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1199SEIU

United Healthcare Workers East

Independent Long Term Supports and Services Coordinator

Utilizing and mirroring language from MassHealth's recent One Care Demonstration Proposal that establishes an ILTSS Coordinator role:

Home and community-based long term support and services (LTSS) are critical to enabling people to live independently and to remain in their homes and communities. It is essential that MassHealth ACO care teams have a designated resource with expertise in understanding different kinds of LTSS needs and the resources available in the community to address them.

Each MassHealth ACO applying for DSRIP incentive payments will contract with an independent, qualified LTSS Coordinator from a community based organization (CBO) such as an Independent Living Center (ILC), a Recovery Learning Community (RLC), an Aging Services Access Point (ASAP), Deaf and Hard of Hearing Independent Living Services programs, The ARC, or other key organizations expert in working with people with disabilities. MassHealth ACOs will contract with these CBOs to provide staff specifically trained to serve as independent LTSS Coordinators for their enrollees.

MassHealth ACOs will be required to maintain contractual agreements with CBOs that have the capacity and expertise to provide LTSS coordinators and to oversee the evaluation, assessment, and plan of care functions to assure that services and supports are delivered to meet the enrollees' needs and achieve intended outcomes. The MassHealth ACO shall not have a direct or indirect financial ownership interest in an entity which provides an LTSS Coordinator.

The independent LTSS Coordinator shall be a full member of the care team, serving at the discretion of the ACO enrollee. For enrollees without LTSS needs, the LTSS Coordinator need not continue on the care team; however, the ACO must make an LTSS Coordinator available at any time at the request of the enrollee, and in the event of any contemplated admission to a nursing facility, psychiatric hospital, or other institution.

Following the initial assessment, the LTSS Coordinator will work with the enrollee to address his or her ongoing LTSS needs, and to incorporate community based services and other available community resources appropriate into the enrollee's individualized care plan. The LTSS Coordinator will connect the enrollee to services - drawing on the provider network and other resources of the ACO, as well as on community-based resources - and assist providers in securing any authorizations or service orders necessary to begin services.

MassHealth ACOs will be responsible for ensuring that LTSS Coordinators meet specific qualifications, including necessary (1) training, (2) experience and (3) expertise in working with people with disabilities and/or elders in need of independent living supports and LTSS, and a thorough knowledge of the home and community-based service system. ACOs will need to verify that CBOs providing LTSS Coordinators are not providers of other services covered by the Demonstration or, in situations where this cannot be avoided, that CBOs have the necessary firewalls in place to prevent self-interested referrals.



July 12, 2016

Assistant Secretary Daniel Tsai
EOHHS Office of Medicaid
One Ashburton Place - 11th Floor
Boston, MA 02108
Attention: 1115 Demonstration Comments

Dear Assistant Secretary Tsai:

On behalf of the 52,000 healthcare workers of 1199SEIU we write to respectfully share our comments, key priorities and specific recommendations for MassHealth reform and on the state's request to amend and extend the MassHealth Section 1115 Waiver Demonstration.

We are fundamentally supportive of the proposed efforts to incentivize delivery system reform. We believe in the real potential for Accountable Care Organizations and the shared savings/shared risk payment structures to provide essential cost savings for the Commonwealth, to improve integrated care for consumers, and to offer quality care incentives for Massachusetts providers. The state's extension request will certainly help to ensure that the 1115 Waiver Demonstration advances state and national health care reform efforts, incentivizes reform, and furthers cost containment. That said, we do have questions and some concerns about certain aspects of the proposal as outlined below.

Workforce Engagement & Training

The Commonwealth has made commendable efforts to bring diverse stakeholders together through a collaborative and transparent dialogue in order to achieve the reforms necessary to ensure cost sustainability, and to deliver better integrated and higher quality healthcare. These efforts are compatible with our own organization's commitment to ensuring that health care workers are at the center of any reform efforts and that special attention is paid to the critical role of acute care, nursing home and home care workers. By ensuring true workforce engagement, healthcare delivery reform will benefit from listening to experienced caregiver voices.

Accordingly, we greatly appreciate the inclusion of the proposed Workforce Development Grant Program (Section 5.5.1.4) and the dedication of DSRIP funds for that purpose under the statewide investment funding stream. We also thank MassHealth for the attention paid throughout the Demonstration to workforce capacity and the multiple clearly-stated commitments to use DSRIP funds to assist Accountable Care Organizations (ACOs) and their Certified Community Partners (CCPs) with their workforce capacity building efforts.

With respect to the Workforce Development Grant Program, we respectfully suggest a few improvements: (1) The required "workforce engagement plans" should include a requirement that ACOs offer a detailed plan for targeting the incumbent workforce; (2) MassHealth ACOs should be required to include a plan for including the incumbent workforce in a cooperative effort to improve care quality care; and (3) Any labor organizations representing the ACOs' workforces should be mandatory and full members of an ACOs grant implement team. In applying for a grant, the ACOs should also be required to include at least a letter of support from any and all labor representatives of

the ACO's workforce. Finally, we request that a fixed annual dollar amount be formally dedicated to the proposed Workforce Development Grant Program in the Waiver itself. Without such dedicated funding, we are concerned that the Program will unnecessarily compete with the other laudable initiatives included in the "statewide investments funding stream" section of the waiver.

Staffing Impact Report

MassHealth Accountable Care Organizations (ACOs) and the Commonwealth will rely on a skilled and experienced healthcare workforce that is fairly compensated to implement the planned reforms. Restructuring will also have a significant disruptive impact on the entire health care workforce. Therefore, the state must fully understand the structural delivery system changes contemplated by the ACOs and must also collect the data needed to better understand the impact of such reforms on the Commonwealth's current health care workforce.

It is our understanding that Massachusetts hospitals currently report almost no data about how they are building, compensating or structuring their workforces. The new ACOs should be required to submit all workforce data necessary for MassHealth to produce an annual *Staffing Impact Report*. These data and the report should at least detail any new hiring - including the use of part-time, temporary, per diem and subcontracted staff - as well as redeployment, retraining, or other significant workforce changes. MassHealth, in collaboration with the Center for Health Information and Analysis and/or outside consultants as needed, should then publish a statewide annual report aggregating these data.

Safety Net Care Pool

Since the renewal of the Commonwealth's current 1115 Waiver, MassHealth has fully committed to a substantial redesign of our Safety Net Care Pool (SNCP) and the restructuring of payments to safety net providers under the SNCP. Consistent with this commitment, the amendments proposed to the new waiver carefully and creatively align the restructured payments with the new reform outcome measures for the ACOs and the DSRIP program. At the same time, the Commonwealth seeks to use the SNCP to support cost sharing subsidies for the ConnectorCare program and to better support care for the uninsured provided by Cambridge Health Alliance and other providers. We fully support each of the underlying goals of the proposed redesign.

