September 18, 2012

Secretary JudyAnn Bigby, MD

EOHHS

One Ashburton Place

Boston, MA 02108

Ms. Melanie Bella, Director

Medicare-Medicaid Coordination Office

Centers for Medicare and Medicaid Services

200 Independence Avenue, SW

Mail Stop: Room 315-H

Washington, DC 20201

Dear Secretary Bigby and Director Bella:

DAAHR is writing in response to the signing of the Memorandum of Understanding (MOU) between CMS and EOHHS. While we understand that the MOU had to be signed as a means of moving the Dual Eligibles Demonstration project forward, we have a number of major concerns with it even as we continue to strongly support the goals of the initiative.

The MOU advanced principles important to the success of the project such as prescribing increased integration of the recovery model and an elevated status for the IL-LTSS coordinator, while firming up critical new benefits such as home

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modifications and PCA services for those needing cuing and prompting . We recognize the efforts and progress made by EOHHS and CMS and the complexity of the undertaking. But the document leaves many key items unresolved and raises major questions that need to be answered. Significantly, the MOU retreats from the original vision provided by the Office of Innovation and legislative authority, relying more heavily on standard Medicare frameworks, ones that do not speak in depth on LTSS nor incorporate mechanisms needed to adequately address the complex interplay between the physical, environmental and social determinants that define medical well-being and quality of life for people with disabilities. The comments that follow are designed to highlight areas of concern—as well as positive elements—with the aim of enhancing an integrated system of healthcare delivery, pivoting on LTSS, that improves healthcare access and outcomes for dual eligibles in a cost-effective manner.

As you read this letter, you will note reoccurring themes presented in previous communications, as well as new themes and points that reflect input from potential Integrated Care Organizations (ICOs), healthcare providers, EOHHS and CMS, and especially people with lived experience of disability. It is our hope that EOHHS and CMS will respond to the concerns DAAHR presents, as well those raised in our July 21 letter on the EOHHS RFR for ICOs, providing us with comprehensive answers detailing how you intend to address various matters and, when not possible, providing explanation for why those concerns cannot be addressed. We expect to use the information provided by your responses as part of two DAAHR forums that will update the disability community on progress with the Demonstration. DAAHR is also finalizing a report card it will use to rate ICOs selected by EOHHS as a means of advancing the Demonstration project and educating the disability community on ICOs' strengths and weaknesses. As we move forward at this critical point, we want to be sure the message DAAHR puts forward to EOHHS and CMS reflects the sentiments of the disability community. The forums are tentatively planned for mid October and early November; we will provide details as they emerge so that EOHHS and CMS can attend.

The analytical framework of this response again uses the principles DAAHR developed in early 2011. In addition, we wish to initially highlight an overarching concern, that being the unresolved gap between competency and capacity at the systems level. Neither the MOU nor the RFR provides any evidence of this gap being resolved within the timeframe set out for the project rollout. Many ICOs may display capacity, but we remain skeptical that in six and a half months they and their provider networks will develop the competency to serve highly medically-involved people with disabilities with significant need for long term services and supports (LTSS). We also are skeptical that community-based organizations, fundamental to the success of the project because they will be providing IL-LTSS coordination and training on critical cultural competency issues for ICOs and providers, will have the infrastructure in place to carry out needed tasks within the current timeframe.

Primary concerns around <u>competency</u> include but are not limited to the ability of ICOs and providers to:

- Comply with the Americans with Disabilities Act;
- Seamlessly integrate independent living and recovery models into traditional models of healthcare service;

- Understand and incorporate LTSS into care plans in an effective manner;
- Understand best-practice models for providing care and services for people with complex physical, behavioral and/or intellectual/developmental needs;
- Provide services in the language and manner necessary as set out in the CLAS standards set up by the Office of Minority Health and the Massachusetts Department of Public Health;
- Collect data appropriate for measuring quality of services and outcomes using population-based quality-of-life and patient-confidence measures.

