MassHealth 1115 Waiver Hearing Meeting with MCAC and PPAB

Friday, June 24th, 2016
2:30 – 5:00pm
One Ashburton Place, 21st Floor, Rooms 2 & 3

MassHealth Presenters:

Dan Tsai, Assistant Secretary
Ipek Demirsoy, Director of Payment and Care Delivery
Amanda Cassel Kraft, Chief of Staff
Scott Taberner, Chief of Behavioral Health

Comments from participants:

- **David Matteodo, MABHS:** The 1115 waiver has great emphasis on behavioral health. The details about care coordination and addressing substance use disorders are also important elements of the 1115 waiver proposal as well. Consider specialized units to address ED boarding issue

- **Dan McHale, MA Hospital Association:** I too agree that the documents were well written; I look forward to the upcoming negotiations and important collaboration before the rollout of the ACO program. However, there are details within the waiver proposal that stand out as well. First, all of the models assume downside financial risk. Because of the complexity of this program, on top of the complexity of the population that MassHealth aims to serve through an ACO, we believe that upside financial risk modeling should also be included as an additional option for each of the three proposed ACO models. In addition, because there are ACOs who do treat MCO and non-MCO-attributed lives, potential ACOs should be able to participate in more than one proposed model at the same time. Also, more transparent information about how MassHealth will support safety net providers, PCC Plan benefits and copayment changes and specific financing details are needed; we want to understand in exact detail what is being submitted to CMS. Lastly, as a supporter of the hospital assessment fee, we support the plans proposed by MassHealth leadership. We look forward to working with MassHealth to ensure that this feature of the 1115 waiver gets implemented.

- **Brian Rosman, Health Care For All:** Our organization is quite happy with the 1115 waiver proposal; we believe that the goals of the document provide an important opportunity to do great good for those in need in Massachusetts. The mental health / physical health integration, combined with the integration of LTSS services is an important goal to treat the entire person. Before our written comments are submitted we have three suggestions for improvement. First, to increase ACO program transparency and oversight we suggest that MassHealth creates a committee analogous to the One Care Implementation Council. That committee should include policy makers, stakeholders (both clinical and non-clinical), state legislators and others. Second, we recommend that the ACO program's steering committee create a "real-time" public dashboard that publishes annual data on the ACO program's progress. But creating such a platform will require clear, published ACO program goals – and those goals have yet to be decided on. Third, rather than emphasizing the increase in premiums and co-pays as a way to

push members into an ACO, it's important that the messaging to ACO enrollees emphasizes the program's benefits for members. Finally, MassHealth must recognize that additional member education and navigation support will be needed in order to help members traverse this new – and confusing – landscape.

- **Rep. of Mass. Medical Society:** We strongly support the expanded coverage for substance use disorders. The Medical Society does support the proposed ACO innovation, but disagrees with elements of proposed waiver as well. MassHealth should move forward with the ACO program as described in the waiver proposal, but not at the expense of changes to PCC plan services and increasing co-payments for members. Prior to the suggested changes to the PCC plan, MassHealth should spend more time understanding how and why members choose the PCC plan, as well as the potential impact of the lock-in provision on members who receive their continuum of care through the PCC plan. Also, the ACO program is confusing for providers as well as potential members; as a rural-based primary care provider, I do not know how I will fit into the proposed ACO structure.

- **Kate Nordahl, MMPI:** It has been encouraging to see how comprehensive the stakeholder engagement process for the ACO program has been. Continuing a transparent and engaged stakeholder process will be equally important in the coming months. In order to move forward with solidifying the operational details of the ACO program, we will need access to timely financial, quality of care and access-to-services data moving forward. Also, it is great to read that some of the proposed DSRIP funding will be available to support MassHealth staff training and resources. Having well trained, well-supported MassHealth staff will help future data mining and data compilation for providers and consumers. Lastly, I would encourage MassHealth leadership to think about the impact that premium increases will have on the goal of maintaining near-universal health insurance coverage in Massachusetts. Premium increases could actually deter eligible MassHealth members from signing up in the first place. The cost of premium increases for MassHealth eligible members (who, by definition are low-income people juggling other expenses) may come at the expense of other necessities.