However, the draft request lacks sufficient detail around several aspects of the proposed SNCP redesign. First, MassHealth should provide more details on the proposed value-based performance standards that are to be imposed on the safety net providers that will receive SNCP payments. While we recognize that overall funding levels remain subject to negotiation of a final 1115 waiver extension, we nevertheless believe that the safety net providers deserve more precise estimates of the amount of funding they can expect under the new SNCP in each of the waiver years. Second, stakeholders also need more information around the methodology behind the proposal to expand from seven to eleven the pool of providers eligible to receive SNCP payment. Finally, we'd appreciate additional details and financing estimates around the recommended "glide path" to reduce such payments over the five-year waiver term and the vision for "Year Six" (post-waiver).

ACO Design & Fair Payments

Offering three distinct models for new ACOs is a creative and laudable approach to moving lead providers with a broad range of current capabilities from the fee-for-service system to accountable, total cost of care models. However, the complexities underlying the contemplated integrated care models deserve additional explanations.

In particular, while the roles of Medicaid Managed Care Organizations (MCOs) are outlined in the request, stakeholders need additional information about these roles as well as pertinent to the inclusion of the Mass Behavioral Health Partnership as a mandated ACO partner. We request additional details around the planned structures, financing, and payments anticipated under the new model designs. Additionally, more transparency is needed around the planned use of DSRIP incentive payments to support both the ACOs and their Certified Community Partners. Finally, we also request more information around both current MassHealth claims data and the planned methodology for development of total cost of care payment rates.

PCA Program & LTSS Care Integration

The state must continue to ensure the availability of a high-quality workforce prepared to meet the anticipated and growing long term supports and service (LTSS) needs of MassHealth members. As representatives for more than 35,000 personal care attendants serving Massachusetts' disabled populations, 1199SEIU has a strong interest in protecting the PCA program as well as in ensuring that independent, community-based LTSS services are well-integrated.

For these reasons, we appreciate the recognition of the particularly critical role of Personal Care Attendant (PCA) services for members. Under the proposed waiver provisions, an ACO enrollee who chooses to self-direct PCA services will be the employer of the PCA and will be responsible for hiring, training, scheduling and firing workers. MassHealth ACOs will also be required to contract with Personal Care Management (PCM) agencies which will provide skills training to enrollees who choose to self-direct their PCA services. The ACO will retain authority for authorizing all PCA services while the ACO's community partner will play an essential role on the member's care team, assisting in facilitating service authorizations and connecting enrollees to a PCM and a Fiscal Intermediary (FI). Even as we continue to advocate for inclusion of an "Independent LTSS Coordinator" on ACO care teams, we fully support these proposals and believe they will help preserve the essential elements of the current program.

We also greatly appreciate the inclusion of a DSRIP "flexible services" account incentivizing ACOs to use a range of other services as substitutions for utilizing high-cost institutional and other traditional services. With this state support, PCAs working for ACO enrollees could and should be utilized creatively to meet the expected high-demand for community-based LTSS. These dollars could and should also be utilized to offer career ladder opportunities for PCAs. With the explicit permission and cooperation of the enrollee, MassHealth ACOs ought to be encouraged to utilize PCAs to help facilitate more effective communication between the enrollee and their providers and to assist in implementing care plans (including through nutrition counseling, medication administration, and ongoing monitoring of selected mental and physical health metrics).

Thank you for the opportunity to engage in this on-going dialogue. As a union of health care workers, 1199SEIU is fully committed to ensuring quality, accessible health care for all. We intend to remain strong advocates for ensuring the continued success of the Medicaid/MassHealth program through careful reform and fair Medicaid rate payments to providers. We look forward to working with the Commonwealth, the Centers for Medicare & Medicaid Services, and all stakeholders to ensure the success of the state's new 1115 Waiver Program.

Sincerely,



Tyrék D. Lee, Sr.; Executive Vice President



July 15, 2016

Daniel Tsai
 Assistant Secretary for MassHealth
 Executive Office of Health and Human Services
 One Ashburton Place, 11th floor
 Boston, MA 02108

Submitted via email to MassHealth.Innovations@state.ma.us

Re: Comments on 1115 Medicaid Demonstration Extension Request

Dear Assistant Secretary Tsai,

On behalf of the undersigned organizations, all dedicated to improving the health of Massachusetts residents, thank you for the opportunity to provide comments on MassHealth's Section 1115 Demonstration Project Amendment and Extension Request. This demonstration proposal is an opportunity to restructure the delivery system to focus on improving quality of care and promoting the health of MassHealth members while ensuring the sustainability of the MassHealth program. Accountable Care Organizations (ACOs) open the door to a MassHealth system that treats a member as a whole person, rather than as disconnected symptoms.

We appreciate MassHealth's thoughtful and open stakeholder engagement process throughout the development of this waiver proposal, and look forward to continuing to work with you to ensure that implementation of the demonstration improves access to and quality of care for MassHealth members. Implementing ACOs will be a challenging process that demands member and stakeholder involvement, clear consumer protections, and robust oversight.

We have included below comments on specific aspects of the waiver proposal. Many of the undersigned organizations have already or plan to also submit written comments for your consideration.

Benefits and Cost-Sharing

In order to make the ACO options appealing, members need an understandable, unbiased explanation of the advantages and risks of the available models, and should have the opportunity to make their own choices about what is best for them and their health.

We support proposals intended to increase access to services for MassHealth members, including:

- Eliminating copays for MassHealth members with income at or below 50% FPL;
- Assuring the sustainability of the CommonHealth program for working disabled adults age 65 and older;
- Providing continuous eligibility through the duration of the Student Health Insurance Plan (SHIP) period for enrollees receiving Premium Assistance for SHIPs;
- Ensuring the sustainability and affordability of the ConnectorCare program; and
- Expanding MassHealth substance use disorders (SUD) treatment services.

However, we strongly oppose the following proposed changes that would restrict access to care:

- Eliminating coverage of chiropractic services, eyeglasses, hearing aids, orthotics or other state plan services in the Primary Care Clinician (PCC) plan;
- Increasing copays for members enrolled in the PCC plan;
- Expanding the list of services to which copays apply;
- Potentially increasing premiums for enrollees with incomes at or above 150% FPL; and
- Imposing 12-month Managed Care Organization (MCO) lock-in periods.

PCC Plan Changes

We understand that MassHealth is proposing changes to the PCC Plan in order to incentive members to enroll in an MCO and/or one of the new ACO models. However, the proposed policies will impose barriers to care for members remaining in the PCC Plan. MassHealth should not penalize members who make the “wrong” choice. We urge you to rescind the proposal to reduce benefits and increase copays for PCC Plan members.

MassHealth MCOs provide good quality care and are the right choice for many members, but an MCO is not the right choice for everyone. Most MassHealth MCOs’ provider networks exclude some providers who are still available in the PCC Plan. The PCC Plan has been a lifeline for medically complex patients, including people with disabilities, when faced with narrow provider networks and other restrictions in the MassHealth MCOs that may not meet their needs. In fact, PCC Plan membership consists of a higher percentage of people with disabilities (17%) than MCO membership (8%).¹

In addition, the PCC Plan has initiated many innovative programs for people with complex medical needs including:

- A program for housing support services for chronically ill and homeless individuals that has now been extended to the MCOs (CSPECH);
- Recovery peer navigators for repeated users of detox services through a CMS Health Innovations Award; and
- An Integrated Care Management program for members with complex medical, mental health and/or substance use disorders.