Primary concerns around capacity include but are not limited to the ability of CBOs to:

- Have the financial resources necessary to start up and provide appropriate services;
- Build up staffing and administrative systems (including data collection) necessary to implement and oversee critical new services;
- Hire a satisfactory number of qualified persons necessary to provide IL-LTSS coordination and essential trainings for ICOs and providers.

There also is a prevailing uncertainty about funding, enrollment numbers, and the limited amount of upfront investment a non-profit CBO can make. For example:

A disability program is contracted to provide IL-LTSS coordination to 500 consumers (roughly one half of 1% of duals). The job requirements as discussed in the RFR and at stakeholder groups suggest hiring a high-level direct-services staff person, so a reasonable overall cost for the position may be $75,000. If billing an ICO for IL-LTSS coordination at the rate of $70 per member per month (PMPM), a CBO would need to hire six coordinators, each maintaining an active, billable caseload of 89 consumers, with a total overall expense of just under $450,000 to serve the 500 people. The startup expenses combined with Bcaseload size that includes a large percentage of consumers with complex needs could be exorbitant relative to a CBO's budget.

Unfortunately the timeline set out for implementation is too limited and lacking in strategy to address gaps in capacity and competency such as those outlined in this example. This has the very real potential to result in the worst fears of disability advocates being realized, with innovation lost and dual eligibles locked into a system of inadequate managed care as the already-fractured fee-for-service system dismantles. We urge decision-makers to take the steps, many of them outlined below in our review based on the DAAHR principles, necessary for the Demonstration project to succeed.

Principle 1: Participant Enrollment

Participant enrollment must be voluntary, flexible and streamlined, and reflect exiting provider relationships.

It remains a primary concern for DAAHR that CMS and EOHHS will be implementing the project through passive enrollment. Satisfactory protections of dual eligibles have not yet been put in place in what may be a closed system. This system may only provide limited choice of ICOs, a concern particularly for dual eligibles with complex medical and LTSS needs and those dual eligibles living in rural areas. In this regard, it must be restated that passive enrollment remains involuntary because, in general, the population of people with disabilities does not understand the medical system or their rights. This is likely to be especially true for dual eligibles with the most complex medical and LTSS needs, which includes many people with intellectual, behavioral and developmental disabilities. If passive enrollment is to take place it should be done with a methodology designed in conjunction with the disability community. Within this design, ICOs should be held to a rigorous standard of cultural competency with defined guidelines and benchmarks developed in collaboration with DAAHR and other disability advocates before being permitted to passively enroll a dual eligible.

Beginning July 1, 2013, ICOs should only be permitted to passively enroll duel eligibles with low LTSS needs. This will help to bring about scale while giving the state and stakeholder community the time necessary to strengthen the ICO infrastructure statewide. This will ensure that ICOs will have the competency and capacity to provide the appropriate level of services necessary for people with complex medical and LTSS needs. We also ask CMS and EOHHS to reconsider the request of DAAHR to extend the 90-day transition period to a minimum of six months or until an Individualized Care Plan (ICP) is agreed upon, whichever is later. Existing providers and services must remain in place until the member has agreed to alternate providers and services. The current 90-day timeline is impractical, a fact noted by a number of stakeholder groups and a provision made in proposals by other states. This provides a level of protection in the development of the ICP so that it is based on a more developed understanding of the person rather than on an initial interview.

In addition to the above, prior to enrolling any dual eligibles in an ICO, EOHHS should:

- Shore up financing mechanisms to protect against ICO cherry picking or gaming of the system.
- Put in place a strong statewide oversight and ombuds-entity that includes significant consumer and advocate participation.
- Include within ICO readiness review a system-wide set of criteria with benchmarks that ICOs must meet prior to being able to begin passively enrolling dual eligibles with complex needs. These benchmarks should go further than benchmarks required for passively enrolling dual eligibles with low LTSS needs.

