



Disability Advocates Advancing Our Healthcare Rights (DAAHR), a statewide coalition of Massachusetts disability, elder and healthcare advocacy groups, endorses the concept of integrated care for dual eligibles between the ages of 21-64 as a means of improving health outcomes and reducing costs. DAAHR applauds the initiative being taken by the Massachusetts Executive Office of Health And Human Services (EOHHS) to address the unmet healthcare needs of dual eligibles, and has worked closely with EOHHS in an effort to develop a model healthcare delivery system for people with disabilities within the framework set out within the Centers for Medicaid and Medicare Services (CMS) Dual Eligibles Demonstration project. DAAHR and its member organizations would like to express our appreciation of many aspects of both the draft proposal and the process which EOHHS has followed in writing it. In particular, we are pleased with:

- the breadth of services covered under the initiative, including peer supports and the long-needed expansion of PCA services to include cuing and prompting;
- the commitment to assessment measures which go beyond cost and resource utilization to gauge quality as reflected in members' experiences and quality of life;
- the recognition that existing provider relationships are often vital to ongoing wellness, and the willingness to explore single-case agreements to preserve these relationships;
- the public listening sessions in Worcester and Boston, which allowed members of the disability community to speak directly to EOHHS about their healthcare and independent-living needs;
- the intention, expressed in meetings subsequent to the release of the draft, to modify the proposal to include an increased role for community-based organizations;
- the many meetings between EOHHS staff and DAAHR members both before and after the release of the draft proposal; and
- the promise of ongoing close collaboration between EOHHS staff and members of DAAHR and the disability community as the proposal and demonstration process goes forward.

Throughout this process, EOHHS staff have acted in good faith and put a great deal of obvious effort into understanding the perspective of the disability community and incorporating that into their program design.

It is the contention of DAAHR, however, that despite these many positives, the draft proposal as currently written does not address the broken fee for service system and barriers to healthcare experienced by dual eligibles at level that meets the goal of "do no harm." Rather than defining a truly innovative and integrated project, the proposal describes an enhanced MCO system without adequate protections or consumer control. Without further modifications to the proposal, dual eligibles still risk becoming the victims of a healthcare initiative that focuses on maximizing enrollment numbers rather than on better healthcare, better health and reduced cost.

We fully understand that this is only a draft and are encouraged by EOHHS's consistent willingness to work with us. But the vagueness of the document—as well as some of the items, which are explicitly stated— indicate that a great opportunity for true reform may be lost. The draft document:

- lacks a clear goal for the demonstration project and the metrics necessary to measure project outcomes;
- fails to ensure that the establishment of a new healthcare delivery system will not damage the aspects of the current system which are currently working well;
- does not reflect an understanding of the thin margin of health experienced by people with disabilities, particularly people with complex disabilities and extensive need for Long-Term Services and Supports;
- fails to lay out a practical strategy for prevention of secondary disabling conditions;
- lacks a strategy for addressing the social determinants of health that lead to health disparities for the covered population;
- does not provide a roadmap for meeting the so-called “Triple Aim” of improved care, health outcomes, and per-capita costs;¹ and
- fails to outline how it will incorporate contemporary models of disability, independent living philosophy and the recovery model of mental health to fulfill the stated mission of the CMS Innovation Center, which encompasses:
 - “improving all aspects of patient care, including Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity (the domains of quality in patient care as defined by the Institute of Medicine),”
 - “encouraging healthier lifestyles in the entire population, including increased physical activity, better nutrition, avoidance of behavioral risks, and wider use of preventative care,” and
 - reducing cost by “promoting preventative medicine, better record keeping, and improved coordination of health care services, as well as by reducing waste, inefficiency, and miscommunication.”²

DAAHR urges EOHHS to reframe the dual eligibles demonstration project into a format that is based on contemporary understandings of the social, personal, and environmental factors that result in poor health outcomes and the resiliency factors that improve health outcomes. This includes constructing the demonstration project around existing community-based structures with expertise in LTSS, including Independent Living Centers, Recovery Learning Communities, Aging Services Access Points and Deaf and Hard of Hearing Independent Living Services programs.

Success of the demonstration project also requires a commitment to building on models of healthcare delivery with proven capacity to provide services to people with complex disabilities and LTSS needs. These would include the models pioneered by Boston’s Community Medical Group (<http://bcmgweb.org/>) and Independence Care System of New York (<http://www.icsny.org/>). These two healthcare delivery systems, with very distinct approaches, each provide a unique means of providing healthcare and LTSS rooted in the independent living model to people with disabilities. EOHHS is also

¹ Berwick, Donald, Thomas W. Nolan and John Whittington. “The Triple Aim: Care, Health, and Cost.” *Health Affairs*, 27, no. 3 (2008): 759-769

² Center for Medicare and Medicaid Innovation Center. “About the Innovation Center.” <http://www.innovations.cms.gov>. Accessed 1/10/12.

urged to consider how the dual eligibles initiative can incorporate many of the objectives linked to the Healthy People 2020 goal of “promot[ing] the health and well-being of people with disabilities.”³

In addition to the above requests, DAAHR further requests that as part of its reformulation of the Dual Eligibles Demonstration Project that the project:

1. Be developed collaboratively with full representation from the disability community on the proposal and RFR writing teams.
2. Eliminate passive enrollment in favor of active opt-in enrollment. Achieve scale through attainment of enrollment goals set out in collaboration with DAAHR, providers with expertise in provision of care to Medicaid eligible people with disabilities, and *in negotiation with CMS*.
3. Incorporate true "demonstrations" through a pilot program of healthcare delivery option(s) for sub-populations with complex medical, behavioral, intellectual and/or LTSS needs.
4. Establish integrated care systems with networks allowing for single case agreements to be developed around beneficiary needs rather than insurer preferences.
5. Provide a consistent role for consumer voice in the development, implementation, and evaluation of the demonstration project.
6. Include consumer participation in the ICO governance structure and regular consultation between ICOs and their members.
7. Include the establishment of an independent consumer entity, not subject to legislative appropriation, to protect the rights of dual eligibles. (See Appendix I)
8. Follow up on the intention to include an independent LTSS coordinator on care teams. (See Appendix I)
9. Establish a role for community based organizations (CBOs - see Appendix I for definition) to provide wellness services as preventative measures for secondary disabilities/illnesses due to tobacco use, obesity, lack of physical activity etc. To be successful these services must be proactively offered to all members covered by the demonstration, before they are identified as being at the highest risk. (For example, obesity-prevention services should not be dependent upon the member’s having been identified as overweight.)
10. Include protections for current levels of LTSS so that the range of LTSS services offered under the new program can be no less than the base line provided through fee for service programs.
11. Include in the evaluation of the demonstration measures designed to protect LTSS funds against redirection by medical systems. Also ensure that LTSS expenditures, as a percentage of total MassHealth and Medicare expenditures on dual eligibles under age 65, remain at or above the current percentage and that community LTSS expenditures, as a percentage of total LTSS expenditures, remain at or above the current percentage.
12. Establish capitation rates that will incentivize compliance with *Olmstead*, providing incentives for ICOs to maintain beneficiaries in community settings.

³ US Department of Health and Human Services. “Disability and Health – Healthy People.” <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=9>. (Full list of objectives: <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=9>.)

13. Ensure that ICO capitation rates for beneficiaries residing in nursing homes shall not be higher than capitation rates for beneficiaries with comparable medical and LTSS needs residing in the community.
14. Include requirements that ICOs contract with CBOs in the areas detailed in Appendix I.
15. Preserve the consumer control and independent living philosophy of Massachusetts's PCA program, which enables people with disabilities to live independent lives, fully integrated into the community. Preservation of consumer control and the independent living philosophy can be accomplished through either:
 - a) Continuing to fund PCA services through the MassHealth fee-for-services system (as is done with MassHealth MCOs and BCMG), with services expanded to cover cueing and prompting; or
 - b) Including PCA services, expanded to cover cueing and prompting, within the ICO capitation rate and requiring the ICO to contract with the MassHealth approved PCM agencies for all evaluations and skills training, with services to be authorized by the member's medical home. All policies, standards and criteria of the MassHealth PCA program shall apply.

An "opt-in" feature can be added to either model, allowing the consumer can choose to have their medical home perform both evaluations and authorizations, with skills training provided by PCM agencies and all current standards for skills training remaining.

16. Incorporate protections preventing ICOs from financially benefiting from institutionalization of dual eligibles, and rewarding ICOs that achieve compliance and develop best practices that go beyond the ADA base requirements.
17. Develop minimum standards of medical home and person-centered care. For example: the ability to provide 24/7 clinical response capabilities with provider networks that are built around the needs of the dual eligible.
18. Address current unmet healthcare needs resulting from disparities in reimbursement rates of healthcare providers under Medicaid and Medicare by developing a reimbursement formula that rewards primary care providers and specialists for provision of services to dual eligibles.
19. Establish an innovative system that is responsive to the needs of the person as issues arise, whether the need be (for example) for a peer to be present in the emergency room, or for a personal care attendant to assist with ADLs in hospital settings.
20. Determine risk using measures that go beyond aggregate data to include functional status and individual history.

In addition to the requests outlined in this document, DAAHR has put forward legislation (included as Appendix II) that provides the means for implementing of the Dual Eligibles Demonstration Project in a manner that has the potential to achieve the aims sought by both EOHHS and DAAHR.

DAAHR is invested in working with EOHHS to establish a Dual Eligibles Demonstration Project that improves health care access and health outcomes for people with disabilities through the integration of medical services and LTSS that has as its foundation a commitment to the independent living philosophy and recovery model. These requests were echoed in often emotional testimony and feedback provided

by the approximately 400 disability advocates who attended the recent MassHealth public hearings in Worcester and Boston. In addition, we look forward to working with EOHHS to develop a proposal that meets these requests in a manner that also addresses the “Triple Aim” priorities of CMS and the Healthy People 2020 objectives. This is an effort that will necessarily take more time and partnership—nothing less is needed to help us jointly achieve our oft-stated goal, one said with the deepest sincerity, of achieving once-in-a-generation change.

Sincerely,

Dennis G Heaphy co-chair

Bill Henning co-chair