¹ Massachusetts Medicaid Policy Institute, “MassHealth: The Basics (June 2016).” Available at: <http://www.bluecrossfoundation.org/publication/updated-masshealth-basics-june-2016>.

For medically complex members, switching to an MCO may disrupt their ability to see the providers they know and trust. For example, under the proposed change, a disabled child may have to forego eyeglasses to see the medical specialists the child needs given the limited access to certain specialty hospitals in the MCOs compared to the PCC Plan. Members should not have to choose between seeing their preferred providers and having access to the full range of MassHealth benefits.

Further, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a mandatory Medicaid service for children and youth under age 21.² EPSDT includes all medically necessary Medicaid services regardless of what is in the state plan, and provides comprehensive coverage for dental, vision, hearing, and medical screenings and treatment. Children enrolled in all types of managed care, including PCC Plans, “are entitled to the same EPSDT benefits they would have in a fee for service Medicaid delivery system.”³ We believe the proposed PCC Plan benefit cuts violate the Federal EPSDT requirement, and again urge MassHealth not to implement these changes.

MCO Lock-in

While we urge MassHealth to reconsider the proposed 12-month MCO lock-in period, we acknowledge that implementation of this policy is set to occur on October 2016 regardless of the status of the demonstration proposal. Any such policy should include broad exceptions to enable members to change MCOs and access the care they need. In addition, as most MassHealth enrollment volatility, or “churn”, occurs due to eligibility changes, rather than voluntary plan changes, we believe that policies to reduce churn should address the primary cause. MassHealth should consider policy options such as 12-month continuous eligibility, rather than an MCO lock-in policy, to reduce churn.

Appeals and Grievances

Because an individual’s clinicians may have a direct financial relationship with the ACO and its participating providers, ACO grievance and appeals processes should be robust and designed to address new issues that may arise in this context. The introduction of financial incentives makes it even more important that MassHealth members are fully informed of their treatment options and the reasons a provider is recommending one option over another. Members who are concerned about a provider’s decision should have access to a process to seek a second opinion, outside of the ACO network, that does not incur additional cost-sharing.

We strongly support MassHealth’s proposal that members in all ACO models will have access to an ACO-specific grievance process, as well as existing appeals and grievance procedures for eligibility and coverage determinations. We also support the inclusion of an external ombudsperson resource to help resolve members’ problems or concerns. We request more details on the ACO-specific grievance process and the scope of responsibilities of the external ombudsperson. We encourage MassHealth to consider the One Care ombudsperson, with certain improvements, including the ability to track and report systemic issues, and expanded capacity, as a model.

Network Adequacy

We understand that MassHealth members enrolled in an MCO will have access to the full range of providers in the MCO’s network, and appreciate MassHealth’s expressed commitment to ensuring that members have timely access to high quality primary care, specialists, long-term services and supports and behavioral health providers regardless of the delivery model they choose.

² 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

³ Centers for Medicare and Medicaid Services, EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, June 2014. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

MassHealth should establish and make publicly and easily available its network adequacy standards for MCOs, the PCC Plan and ACOs, including time and distance standards. The standards should be developed in consultation with consumers, advocates and stakeholders. In addition, all ACOs should have continuity of care provisions and parameters for contracting with providers outside of the ACO. Finally, we encourage assessment of network adequacy through direct measures such as so-called “secret shopper” surveys which have been used effectively in Medicare and other state Medicaid programs to reproduce the member experience.

Member Education and Assistance

We appreciate that MassHealth will require ACOs and MCOs to make information about their coverage and care options readily accessible and that MassHealth will enhance its own customer service, website, publications, and community collaborations. The proposed ACO initiative will make the system more complicated for members. With the changes, the simple act of choosing one’s primary care setting will bring with it a host of important consequences. Particularly if the MCO enrollment restrictions are put into place, members will need extensive guidance to determine what plan best meets their needs.

We urge MassHealth to:

- Invest in member education and navigation assistance, including implementation of an enhanced community-based public education campaign for members, as well as a major expansion of in-person enrollment assistance;
- Ensure the ombudsperson, or another entity such as the Office of Patient Protection, has a role in arbitrating ACO members’ appeals and grievances for coverage as well as ACO-specific treatment or referral decisions, while identifying and addressing systemic issues; and
- Translate written materials into all prevalent languages.

The need is for tailored, personalized, linguistically and culturally competent assistance both pre- and post-enrollment. Members should have access to individual assistance with choosing a plan and understanding the available coverage and care options.

Access to Services and Care Delivery

We strongly support MassHealth’s goal to promote member-driven, integrated, coordinated care that includes physical health, behavioral health, LTSS, and social services. As set out below, we also believe integrating oral health care will lower costs and improve health outcomes. In the end, successful implementation is key to ensuring meaningful care delivery reforms that enhance health care quality and health outcomes.

Community Partners

One of the unique features of MassHealth’s proposal is the strong emphasis on ACOs’ collaboration with community-based providers. Most of these organizations already serve a high volume of MassHealth members and play a significant role in care coordination and connecting members with non-medical services. We support MassHealth’s proposal to connect ACOs with community-based behavioral health and LTSS providers, who can be certified as Community Partners (CPs), including providing direct DSRIP funding to support the capacity-building of CPs. CPs can use these resources to build out the required capacity to work with ACOs in supporting the integration of behavioral health, LTSS and health-related social services. We request more information about the certification criteria which CPs must meet, including cost and quality goals and checks and balances to guard against excessive self-referral.

Long-Term Services and Supports

We support MassHealth’s plan to phase in integration of LTSS into ACOs, and the utilization of LTSS CPs to offer care coordination and LTSS services. MassHealth should ensure that ACOs rely on community-based providers’ expertise in serving people with disabilities and not over-medicalize the LTSS needs of members.

We appreciate that MassHealth envisions an interdisciplinary care team that includes a LTSS representative for members with LTSS needs. We seek clarification on this role and urge MassHealth to ensure the LTSS representative truly has an independent voice in the care team and offers a level of coordination similar to that provided by the LTSS Coordinator in One Care or the Senior Care Options' Geriatric Support Services Coordinator. In addition, family caregivers are often an important part of an individual's care team, and, with permission and direction from the enrollee, should be consulted and supported in LTSS planning and delivery.

Behavioral Health

We applaud MassHealth's goal of integrating physical health and behavioral health. For many consumers with a behavioral health diagnosis, their behavioral health clinician is their primary point of contact with the health care system. As such, we are encouraged that the waiver plan establishes a strong role for Behavioral Health CPs to manage care coordination, with a goal of fostering communication between an individual's primary care provider and the treatment community, while respecting members' privacy and preferences. The waiver proposal also requires Behavioral Health (BH) Community Partners to either be a Community Service Agency (CSA) or have contracts with CSAs to provide behavioral health services to children. We appreciate that MassHealth acknowledges the importance of CBHI services for children and youth delivered through CSAs, and we urge you to ensure that families maintain the ability to also choose behavioral health providers outside the CSAs who can provide the full range of services needed.