With respect to enrollment outreach and education, DAAHR is concerned about heavy reliance on the SHINE program (Serving Health Insurance Needs of Elders) and ADRCs. The SHINE program has served as an excellent resource for

enrolling seniors into Medicare and other services. We are, however, concerned that expanding the role of SHINE may reduce its ability to continually provide services to their target population while obtaining the competency to be effective in counseling, with a peer focus, younger people with disabilities. Likewise, ADRCs have been an excellent platform for Options Counseling, but with nearly a three-to-one ratio in elder services organizations to disability services—and a duals population of approximately 85,000 under age 60 to be counseled on enrollment— questions exist on whether this network has the ability to come up to speed in a timely way.This matter is complicated by the commensurate need for many organizations within the ADRC framework to rapidly build infrastructure to support their roles as providers of IL-LTSS coordination, disability trainings, and core services to a possibly large influx of new consumers. Significant, in-depth discussion on the enrollment counseling process must commence soon.

Principle 2: Person Centered Care

Person-centered care must treat the whole person, and must be meaningfully directed and led by the individual.

The MOU neglects to build upon the person-centered care model developed in the EOHHS RFR. It is vague, leaving more questions than answers on how person-centered care will function at the care-team level. This includes the issue of continuity of care. The MOU provides no protections against cuts in Medicaid, notice of appeal rights, changes in service or satisfactory plan for providing transition plans when changes take place.

Care Coordination

The MOU makes mention of the role of the IL-LTSS coordinator, but fails to provide the clear guidance to ICOs about the central role the coordinator will play in the development and implementation of a dual eligibles care plan, particularly in the creation of LTSS goals for consumers. Below are key points for what DAAHR views as a model for how the person-centered care team approach should be established for ICOs.

- Team-based care and coordination within the team is essential.
- A single point of contact for the dual eligible must be defined, with that individual ensuring that the rest of the individual's care team are informed as needed. This individual may be a nurse practitioner, IL-LTSS coordinator, behavioral health professional or some other member of the team who the dual eligible identifies as being their contact person of choice.
- The staff who know the dual eligible best (i.e. - their care/support team) should have the authority to make decisions and immediately authorize care and support based on needs identified by the dual eligible.
- Decisions regarding care/support need to be individualized –not rule based. This is done through an individualized assessment and plan of care.

- The care team should be given guidelines to ensure consistency across teams –but also the freedom to make individual judgments based on the unique needs and support context of the participant. Consistency of individual authorizations can be tracked and monitored after the fact, with the team given coaching and training as needed for variances. But, this is behind the scenes and does not interfere with the team's ability to immediately authorize services and supports.

Intake interview

The MOU requires a Registered Nurse (RN) at a minimum to conduct the interview. We ask CMS and EOHHS to require all initial interviews to be done both by an RN and IL-LTSS coordinator. We also ask that this interview take place in the primary residence of the dual eligible, whatever the setting. Only by balancing the medical aspect of the interview with LTSS can a true person-centered care plan be developed.

As put forward by DAAHR on a consistent basis, the MDS-HC is grossly inadequate as a tool for measuring the functional status of people with high LTSS needs. These measures do not incorporate the ADL or IADL needs of an individual in a manner that will enable the care team to effectively develop a set of robust LTSS. The MDS-HC should be augmented with the use of the DREEM model supported by SAMHSA or other models that capture the medical and quality-of-life goals of dual eligibles. ICOs should be encouraged to use innovative tools for this purpose with the understanding that as a demonstration project, one of the goals will be to determine which tools bbest support the work of the care team in providing person-centered care.

Individualized care plans

The description of the care plan remains vague and short on the participation of dual eligibles in the care-planning process. A mechanism needs to be put in place that enables dual eligibles to sign off on individualized care plans. This sign-off should include any objections or appeals the dual eligible may seek in response to the care plan. Dual eligibles should have control over who participates in the care team and over who has clearance to view their records, particularly psychiatric records.