- **Pat Edraos, Mass League:** It will be helpful to have more data on the proposed safety net provider funding, as well as projected impact data of the student health program and proposed premium assistance for employer-sponsored insurance. Also, clarity around how the proposed certified community partners and LTSS services will interact with work led by the Department of Public Health, for example the Prevention and Wellness Trust Fund. Leadership within the organization is currently looking at the planning grant towards creating certified community health agencies. There are elements of the proposed certified community health agency planning activities that may make more sense under the ACO program instead. As a separate point, I am concerned about the use of ICB grant funding in the future. Lastly, there are members who have a concern with technical assistance and education being introduced so late in the ACO program launch process. It may be helpful to introduce more upfront technical support to help smaller providers and community health centers prepare for all of the necessary reporting pieces of the ACO program.

- **Al Norman, Massachusetts Home Care Association:** There are many thoughtful aspects of the proposed 1115 waiver proposal. However, we are concerned that the post-acute care elements appear to be less thought-out compared to the acute care elements of the proposal. Our organization agrees with many of the elements within the waiver proposal, such as the aim of

integrated care for complex members, as well as the idea of a certified community partner and the proposed use of DSRIP funding. As a suggestion, MassHealth should consider requiring all participating ACOs to demonstrate that they are building new connections based on the existing LTSS structure instead of creating redundant, duplicative systems. Also, please add in stronger language for an independent LTSS coordinator into the proposal; the current language is too weak. Like others have stated, we are also concerned about the prescribed lock-in periods for members once they are enrolled with an ACO provider; members tend to stay with a plan that they like, but that may take moving from one plan to another to find that information out. We are also concerned about potentially penalizing low-income MassHealth members for enrolling into the wrong ACO provider plan. Members need incentives, not punishment.

- **Joe Finn, MHSA:** The 1115 waiver proposal does not include language specifically addressing healthcare for the homeless and housing for this vulnerable population. In light of the recent CMS Bulletin on housing-related services and activities, that document made great suggestions about ways to tie Medicaid resources into state-level housing collaborative activites to address the housing needs for homeless members. As a final suggestion, please include more language drawn from the CMS Bulletin on housing and descriptions of other, non-CSPECH innovative recovery-based housing programs into the proposal. There is a lot of great work going on outside the successful CSPECH program going on in Massachusetts, and our proposal should capture more of that innovation for homeless members.

- **Larry Gottlieb, Eliot Community Human Services:** Like others, I too agree with the goals of the waiver proposal and many of the included details in this comprehensive document. However, the proposal provides little detail around housing supportive services. As a suggestion, it may be helpful to review the 2015 CMS bulletin on supportive housing services listed to see how those services can be included into the broader ACO proposal.

- **Gloria Craven:** Previous legislation – specifically, language from Chapter 224, Section 280 – says that EOHHS must seek a federal waiver to permit Medicare to participate in ACOs. The waiver proposal should include more explicit references to how the proposed ACO program will interface with Medicare. It is important, especially for members who have end-stage renal disease.

- **Kelly and Lisa, Oral Health Integration Project:** Oral health disease is one of the most chronic diseases in the state. We believe that the ACO program has a unique opportunity to achieve health equity. New evidence suggests that dental care will lower overall healthcare costs for patients with chronic diseases. We urge you to include oral health throughout the delivery system restructuring; oral health integration should start in Year 1. We are excited to see that the updated quality measure slate will include an oral health quality metric; we hope that MassHealth will include stakeholder input and support for that metric in accordance with national efforts to develop metrics. In its current state, there is very little incentive for care coordination by dental care providers. MassHealth leadership should consider including a pilot program to test dental health integration into the ACO program using alternative payment methods that incentivize good patient outcomes and better oral health integration. Also, we ask that a portion of DSRIP funding be allocated to oral health professional trainings, IT support and other areas.