In addition, we are encouraged by MassHealth's strong proposal to provide enhanced substance use disorders (SUD) services, including expansion of residential care and recovery supports. We also support MassHealth's exploration of preventive models such as Screening, Brief Intervention and Referral to Treatment (SBIRT), and encourage MassHealth to implement these models as part of its strategy to address SUD. Productive collaboration between DPH and MassHealth will bring in more federal resources to address an overwhelming need for SUD treatment services, particularly for residents struggling with opioid addiction. We also support MassHealth's undertaking to address Emergency Department boarding and enhance diversionary levels of care to meet the needs of members within the least restrictive, most appropriate settings.

Oral Health

We are encouraged by MassHealth's plans to promote the integration of oral health with primary health care through a range of methods, such as inclusion of an oral health metric in the ACO quality measure slate and contractual expectations for ACOs. We urge MassHealth to strengthen and facilitate oral health integration in its ACO models by more clearly outlining a plan which includes phased-in dental services and targeted investments. We also urge MassHealth to shift dental service payment methodologies to incentivize high-value, evidence-based, preventative care.

Children's Health

Children and youth have specialized needs that are not adequately addressed in a system built for adults. While children make up 34% of MassHealth membership⁴, the waiver proposal does not specify how the different ACO models will address the unique needs of children. ACOs should emphasize prevention and early interventions with children and their families. Unlike most adult care models, the family plays a far more critical role in managing a child's care. Family experiences can provide a wealth of useful data and information in shaping some of the core elements of an ACO. All ACOs that serve children should have the ability to support the family and make linkages with other state agencies and with key community resources, such as schools (including Head Start programs), social services providers, state agencies and other services, such as Early Intervention.

⁴ Massachusetts Medicaid Policy Institute, "MassHealth: The Basics, June 2016." Available at: http://www.bluecrossfoundation.org/sites/default/files/download/publication/MassHealthBasics_Chartpack_FY2015_FINAL_1.pdf.

ACOs must have sufficient pediatric primary and specialty care providers for the number of children managed by the ACO. In addition, integrating oral and mental health care into the ACO's delivery and payment structure is essential, as oral and mental health issues are among the most common major chronic care conditions children and adolescents experience.

Population Health and Prevention

Social Determinants of Health

We are particularly pleased that MassHealth's proposed restructuring framework seeks to incorporate linkages to social services in an effort to address social determinants of health, including designating a portion of DSRIP funds for "flexible services." As part of ensuring meaningful ACO collaboration with social services providers, we seek to better understand how DSRIP funds will reach these providers. While DSRIP funds will clearly be directed to BH and LTSS CPs for infrastructure and care coordination, it appears that social service providers do not receive direct DSRIP funding as they are not "certified" community partners. For example, social service providers will need upfront investments in order to participate in two-way referral systems with ACOs, building on DPH's community e-Referral system being established under the state's State Innovation Model (SIM) grant and the Prevention and Wellness Trust Fund (PWTF).⁵ We recommend that MassHealth consult with DPH and incorporate lessons learned from PWTF, especially in regards to community partnerships.

In determining the criteria that must be met to pay for such flexible services, we urge MassHealth to take a broad and flexible approach to encourage ACOs to innovate around how to use DSRIP funds to address social determinants of health. One promising idea to ensure members have the broadest access to social services agencies is through a social services "hub." Such a hub can offer a single point of coordinated access to a wide range of social services which have a documented impact on health outcomes and on reducing the cost of care. A hub model could work with multiple ACOs to bridge medical and social service systems, delivering culturally and linguistically competent services, engaging multiple social services agencies, and providing access to medically beneficial, evidence-based programs in each geographic region. With any model connecting medical care to social supports, MassHealth should work to promote access to all available services, such as nutrition (e.g. SNAP and WIC), housing, income, and child care supports.

In addition to promoting community-clinical linkages, it is necessary for an ACO to look beyond its members to address the public health needs of the greater population, for example, the service area or community where the practice is located. Priorities can be determined through such mechanisms as community health needs assessments, with strong involvement from ACO enrollees and community members. By focusing on the underlying social determinants of health at the community-wide or geographic level, ACOs have an opportunity to work towards truly improving health outcomes and advancing health equity.

Community Health Workers

ACOs have the opportunity to promote public and community health by strengthening the role of community health workers (CHWs) in connecting people to care resources and promoting overall health. Including CHWs as part of health care teams has been shown to contain costs by reducing high risk patients' use of urgent and emergency room care and preventing unnecessary hospitalizations.⁶ CHWs also improve quality of care and

⁵ For additional examples of why social services organizations need upfront funding for effective and ongoing collaborations to address social determinants of health, see Bachrach, D., Bernstein, W. et al., *Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform*, Commonwealth Fund (April 2016); Guyer, J., Shaine, N. et al., *Key Themes From Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States*, Kaiser Family Foundation (April 2015).

⁶ Massachusetts Department of Public Health, "Achieving the Triple Aim: Success with Community Health Workers," May 2015. Available at: <http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/achieving-the-triple-aim.pdf>.

health outcomes by improving use of preventive services and offering chronic disease self-management support and maternal-child home visiting and perinatal support.

While ACOs will have flexibility in how to structure care teams, including CHWs, we recommend that the role of CHWs be more formally incorporated into the ACO models. MassHealth should require that ACOs demonstrate how they will integrate CHWs into multi-disciplinary teams for high risk/high need members.

Quality and Outcome Metrics

In order to assess the progress of the DSRIP program and ACO models, it is essential to establish specific quality metrics and outcome goals. We support MassHealth's priority domains for quality measurement:

- Prevention and Wellness (including sub-populations such as pediatrics, adolescents, oral, maternity);
- Reduction of Avoidable Utilization;
- Behavioral Health/Substance Use Disorders;
- Long-Term Services and Supports; and
- Member Experience.

We seek clarification of MassHealth's goals related to these quality metrics. We recommend that MassHealth:

- include a measure of reduction in health disparities, including data collection by race, ethnicity, primary language, disability status, gender, sexual orientation, gender identity and other factors;
- define avoidable utilization and track progress in that area, while also measuring under-service and underutilization;
- align LTSS measures with those used in the One Care program, adding specific measurement of growing community-based services; and
- broaden member experience metrics beyond the Consumer Assessment of Healthcare Providers and Systems (CAHPS) metrics to include patient reported outcomes measures and patient activation measures.

Collecting data on key sociodemographic factors is a critical first step to understanding key barriers to health and how those barriers are distributed across the member population, addressing risk factors that lead to poor health outcomes, appropriately targeting intervention points and strategies, and effectively managing the health of an ACO's patient population. Outcomes and other quality metrics should be stratified by social determinants of health indicators in order to appropriately target population health interventions, uncover and address health disparities, and improve how ACOs deliver care.

Monitor and Track Underutilization

Increased levels of risk for losses coupled with influence over utilization management shift the balance of incentives for providers, increasing the potential for ACOs to stint on care. ACOs should therefore be required to establish internal monitoring mechanisms for under-service in order to safeguard against potential incentives to deny or limit care, especially for members with high risk factors or multiple health conditions. MassHealth should further conduct retrospective monitoring of under-service by assessing claims data and health outcomes over time to identify patterns of variation, which should be part of ACOs' quality metrics and reporting.