The RFR describes an initial comprehensive assessment that results in an individualized care plan. The MOU describes an initial assessment and an "additional" comprehensive assessment that results in an individualized care plan. Because the continuity of care and appeal sections are tied to the "initial assessment" the MOU seems to allow for services to be terminated before a comprehensive assessment or development of a care plan has occurred and this would short-circuit both continuity of care protections and appeal rights. Please clarify that the Individualized Care Plan must be in place

prior to the modification of existing services and that the enrollee must be given notice and appeal rights (including rights to aid pending appeal) prior to any proposed modifications to existing services.

Principle 3: Delivery System

The delivery system must include medical homes and a broad network of providers, and ensure the full range of Medicare and Medicaid services, long term services and supports.

The MOU fails to adequately address a number of other concerns raised by DAAHR in its response to the EOHHS RFR including the following two key items.

Network adequacy: We are particularly concerned about the definition of adequacy for behavioral health providers as two within a 30-minute or 15-mile radius. Given this definition of network adequacy and where personal relationship with the provider is so important, the need for single-case, out-of-network agreements should be obvious and guaranteed to enrollees.

Medical necessity: The definition of medical necessity and the standards by which appeals of services, care plans, and out-of-network care denials are judged need to be refined to reflect a more expansive definition of medical necessity that is appropriate to person-centered care and the services to be offered by ICOs.

Grievances and Appeals

This section of the MOU is weak. For this reason DAAHR reiterates key points put forward in its comments on the EOHHS RFR. It is crucial that, at any point in the appeals process, the enrollee have the right to access an external ombudsperson. The ombudsperson should be available before, simultaneously with, an after a formal appeal. We welcome the opportunity to speak further with EOHHS about our concerns with this critical point. To this end, we are also seeking clarification of language specific to the expedited handling of appeals as this language seems awkward. We want to be sure that if a physician states that an appeal needs to be expedited, that the ICO will do so without question as is now the rule in MassHealth, in the SCOs, and in Medicare. (130 CMR 508.010)

It also is important that there be some cross reference between the continuity-of-care provisions and the appeal process. It should be clearly stated that a member who disagrees with the ICO decision whether to continue services that were authorized prior to enrollment in the ICO may continue receiving these services pending appeal to the same

extent as if the ICO had made the original authorization. This is important even if the transitional continuity period is extended from 90 days to six months as we urge you to do.

Furthermore, it should be clarified that an ICP must be in place prior to the modification of existing services and that the enrollee must be given notice and appeal rights prior to any proposed modifications to existing services. Since an in-person comprehensive assessment is necessary to formulate an ICP, this will prevent the breach of existing service relationships prior to speaking with the affected enrollee, thereby also ensuring that the care plan will be person-centered.

In terms of Part D appeals and hospital discharge appeals, the Demonstration should take care not to restrict the existing rights of people on Medicare. Further clarification is needed to assure this.

We are pleased with the related right of consumers to move out of a plan to fee-for-service or to another available ICO on a monthly basis if this best suits them. This will need to be conveyed by enrollment counselors.

Benefits

With regard to benefits, we would be remiss not to applaud the cementing of certain benefits, including, beyond those mentioned earlier, non-medical transportation, dental care, and improved provision of DME. We do need more substantial information on what an agency model for PCA services would entail. And there should be guarantees that the benefits package will not be altered even if Medicaid State Plan services are negatively altered. In this regard, the social determinants that lead to secondary disability must be directly addressed within the design of the benefits. Please consider:

The Behavioral Risk Factor Surveillance System shows high incidence of isolation and depression among people with disabilities. Within the deaf blind community, people are allowed 16 hours a month of “provider” hours to facilitate community engagement. Devastatingly, people who are deaf blind are left in complete isolation beyond the average of four hours a week. One might rightly conclude that such long periods of isolation might lead to depression, substance abuse and other unhealthy behaviors.

Good public health practice would dictate that members of the deaf blind community as well as other populations facing extreme isolation should have benefit packages that include opportunities to increase involvement in the community and greater integration into society. This includes information on volunteer opportunities in employment.

Principle 4: Cultural Competence and Health Disparities

Integrated Care Organizations must have the capacity to provide services appropriate to the complx needs of a diverse population.

