for the open communication you have provided throughout the past nine months and look forward to future communication with you as the project progresses.

Sincerely,

Dennis G Heaphy M.Div., M.Ed., MPH

Appendix I

Active Enrollment: This is a demonstration project, and every effort should be made to reach scale through creative collaboration involving CMS, EOHHS, the disability community and health care providers with a history of providing quality care to people with disabilities. At least for the first year, enrollment should be based on active marketing to dual eligibles, preferably those with the most complex physical, behavioral and intellectual needs. Enrollment in years two and three should be built on successful strategies used in year one, along with development of new strategies to broaden outreach and attain scale.

Choice: ICOs should build provider networks around the needs of dual eligibles. In the general population, closed networks are common means of controlling costs. However, given the complex health care needs of a significant portion of the dual eligibles population, this method will result in increased cost resulting from failure to maintain continuity of care, as well as failure to provide bridges for new clinical relationships that require expertise that go beyond the closed network system.

Independent Long Term Services and Supports (LTSS): Systems should be put in place to protect current levels of LTSS over the course of the three-year Demonstration Project. In addition, formulas must be developed to protect LTSS as costs increase. Emphasis must be placed on bending the cost curve. Expecting large cost savings in the provision of health care to a population which, by its very composition, requires intensive medical and LTSS will result in draconian cost-cutting measures that will inevitably drive costs up and reduce quality of care.

Consumer Control: All policies, practices and procedures should incorporate Independent Living and Recovery Model principles. In addition to an independent LTSS Coordinator, the provision of LTSS should remain in the domain of community-based, consumer-controlled organizations, including ILCs and RLCs. Consumer control also includes the right of consumers to maintain their employer status with PCAs in hiring, firing and training.

Consumer Education: Person-centered care can only function if consumers are empowered, and understand their rights and obligations as beneficiaries in the Project. People with disabilities in general have been disempowered by and/or alienated from the medical establishment as a result of a history of dehumanization and discrimination by that establishment. To counter this history, an explicit requirement of the Project should be the education of consumers. Ideally, education should be provided by contacting with RLCs, ILCs and other community-based advocacy organizations.

Consumer Oversight: The population directly affected by the Dual Eligibles Demonstration Project—people with disabilities—need to have the ability to monitor the Project, and work in coordination with EOHHS and ICOs to improve quality of services through training on cultural competency and ADA compliance. Because of the geographical nature of most community-based organizations, a contract should be provided to a consortium of community-based organizations and/or to a community-based organization that does not have a contractual relationship with an ICO.

Governing boards of ICOs should include representation from the disability community. To avoid tokenism, representatives on governing boards should be chosen by community-based disability advocacy groups.

Measurable Consumer Engagement: Consumers should be directly involved in developing procurement contracts and the procurement process itself. Identifying information that might compromise the procurement process can be redacted. Such information includes the name and location of the RFR respondent. Continued consumer engagement should also include, but not be limited to, development of:

- Quality measures (patient confidence, community involvement, provision of LTSS, etc.)
- Data collection (race, ethnicity, education, employment status, etc.)
- Data collection methodology

Consumers should also remain engaged as partners with EOHHS in evaluating the Demonstration Project and developing modifications as needed.

Community First and Olmstead: Emphasis should be placed on de-institutionalization and provision of care in the community. Beneficiaries requiring nursing home level services should not be penalized by a payment structure that results in de facto institutionalization. Financial incentives for ICOs should favor provision of care in the community. This includes doing away with rate structures that pay more money to institutions for services that could be provided in the community.

Financing and Payment: Financing and payment should be based on sound risk adjustment estimates. Risk adjustment should include aggregate and individual data. It should also include functional status and social determinants of health. Such determinants include, but are not limited to: race, ethnicity, language, gender, income, housing, transportation and employment status. Financing structures should be transparent and provide incentives for improved quality of care (based on quality measurements), with cost savings secondary to quality improvement. Financing should also include penalization and/or oversight of dollar expenditures to improve quality of care. And financing should contain a mechanism for a percentage of profits to go back into improvements in provision of care, and back into the MassHealth budget.

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February 10, 2012

Melanie Bella
Centers for Medicare & Medicaid Services
Baltimore, Maryland 21244-1850
Melanie Bella

Dear Ms. Bella,

We are writing as a state agency that has been involved in the development of the Commonwealth's Integrating Medicare and Medicaid for Dual Eligible Individuals demonstration proposal and would like to express our support of the grant proposal.

This demonstration will significantly improve the health outcomes and quality of life of dual eligible residents in Massachusetts by expanding access to services such as enhanced behavioral health services and community supports and by ensuring coordination of medical and non-medical services. Members will be empowered to participate in decision making through their central role within a care team that can include medical providers, providers of community support services, and other key individuals identified by the member as important contributors to his or her care, such as peers and family caregivers. This initiative will give the care team greater flexibility in developing a package of acute, behavioral health, long-term services and supports, and community support services to meet the needs of dual eligible individuals.

We believe that this demonstration will eliminate barriers to efficient, high quality care and positive health outcomes for dual eligibles adults by: 1) establishing coordinated, person-centered care; 2) increasing access to comprehensive, appropriate, and cost-effective services; and 3) integrating various administrative processes for beneficiaries and providers. These efforts will promote timely, efficient and effective care without the added strain of navigating multiple systems and processes.

We look forward to continuing our work with the Office of Medicaid to implement this demonstration. We strongly believe that this model of care delivery will improve the health outcomes of dual eligible members and reduce costs associated with serving this population due to a decline in need for acute and facility-based care.

Sincerely,

Elin M. Howe

Elin M. Howe
Commissioner
Department of Developmental Services

The Commonwealth of Massachusetts
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Department of Mental Health
25 Staniford Street
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February 10, 2012

Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Bella:

I am writing to you as Commissioner of the Massachusetts Department of Mental Health (DMH) and full partner in the development of the design of the Commonwealth's *Integrating Medicare and Medicaid for Dual Eligible Individuals* demonstration application, to express my enthusiastic support for this exciting proposal.

This demonstration will significantly improve the health outcomes and quality of life for Massachusetts citizens who are dually eligible for Medicaid and Medicare who choose to participate. Nearly half of the adults receiving services through DMH, who experience serious and persistent mental illness and who are dually eligible, will for the first time be able to benefit from the expanded access to services and coordination across primary and behavioral health care systems that will be available through this demonstration. This will be achieved through the establishment of person-centered care teams that can include medical providers, providers of community support services, and other key individuals identified by the member as important contributors to his or her care, such as peers and family caregivers. This initiative will give an individual and his/her care team the requisite flexibility to develop a package of acute, behavioral health, long-term services and supports, and community support services that will best meet the individual's health, wellness and recovery needs.

I am extremely hopeful that this demonstration has the right components to ensure the elimination of barriers to efficient, high quality care and positive health outcomes in a manner that is person-centered and cost-effective and will simplify and increase access to necessary and appropriate services through effective integration of various administrative processes for beneficiaries and providers. These efforts will promote timely, efficient and effective care without the added strain of navigating multiple systems and processes.

I look forward to the DMH team continuing to work closely with our partners in MassHealth to further develop and implement this demonstration. I strongly believe that this model of care delivery will greatly improve the health outcomes and quality of life for dual eligible individuals throughout the Commonwealth while reducing costs associated with separate and fragmented care systems that have inadvertently contributed to avoidable use acute and facility-based care.

Sincerely,

Marcia Fowler
Commissioner