Transparency, Oversight and Member Engagement

We are pleased that the waiver proposal calls for ACOs to include members in their governance boards and requires ACOs to establish Patient and Family Advisory Councils (PFACs). In order to ensure meaningful engagement, members should be formally integrated as advisors in the design and governance of ACO policies and procedures. In addition, the ACO-level PFACs must coordinate closely with the already established hospital-level PFACs.

We have two additional suggestions to strengthen the transparency and oversight of ACO implementation. First, MassHealth should establish an oversight Steering Committee modeled after the One Care Implementation Council. The Steering Committee should have significant authority, and include stakeholders, both clinical and non-clinical, including members, community-based organizations, and social services agencies, as well as key state legislators and other policymakers. The Committee should serve as a public forum to provide accountability to make sure the demonstration is meeting its goals, and to identify areas for improvement.

Second, MassHealth and the ACO Steering Committee should continuously monitor and evaluate the program's implementation through development and dissemination of a public dashboard. This will also require publicly setting system-wide, measurable goals for what we hope to accomplish by moving care to ACOs, such as reduced hospitalizations and institutionalization, improved quality of life, improved health outcomes, and reduction of health disparities.

We appreciate the opportunity to provide feedback on the MassHealth 1115 Medicaid Demonstration Waiver proposal. Should you have any questions or wish to discuss these comments further, please contact Suzanne Curry, Senior Health Policy Manager, Health Care For All, at (617) 275-2977 or scurry@hcfama.org. Thank you for your consideration.

Sincerely,

1199 SEIU - United Healthcare Workers East
Action for Boston Community Development, Inc.
The Arc of Massachusetts
Boston Center for Independent Living
Center for Living & Working, Inc.
Children's Mental Health Campaign
Community Servings
Disability Law Center
Disability Policy Consortium
Easter Seals Massachusetts
Ethos
Federation for Children with Special Needs
The Greater Boston Food Bank
Greater Boston Interfaith Organization
Greater Boston Legal Services

Health Care For All
Health Law Advocates
MassADAPT
Massachusetts Association of Community Health Workers
Mass Home Care
Massachusetts Law Reform Institute
Massachusetts Organization for Addiction Recovery
Massachusetts PublicHealth Association
Mental Health Legal Advisors Committee
Medical-Legal Partnership Boston
MSPCC
NAMI Mass
Parent/Professional Advocacy League
Stavros



Real Possibilities in

Massachusetts

July 15, 2016

The Honorable Marylou Sudders, Secretary
Executive Office of Health and Human Services
Commonwealth of Massachusetts
Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: 1115 Comments on Demonstration Extension Request

Dear Secretary Sudders:

AARP Massachusetts would like to thank the Executive Office of Health and Human Services' Office of Medicaid for the opportunity to submit our comments to your Section 1115 Waiver Demonstration Project and Amendment Request. AARP is a nonprofit, non-partisan membership organization for people 50 and over. We have more than 38 million members nationwide and 800,000 members in the Commonwealth. We know the Commonwealth provides essential services for the older population – services that keep people healthy and living with dignity. It is critical that adequate funding remain for these programs and services.

We are encouraged by the goals you have set for this demonstration extension request, namely, the adoption of alternative payment methodologies, improvement in the service needs of MassHealth participants and movement towards a more integrated and coordinated system of care. We appreciate the year-long process you established to engage and receive input from stakeholders. The proposal represents an ambitious and innovative undertaking and one that merits close attention.

AARP Massachusetts believes that many components of the waiver align with AARP principles and policies. Some of these components are:

Managed Care Organizations

AARP understands that the state intends to have Managed Care Organizations (MCOs) gradually assume expanded responsibility in the delivery and coordination of long-term services and supports (LTSS) to vulnerable older adults, with key objectives being to improve quality, outcomes and the consumer experience. As you move in this direction, AARP asks that the state takes steps to put financial risk mitigation strategies in place in order to ensure MCO solvency and sustain adequate access to services for beneficiaries.

As the waiver proposal points out, MCOs will be required to adopt a person-centered approach to care. With respect to how person-centered care is defined, we believe the definition should use the term “family caregiver” defined broadly and that this is preferable to the term “natural supports”. A person-centered approach should emphasize keeping individuals who need LTSS in the community rather than institutional settings. AARP would like to recommend that these principles be spelled out in the waiver proposal. We are pleased to see that MCOs will be required to demonstrate compliance with the new federal Medicaid Managed Care regulations and must demonstrate competencies and readiness before enrolling people who require LTSS. We agree that it is essential that these requirements be met before vulnerable adults are allowed to enroll in capitated health plans.

Accountable Care Organizations

Under the waiver proposal, MassHealth Accountable Care Organizations (ACOs) will have explicit requirements to partner with community-based behavioral health (BH) and LTSS providers to serve members with complex BH, LTSS and co-occurring needs. We commend MassHealth’s commitment to ensure that ACOs, other providers and MCOs will deliver care in a culturally competent manner that is appropriate to the cultural and linguistic needs of consumers. The waiver proposal also points out that ACOs will be expected to work with social service providers to address consumers’ health-related social needs. We are encouraged to see that a portion of Delivery System Reform Incentive Program funding to ACOs will be explicitly designated for “flexible services” to fund members’ social service needs.

AARP supports the requirement that all MassHealth ACOs (except those in the pilots) have a Patient and Family Advisory Committee. We strongly encourage the inclusion of family caregivers in this Advisory Committee. It is important to recognize that some family caregivers may have mobility or health conditions that could impede their ability to participate in the Advisory Committee. Therefore, we ask that you seek ways to facilitate their engagement.

Other Long Term Services and Supports Provisions

AARP strongly supports the establishment of seamless, person-centered care coordination for consumers who have complex LTSS and social needs. We believe that care coordination is best served when interdisciplinary care teams are formed, and that both community-based LTSS providers and family caregivers should be included as members of these teams.

While we commend MassHealth’s commitment to ensure network adequacy that will provide consumers with the right and opportunity to select a Primary Care Clinician (PCC) plan or one of the other managed care plans, network adequacy should also ensure that consumers’ needs for LTSS are met.

Other Issues

We appreciate the proposal’s commitment that MassHealth will adhere to robust requirements that support consumers’ rights and protections, including existing appeals and grievance procedures and the establishment of an external Ombudsman. We also applaud MassHealth’s commitment to a set of performance metrics over a five-year period that will address and measure total cost of care, quality, consumer experience and care integration.

We also commend the provision in this proposal that will allow individuals in the CommonHealth program to continue their enrollment even after they turn age 65 and that this expansion will help preserve needed services for working seniors in Massachusetts.

We are glad to see the requirement that ACOs and MCOs make information about their MassHealth plans easily accessible. We are also pleased that MassHealth will be taking steps to enhance their

website, publications, customer service operations and community engagements. AARP commends the state for placing an emphasis on integrating behavioral and physical health.

Questions and Concerns

In addition to the issues addressed above, there are some additional concerns and questions we wish to raise.

The waiver proposal points out that certain benefits will be available through an ACO or MCO but will no longer be available, or will be limited, in the PCC plan (e.g., chiropractic services, orthotics, eye glasses, and hearing aids). In addition, the proposal states that differential co-pays will also be structured (lower copays for members enrolled in MCO/ACO options) to encourage enrollment in more coordinated models of care. We are concerned that limited services and higher co-pays will have adverse effects on consumers who elect the PCC plan and we ask that you reconsider this provision.