The stated requirement that ICOs must comply with Olmstead mandates and the Americans with Disabilities Act are most encouraging, with the ADA language groundbreaking. DAAHR expects to continue to work with EOHHS on developing an enforcement mechanism for ADA compliance, as well as a plan for implementing national and state Cultural Linguistically Appropriate Services (CLAS) standards across ICOs. As mentioned earlier, one barrier to surmount for increasing cultural competence is the extraordinarily tight timeframe for project rollout. Another barrier is the lack of mandated training of providers by duals to eliminate misconceptions and stigma associated with the enrollee population.

Principle 5: Prevention

Prevention services must be accessible to people with disabilities and target additional risk factors.

Prevention of secondary conditions must be foundational to the Demonstration. The MOU provides no clear direction for prevention of secondary conditions will be attained through the development of more robust LTSS will be required at the systems level within the Demonstration. It leaves open to interpretation how Medicare and Medicaid dollars are to be used in the development of the dual eligible care plan. Traditional medical interventions alone will not address the unique risk factors and social determinants that lead to secondary disability. Beyond consumers with complex medical and LTSS needs, at risk are consumers with low medical needs who could benefit from LTSS as a means of preventing secondary disability and associated costs. Please consider:

A 35-year-old man with an intellectual disability and borderline diabetes does not have a history of using the emergency room or needing regular medical interventions. However, the man's primary social activities involve watching TV and eating unhealthy foods. Monitoring the man for borderline diabetes will not, in isolation, prevent him from becoming insulin-dependent. LTSS in the form of transportation and a peer paid to engage the man in to a gym has the potential to work in continuity with the direct medical intervention to prevent the man from developing a more severe form of diabetes.

It is imperative that both CMS and EOHHS provide clear guidance to all ICOs that Medicaid dollars are to be used for preventive services in addition to traditional medical services. The disability community and the broader provider stakeholder community are concerned that ICOs will use more restrictive Medicare guidelines in provision of LTSS. No ICO should be provided a contract if it fails to outline how the capitated model will be used to develop prevention strategies for dual eligibles they serve. This includes the role durable medical equipment, peer services and other community-based, non-medical interventions will play in the overall strategy of the ICO to improve healthcare outcomes for dual eligibles in a more cost-effective manner.

Principle 6: Consumer Voice

The consumer voice must be incorporated into the design, implementation and monitoring of the program, and individual consumer rights must be protected.

One of the weakest components of the MOU is in the area of consumer voice. The requirement that ICOs develop consumer advisory boards is a positive step, but it alone is inadequate to ensure a strong role for consumers. As communicated consistently with both EOHHS and CMS, the success of the Demonstration depends on transparency across all ICOs with robust oversight and involvement of the disability community. Unfortunately the MOU, as with the RFR put forward by EOHHS, does not provide a comprehensive strategy for involvement of the disability community in the project. DAAHR urges CMS and EOHHS to work with the disability community to develop a comprehensive plan that will contain a clear role for the disability community as a liaison for dual eligibles with the state and ICOs. The planned stakeholder meeting for September 21 may help advance this goal. Further specific DAAHR recommendations on consumer voice follow.

Readiness reviews

DAAHR applauds EOHHS for including duals in the review of potential ICO RFR responses. However, we ask that at least some of the persons appointed to any future review bodies be members of or recommended by organized advocates for persons with disabilities. We also specifically request that EOHHS and CMS continue to include dual eligible persons in the development and implementation of the ICO readiness reviews. An initiative solely for people with disabilities cannot have this voice absent from critical activities to be undertaken to implement the project.

