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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,

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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.