The proposal states that following its MCO re-procurement scheduled to launch in late 2017, MassHealth will transition LTSS into a set of services for which MCOs will be responsible. The transition of consumers from one care program to another can oftentimes be confusing for both beneficiaries and their families. In the event provider changes occur, MassHealth should ensure that any transition to new providers is smooth, coordinated, and includes appropriate transfer of records and medication reconciliation. In addition, beneficiaries should be held harmless for the cost of any care as they transition to new providers or new networks. We would like to know more about how this transition process will work, such as safeguards that will facilitate smooth transitions.

The waiver proposal indicates the ACOs will be delivering services for some recipients of LTSS while others, dual eligible beneficiaries and some HCBS waiver beneficiaries, will not initially be eligible to enroll in ACOs. What assurances can the State provide that consumers will receive the same quality of care irrespective of the delivery model they are enrolled in?

Another concern we have is with MassHealth beneficiaries who, as they approach the age of 65, become eligible for Medicare. Irrespective of their enrollment in an ACO, a PCC, SCO or PACE, it is critical that these beneficiaries receive timely, clear and plain language notification of their coverage and benefit options, with a clear and comprehensive explanation of the process for making a smooth transition to Medicare. Beneficiaries should also be made aware of any potential enrollment penalties that they may be subject to if they decide not to enroll in Medicare (Part B and D) at the time they turn the age of 65. We are very interested in learning how MassHealth will be addressing this concern.

The proposal points to expectations for the coordination and delivery of care for frail seniors, or members with disabilities, including building in explicit expectations to ensure members' LTSS care is not "over-medicalized." We would appreciate some more details on how this coordination will be achieved.

We encourage the inclusion of the family caregiver experience as a core measure among the quality measures used to evaluate the waiver. We would also like to be assured that the family support services provided by LTSS Community Partners (CPs) are going to be sufficient and appropriate to meet the needs of family caregivers in Massachusetts.

The proposal points to a tiered approach (page 6) that MassHealth will employ for outlining its expectations for care delivery integration based on the complexity of members' needs. AARP would like to have a more detailed explanation of what constitutes a tiered approach.

With respect to the Safety Net Care Pool (SNCP) redesign, the proposal indicates that MassHealth will continue to provide necessary and ongoing funding support to safety net providers through a new

stream of Safety Net Provider payments. AARP would appreciate having more details on where this new funding stream will come from and how it will be sustained.

Finally, the proposal indicates that LTSS (CPs) will receive funding to provide independent assessments, person-centered counseling on service options and referrals to LTSS providers. LTSS CPs will also receive funding for their participation on the member's care team, which will be led by the ACO. We would like to know more details on how this funding stream will operate.

We look forward to working with you as this demonstration progresses and would be happy to assist you in any way possible. Please do not hesitate to contact Jessica Costantino, Director of Advocacy, at 617.305.0538 or jcostantino@aarp.org, if you have questions or concerns or need additional information.

Very truly yours,



Michael E. Festa
State Director



Sandra K. Albright
State President



July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted via email to MassHealth.Innovations@state.ma.us

RE: Comments on MassHealth 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai,

On behalf of the Affordable Care Today (ACT!!) Coalition, thank you for the opportunity to comment on MassHealth's Section 1115 Demonstration Project Amendment and Extension Request. We appreciate MassHealth's thoughtful and open stakeholder engagement process throughout the development of this waiver proposal, and look forward to continuing to work with you to ensure that implementation of the demonstration improves access to and quality of care for MassHealth members. We have included below comments on specific aspects of the Waiver Request, focused on proposed changes to benefits, cost-sharing, eligibility and enrollment.

The ACT!! Coalition is dedicated to ensuring that Massachusetts residents have access to affordable, quality health coverage. We appreciate MassHealth's commitment to prioritizing this goal. As such, we support the proposals intended to increase access to services for low-income residents, including:

- Eliminating copays for MassHealth members with income at or below 50% of the federal poverty level (FPL);
- Assuring the sustainability of the CommonHealth program for working disabled adults age 65 and older;
- Ensuring the sustainability and affordability of the ConnectorCare program;
- Providing continuous eligibility through the duration of the Student Health Insurance Plan (SHIP) period for enrollees receiving Premium Assistance for SHIPs; and
- Expanding MassHealth substance use disorders (SUD) treatment services.

However, we oppose several proposed changes to the MassHealth program that would restrict access to care for members, including:

- Eliminating coverage of chiropractic services, eye glasses, hearing aids, orthotics or other state plan services in the Primary Care Clinician (PCC) plan;
- Increasing copays for members enrolled in the PCC plan, in relation to MCO members;
- Expanding the list of services to which copays apply; and
- Potentially increasing premiums for enrollees with incomes at or above 150% FPL.

PCC Plan Changes

We understand that MassHealth is proposing changes to the PCC Plan in order to incentive members to enroll in an MCO and one of the new ACO models. However, we believe the proposed policies will impose barriers to care for members remaining in the PCC Plan, particularly for people with disabilities who have established relationships with their providers. Members should not have to choose between seeing their preferred providers and having access to the full range of MassHealth benefits. We urge you not to implement PCC Plan benefit reductions or copay increases.

MassHealth MCOs provide good quality care and are the right choice for many beneficiaries, but a MCO is not the right choice for everyone. Most MassHealth MCOs' provider networks exclude some providers who are still available in the PCC Plan. The PCC Plan has been a lifeline for medically complex patients, including people with disabilities, when faced with narrow provider networks and other restrictions in the MassHealth MCOs that would not meet their needs. For these members, switching to an MCO may disrupt their ability to see the providers they know and trust. For example, under the proposed change, a disabled child may have to forego eyeglasses to see the medical specialists the child needs given the limited access to certain specialty hospitals in the MCOs compared to the PCC Plan.

Further, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a mandatory Medicaid service for children and youth under age 21.¹ EPSDT includes all medically necessary Medicaid services regardless of what is in the state plan, and provides comprehensive coverage for dental, vision, hearing, and medical screenings and treatment. Children enrolled in all types of managed care, including PCC Plans, "are entitled to the same EPSDT benefits they would have in a fee for service Medicaid delivery system."² We believe the proposed PCC Plan benefit cuts violate the Federal EPSDT requirement, and again urge MassHealth to reconsider these changes.

Cost-Sharing

We oppose MassHealth's proposal to increase cost-sharing for PCC Plan members as well as expand the list of services to which copays apply. Data from Oregon and Connecticut Medicaid programs show that higher cost-sharing contributes to Medicaid disenrollment.³ In Oregon, those who left Medicaid programs due to higher cost-sharing had lower primary care utilization and higher emergency room visits.⁴ A Kaiser Family Foundation report describes how higher cost-sharing results in delayed care and poorer health outcomes.⁵ Increased cost-sharing for Medicaid enrollees leads to access barriers and puts greater strain on safety net resources, shifting costs rather than saving costs or improving health outcomes.