External oversight and consumer protection entity

Ongoing external oversight of ICOs both within and beyond the duration of the Demonstration is necessary both for the success of the Demonstration and the ongoing support of the disability community. DAAHR Is developing the key components that such an entity will have, with its aim being to advance the demonstration project, working with all stakeholders to improve healthcare access and outcomes for dual eligibles. While having an oversight and ombudsman role, the primary purpose of these responsibilities will be to work with the state, CMS, ICOs, providers and dual eligibles to improve the new healthcare delivery system moving forward. In addition, the entity will provide ongoing education and outreach to dual eligibles as well as training for ICOs and the broader stakeholder community as needed to promote excellence in the new system. Financing in part for this entity could come from any surplus profit that the ICOs make through the Demonstration.

Principle 7: Financing Mechanisms

Payments must reward increased quality of health outcomes rather than reduction in costs, and any savings must be shared in order to support enhanced services.

Prior to discussing specifics of the financing model, DAAHR first expresses its strong opposition to forced savings requirements put forward by CMS. Emphasis on savings at the start of a project designed to provide services to thousands of people with complex healthcare and LTSS needs and very thin margins of health will not succeed. DAAHR and the broader disability community in Massachusetts have for the past year and a half worked in good faith with EOHHS in the understanding that cost savings would not be sought in the first year nor would cost savings be the primary focus of the project. DAAHR recognizes the realities of the current fiscal crisis and the resulting call for innovative and effective methods of improving the delivery of healthcare. We embrace this and believe the ideas put forward by DAAHR have the potential to achieve savings long term without undermining the healthcare provided to dual eligibles. But expecting savings at the start is unrealistic, a point many ICOs and providers have shared with us as well. Please consider:

A 45-year-old woman with quadriplegia may require more PCA hours as she ages as a result of decreased ability to carry out ADLs, need more personalized wheelchair seating solutions to prevent decubitus ulcers and more professional and peer supports to prevent depression.

Forced savings shows a lack of understanding of the population to be served. While innovative and integrated care has the potential to better use healthcare dollars more effectively, it cannot reliably reduce the cost of care for the woman in the above example. Required savings will place pressure on capitated ICOs to cut expenditures, and without sufficient protections, there will be great risk of LTSS dollars being diverted away from supporting this woman's community-based

needs toward traditional and often more expensive medical care. Not only would the reduction of community and person-centered services lead to a reduction in this woman's quality of life, it likely would lead to her unnecessary institutionalization, causing healthcare costs to spike from perhaps $70,000 a year to well over $100,000. DAAHR cannot advocate for enrollment into a system that is being so significantly driven by a cost-savings imperative right from the opening bell.

With respect to the financing and risk structure set out in the MOU, we believe it is grossly inadequate and raises great concerns for disability advocates about the potential success of the Demonstration project. As written, as we understand it, there is a disincentive for ICOs to care for people with the highest medical and LTSS needs, while there also may be a windfall for ICOs with high percentages of dual eligibles with lower medical and LTSS needs. Specifically:

1. Rates are preset and are based only on the expected expense of the population with little or no LTSS needs and thus are mainly determined by the Medicare risk-adjustment system with very little Medicaid contribution to the premium prior to the ICO doing an initial evaluation with a dual eligible. This works for ICOs where the lion's share of their enrollees has little or no LTSS needs. While it is very worrisome for ICOs and their enrollees with a disproportionate enrollment of high-LTSS members, it will be a disaster for any ICO (and their enrollees!) that is new to providing care and services for individuals with the highest LTSS needs. The disparity between "fixed LTSS expense" and the Medicaid premium to cover those expenses even for a month will be significantly destabilizing. For ICOs enrolling a disproportionate number of beneficiaries with moderate or high LTSS needs, CMS and the state must adopt the existing Senior Care Options policy that allows an LTSS assessment prior to enrollment to determine the level of Medicaid premium that will be in effect on day one of enrollment.

2. The risk corridors set out in the MOU could lead to gouging by some ICOs and reduced LTSS for dual eligibles. In particular, the MOU fails to clearly delineate the reimbursement rates for dual eligibles needing LTSS between $500 and $700 or $800 per month and those dual eligibles needing LTSS between $800 and $5000 + per month. Under the Medicaid capitation rates set out by the MOU, ICOs enrolling dual eligibles who average between $500 and $1000 PMPM of LTSS services will reap unearned windfall profits. Conversely, ICOs that have the overwhelming majority of their enrollees with LTSS needs that average $4800 PMPM (where average PCA use is about 70 hours per enrollee per week) will suffer catastrophic losses, and thus have incentives to reduce services that would pose great risk to the most vulnerable beneficiaries.