- **Bill Henning, BCIL/ DAAHR:** I appreciate the waiver proposal's commitment to improving accessibility and accommodations for people with disabilities. We agree with others around the importance of an Implementation Council –like committee for the ACO program. Please also note that the cost of care is going to be very important for members that have several costs that they need to balance; incremental changes in cost truly do matter. Disincentives may deter people from getting needed care. We also support the idea of an independent, conflict-free LTSS Coordinator.

- **Peter Doliber, Alliance of MA YMCA:** Although we generally agree with the waiver proposal, we feel that there should be more detail about the support services and how they will interact with ACOs. We recommend creating a community responsive hub that connects to a local agency offering services that impact the social determinants of health for the ACO program.

- **Two unidentified meeting participants, Center for Health Policy Innovation, Harvard Law School:** As a provider suggestion, we wanted to highlight the importance of working with food nutrition providers to provide medically-tailored meals to chronically ill patients. We believe that these meal providers are an important part of lowering patient costs and achieving the goals of the Triple Aim. In addition, we are asking for more clarity on the flexible spending requirements (for example, what does MassHealth mean by the "cost-effective" flexible spending requirements mentioned in the waiver proposal). We hope to understand the relationship between programs such as SNAP and how they will work with an ACO, especially if there are gaps in services for ACO members.

- **Greg Watts, Steward Healthcare:** We appreciate all of the current detail and work that has gone into the waiver proposal. We have two specific points to raise to MassHealth leadership. First, for Model B, the waiver directs that ACOs will work with the MBHP to provide behavioral health services; we are hoping that MassHealth will provide more clarity on how an ACO within this model will reconcile end-of-year costs with MBHP. Second, for Models A and B, we would like more clarity on the behavioral health and total cost of care triggers.

- **Roxanne Reddington-Wilde, ABCD:** My comments are specifically about referrals to social services. MassHealth has made a really great effort to think about, understand and address the health needs for those who use LTSS, as well as those who use behavioral health services and those with challenging health needs. It is also important to think about the importance of referrals for others who do not have the aforementioned needs, but who could benefit from social services. It is important to ensure that providers within an ACO do not limit service referrals only to those with a chronic disease. It is also important that PCPs know who to refer the less-severe MassHealth members to, like a community health worker who has an understanding of the holistic need of an individual or family. That community health worker can then make the referrals to social services that best fits the needs of that individual or family. ABCD and others are currently partnering to create a social services hub; we hope that instead of an ACO referring members to an individual organization, an ACO would make a social service recommendation to the hub instead. Through the idea of a social services hub, both large and small social service organizations will be able to interact with ACO members and still thrive. We would like to be part of the thinking process around the design of a social services hub for ACOs to connect to in the future.

- **Amy Coolidge, Pine Street Inn:** I am encouraged by the inclusion of CSPECH in the supportive services that will be provided for homeless MassHealth members who will be in an ACO. At the Pine Street in, we know that social services like those offered through the CSPECH program are valuable to the treatment of homeless members, and we are excited to see that MassHealth leadership wants to address the social determinants of health through care for these members. We are also encouraged by the talk around the inclusion of the proposed community partners, and, moving forward, we offer our knowledge and experience to help MassHealth leadership think through how those partnerships will work in the future.

- **Deborah Delman, The Transformation Center:** There are several exciting opportunities to partner with community experts inside the waiver proposal. However, it is important to note that without the inclusion of peer specialists, recovery learning communities and other resources that are focused on recovery – combined with other mental health services and supports – the ACO program will become very reliant upon drug prescriptions to care for people with mental health needs in the ACO program. There are many healthcare providers that do not understand the value of partnering with providers within the recovery model. We know that MassHealth is working with organizations that advise DMH, and, in combination with the lessons learned from the One Care program, we hope that the information provided will support the success in integrated care. We believe that DSRIP funding provides a unique opportunity for providers to understand the value of the recovery model and how that model impacts health care delivery.

- **Unidentified meeting participant:** We have worked with others around One Care privacy and information sharing. We hope that ACOs will be required to implement the same privacy principles and best practices that the One Care program developed. There are very real benefits and concerns when considering the value of those privacy principles for people with mental challenges seeking medical care.