MCO Lock-In

We understand that MassHealth plans to implement the MCO lock-in policy in October 2016 regardless of the status of the demonstration proposal. As such, we appreciate that MassHealth has reached out to

¹ See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

² Centers for Medicare and Medicaid Services, EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, June 2014. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

³ <https://www.cthealth.org/wp-content/uploads/2011/04/Policy-Brief-2-Proposed-Medicaid-Cost-Sharing-Evaluating-The-Impact.pdf>.

⁴ <http://content.healthaffairs.org/content/24/4/1106.full>.

⁵ <https://kaiserhealthnews.files.wordpress.com/2014/07/8417.pdf>.

advocates and providers for suggestions on the lock-in exceptions policy. MassHealth should ensure broad exceptions to enable members to change MCOs and access the care they need.

In 2014, of the 36% of the MassHealth caseload that experienced plan changes during the year; 30% were caused by involuntary plan changes related to eligibility and only 6% by voluntary plan changes.⁶ Involuntary plan change or churn is a serious problem. Coordination and continuity of care depend on continuity of coverage. For members, churn means disruptions in coverage, delayed care, worse health outcomes and medical debt.⁷ For MassHealth, it means the added administrative costs of terminating and reinstating eligibility.⁸

As most MassHealth enrollment volatility, or “churn”, occurs due to eligibility changes, rather than voluntary plan changes, we believe that policies to reduce churn should address the primary cause. MassHealth should consider policy options such as 12-month continuous eligibility to reduce churn. One study estimated that within a six-month period, 35% of adults with incomes below 200% FPL would have income changes that would shift their eligibility from Medicaid to Marketplace coverage or the reverse; within a year, an estimated 50% would have income changes requiring a program change.⁹

Research shows that when beneficiaries are enrolled in Medicaid for longer periods, the average monthly cost for their care declines.¹⁰ The Federal Medicaid statute includes a state option to enroll children for 12-months of continuous eligibility, which to date 23 states have taken up in both their Medicaid and Children’s Health Insurance Programs (CHIP), and a further 10 states in their CHIP programs alone.¹¹ While the Medicaid state plan option is limited to children, other authorities are available to extend the policy to adults.

CMS endorsed 12-month continuous eligibility for parents and other adults as a strategy available to states through 1115 demonstration authority.¹² New York and Montana have 1115 Waiver authority to extend continuous eligibility to parents and other adults.¹³ After analyzing studies of the adverse effects of churning, the Medicaid and CHIP Payment and Access Commission has recommended that Congress give states an option to provide 12 month continuous eligibility for adults.¹⁴ There is also more limited

⁶ Report of the Working Group on Medicaid Managed Care Organizations, MA House of Representatives, October 2015.

⁷ R. Seifert, et al., Enrollment and Disenrollment in MassHealth and Commonwealth Care, Massachusetts Medicaid Policy Institute, 2010; L. Ku, New Research Shows Simplifying Medicaid Can Reduce Children’s Hospitalizations, Center on Budget and Policy Priorities, June 2007; L. Olson, et al., Children in the United States with Discontinuous Health Insurance Coverage,” NEJM, 353:382-391 (2005).

⁸ Supra.

⁹ Sommers, B., and S. Rosenbaum. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. Health Affairs 30, (2011) no. 2: 228–236.

¹⁰ L. Ku and E. Steinmetz, Bridging the Gap: Continuity and Quality of Coverage in Medicaid, George Washington University, (Association for Community Health Plans, Sept. 10, 2013).

¹¹ Data displayed on Medicaid.gov at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/continuous.html>.

¹² Letter from Cindy Mann, Director, CMS, to State Health Officials, Re: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014, May 17, 2013.

¹³ See: <http://kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-medicaid-and-chip-enrollment-and-renewal-processes/>.

¹⁴ Medicaid and CHIP Payment and Access Commission, Report to the Congress on Medicaid and CHIP, Washington, DC: MACPAC; Chap. 2, p. 21–32. Mar. 2013.

authority to guarantee eligibility for 6 months at a time for managed care or PCC Plan enrollees.¹⁵ We understand that MassHealth is currently focused on stabilizing its caseload, and ask that you keep the 12-month continuous eligibility policy option in mind for future consideration.

ConnectorCare Program

We applaud EOHHS and the Health Connector for ensuring that ConnectorCare premiums and cost-sharing remain affordable. In a high cost state like Massachusetts, many residents living at or below 300% FPL are struggling to make ends meet and will not be able to afford the additional premiums or cost-sharing if the ConnectorCare program is not available.

In addition to premium assistance, ConnectorCare plans include reasonable copays for services, and do not impose deductibles or coinsurance. Reverting to federal premium and cost-sharing levels would expose low and moderate income individuals and families to higher out-of-pocket costs, which may include deductibles and coinsurance, well above what is required through ConnectorCare. Without the ConnectorCare program, we risk residents dropping coverage, going without necessary care, falling into debt, and unraveling the gains we have made under the Massachusetts health reform law and the ACA.

The sustainability of the Commonwealth's coverage gains, made possible by offering affordable coverage through MassHealth and the Health Connector, requires adequate financing. We support the Commonwealth's efforts to seek federal reimbursement for state-funded cost-sharing subsidies, in addition to premium subsidies.

The ACT!! Coalition appreciates the opportunity to provide feedback on the MassHealth 1115 Medicaid Demonstration Waiver Request. We look forward to continuing to work with you to sustain and improve access to affordable, quality health coverage for Massachusetts residents. Should you have any questions, please contact Suzanne Curry at Health Care For All at (617) 275-2977 or scurry@hcfama.org. Thank you for your consideration.

Sincerely,



Suzanne Curry
Senior Health Policy Manager, Health Care For All
Director, ACT!! Coalition

¹⁵ 42 U.S.C. § 1396a(e)(2).



ACT!! Coalition Member Organizations

- AARP Massachusetts
- Action for Boston Community Development
- AIDS Action Committee
- American Cancer Society Cancer Action Network
- American Heart Association / American Stroke Association
- Association for Behavioral Healthcare
- Boston Center for Independent Living
- Boston Children’s Hospital
- Boston Medical Center
- Boston Public Health Commission
- Cambridge Health Alliance
- Children’s Health Access Coalition
- Coalition for Social Justice
- Committee of Interns and Residents/SEIU Healthcare
- Community Catalyst
- Community Servings
- Disability Policy Consortium
- Episcopal City Mission
- Families USA
- Greater Boston Interfaith Organization
- Greater Boston Legal Services
- Health Care For All
- Healthcare for Artists
- Health Law Advocates
- Home Care Alliance of Massachusetts
- Joint Committee for Children’s Health Care in Everett
- JRI Health
- Massachusetts Academy of Family Physicians
- Massachusetts Association of Community Health Workers
- Massachusetts Association of Behavioral Health Systems
- Massachusetts Breast Cancer Coalition
- Massachusetts Building Trades Council
- Massachusetts Business Leaders for Quality, Affordable Health Care
- Massachusetts Chapter of the American Academy of Pediatrics
- Massachusetts College of Emergency Physicians
- Massachusetts Communities Action Network
- Massachusetts Council of Community Hospitals
- Massachusetts Immigrant and Refugee Advocacy (MIRA) Coalition
- Massachusetts Health Council
- Massachusetts Hospital Association
- Massachusetts Law Reform Institute
- Massachusetts League of Community Health Centers
- Massachusetts Medical Society
- Massachusetts Organization for Addiction Recovery
- Massachusetts NOW
- Massachusetts Public Health Association
- NARAL Pro-Choice Massachusetts
- National Association of Social Workers – Massachusetts Chapter
- Neighbor to Neighbor
- Partners HealthCare
- Public Policy Institute
- 32BJ SEIU New England 615
- 1199 SEIU United Healthcare Workers East
- Tobacco Free Mass
- Treatment Access Expansion Project
- UMass Memorial Health Care