It is therefore essential for CMS and the state to create either a reinsurance mechanism or a C4and C5 Medicaid rate cells— or both— to appropriately address these concerns and insure that the LTSS needs of the 20% of dual eligibles driving 70% of the cost are met.

3. DAAHR has long been concerned about the very real possibility of profiteering by ICOs seeking to use the project as a means of maximizing profits at the expense of services to consumers. One only need to follow the Wall Street Journal to see how the insurance industry views the project. DAAHR urges CMS to hold ICOs to a profit margin of 2% to 3% of their premium surplus with the rest of the profit returning back to EOHHS to help support the ombudsperson role and oversight by an external consumer-run entity.

4. A further protection for well-meaning ICOs and their enrollees would be to set capitation rates to ensure payment for truly patient-centered care. Shortly into the Demonstration, if not before, payments should be adjusted to reflect:

- The average amount of time each type of provider should spend with each enrollee to provide person-centered care;
- Reasonable caseloads for providers;
- Coverage of collateral contacts;
- Coverage of time spent to do care coordination and meaningfully participate in team meetings;
- Coverage of time spent to research best practices and education;
- Coverage of time spent in documentation of the enrollee's needs and progress (or lack thereof); and
- Payment of a living wage with benefits to service providers such as PCAs and peer-certified specialists.

We are concerned that without focusing on the components of adequate reimbursement rates to deliver person-centered care, ICOs will reflect our worst experiences with managed care: overworked providers with huge caseloads and little time to hear what their patients are telling them and even less time to do the care coordination, research, and dissemination of best practices that will ultimately control healthcare costs and enhance enrollee quality of life. We also are concerned that healthcare workers, especially those currently without status in the industry, are compensated at a level that they feel their work is valued and at a rate that enables them to be present for enrollees rather than distracted by worries about their own financial health.

Principle 8: Quality Measurement

Consumer perspectives must be central to the assessment of services provided by the ICO.

As with the financing mechanisms, the quality metrics section of the MOU is distressing. The emphasis of the quality measures is on narrow medical-care-based measures of NCQA, CAHPS, HEDIS and the like. It was the understanding of DAAHR that one goal of the project was to develop quality metrics appropriate for the populations participating in the project, particularly people with complex medical and LTSS needs.

DAAHR urges CMS and EOHHS to develop a clear strategy and guidelines for ICOs to develop quality metrics to reflect contemporary understandings of disability as a social, environmental and personal construct. The quality metrics currently contained within the MOU place the locus of disability on the individual and therefore are not valid indicators of the actual health of the individual. Quality-of-life along with other social determinants must be included in measuring and be given very significant weight.

Complementary circuit breakers also must be established. These would be measures of LTSS use that would trigger state intervention, up to revocation of contracts, if there was demonstrated, measurable reduction in use of LTSS by an ICO's enrollees.

Summary

As stated earlier, the disability community in Massachusetts remains supportive of the Demonstration Project's goals and are pleased with many aspects of what has been advanced. But as has been consistently expressed, we are requesting that EOHHS and CMS both slow down the process and reduce the scale of initial project rollout in order to give the Demonstration a fair opportunity to succeed. There are a number protections put forward in this letter and in the previous response to the EOHHS RFR that have yet to be addressed. DAAHR urges CMS and EOHHS to respond to the specific concerns outlined in this letter and the previous letter sent to EOHHS in response to the RFR in our mutual goal to move the Demonstration project forward in a sustainable manner that will not jeopardize the health of enrollees.

Thank you for your ongoing, thoughtful consideration of DAAHR's concerns.

Sincerely,

Dennis G. Heaphy co-chair Bill Henning co-chair