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Section 1115 Demonstration Project Amendment and Extension Request

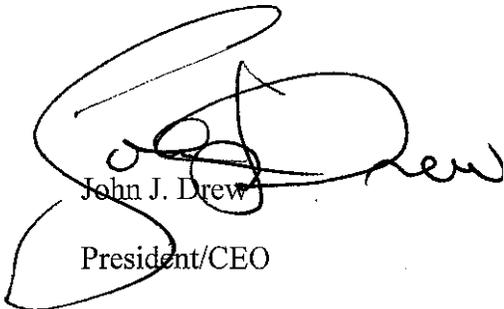
Dear Assistant Secretary Tsai:

Action for Boston Community Development, Inc. (ABCD) is pleased to transmit the attached concept paper, developed by a consortium of major Massachusetts human service providers, which describes a potential structure for organizing access to consumer services which can positively impact social determinants of health (SDOH)-a SDOH Service Hub.

We are confident that such a structure, which the concept paper discusses in detail, will assist significantly in building a MassHealth system which is both cost-efficient and responsive to the needs of the Commonwealth's most vulnerable residents.

Thank you for the opportunity to provide this input to the crucial process of developing the MassHealth 1115 DSRIP waiver proposal to the federal Center for Medicare and Medicaid Services.

Yours sincerely,



John J. Drew
President/CEO

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Section 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai:

Action for Boston Community Development, Inc. (ABCD) supports MassHealth's submission of an 1115 DSRIP waiver proposal to the federal Center for Medicare and Medicaid Services, and offers these additional suggestions to refine the proposed waiver, especially for those MassHealth members being referred to health-related social services.

Since its founding in 1961, ABCD has sought to be a catalyst for empowerment and opportunity, providing hands-on assistance to those in need and responding promptly to emerging issues. ABCD is the anti-poverty, community action agency for Boston and, as of last year, for Malden, Medford and Everett too. We also reach beyond these municipalities into Newton, Brookline, Stoneham, Winchester and Woburn. Within these towns and cities, ABCD has some 40+ neighborhood locations, offering uniquely accessible services to low-income communities which are too often isolated and disenfranchised.

ABCD's capacity to bring about positive change impacts more than 100,000 low-income households every year in these communities; most of these households participate in MassHealth. ABCD has developed a broad spectrum of programs to reach out to people in need and equip them with the skills they need to move forward in their lives. These include SNAP and other public benefits application assistance, housing services, Head Start and child care voucher assistance, elder nutrition, job training, youth career development, fuel assistance and many other supports.

ABCD wishes to thank you for putting much time into listening to input from a wide range of MassHealth constituents, and for your thoughtful consideration of the way MassHealth delivers health care to the low-income residents of our state.

In general, we urge you to conceptualize social services broadly. Childcare and Head Start, (free) tax preparation, programs which counter social isolation (such as Foster Grandparents) and other services should be as much part of a toolkit of referrals as housing, nutrition and utility supports. Similarly, MassHealth members may be eligible but unaware that they qualify for many existing social services.

Community Health Workers.

ABCD applauds MassHealth's inclusion of Community Health Workers (CHWs) in its waiver. They are one of the most cost effective means by which ACOs can work with individuals and families, and should be integrated with members' Interdisciplinary Care Teams.

In addition, many social services agencies and programs, such as ABCD's health services and neighborhood-based programs, employ community health workers for their unique ability to reach specific, often marginalized populations, explain complex social and health issues, and assist in navigating social and health care systems. MassHealth should explicitly recognize the value and service-delivery effectiveness of CHWs in community-based settings.

Fuel Assistance.

ABCD is particularly pleased that MassHealth recognizes the value of connecting MassHealth members to Fuel Assistance and related utility supports. ABCD's Low-Income Home Energy Assistance Program (LIHEAP) covers 10 cities and towns in Greater Boston and is part of a statewide coverage net-one which also ensures access to other related programs, such as weatherization, utility discounts and heating system repair. Fuel Assistance is only one example of many social service supports which are revenue-neutral to MassHealth, and for which the vast majority of MassHealth members will qualify. Such no-cost referrals represent an important source of leveraged supports for MassHealth members, which could be readily facilitated through a structure such as the SDOH Hub, as described above. Such referrals should be permitted- and encouraged-in the design for social service access.

Recovery High Schools.

ABCD operates the William J. Ostiguy Recovery High School. We were pleased to see, in MassHealth's waiver proposal, the request to bring Recovery Coaches under MassHealth covered services.

In conclusion, we wish to thank you again for including social services in your development of MassHealth's health care and payment delivery systems redesign. ABCD is pleased to have had the opportunity to be involved in this process over the past year. We hope that, as these system

CONCEPT FOR A SOCIAL DETERMINANTS OF HEALTH SERVICE HUB

as a Key Element of

MassHealth Delivery System Restructuring

July 15, 2016

This concept paper is presented to the Massachusetts Executive Office of Health and Human Services (EOHHS) in response to the circulation of a request to amend and extend the MassHealth Section 1115 Demonstration to the Centers for Medicare and Medicaid Services.

It has been developed by a consortium of nonprofit human services agencies, including the following.

Action for Boston Community Development, Inc.
178 Tremont Street
Boston, MA 02111

Alliance of Massachusetts YMCAs
14 Beacon Street, Suite 803
Boston, MA 02108

Medical Legal Partnership/ Boston
75 Arlington Street, Suite 500
Boston, MA 02116

Metropolitan Boston Housing Partnership, Inc.
125 Lincoln Street, 5th Floor
Boston, MA 02111

Massachusetts Association for Community Action
105 Chauncy Street, Suite 301
Boston, MA 02111

I. OVERVIEW OF CONCEPT

To improve health outcomes while reducing costs for some of the Commonwealth's most vulnerable populations, the MassHealth Delivery System Restructuring project requires Accountable Care Organizations to work with Community Based Organizations to provide behavioral health and long-term support services, while also engaging social service providers.

The effectiveness of this effort will depend on creation of systems which break down traditional silos between clinical and community services. To meet this challenge in the most impactful and cost-efficient way, we propose that the model of a **unified service hub** be adopted by Massachusetts as the preferred delivery mechanism for social services. Such a Social Determinants of Health Hub (SDOH Hub) can offer **a single point of coordinated** access to a wide range of social services which have documented impact on health outcomes, on use of medical services by High Utilizer (HU) and other MassHealth populations, and on reducing the costs of care. We believe that there are three key areas of advantage in adoption of an SDOH Hub model.

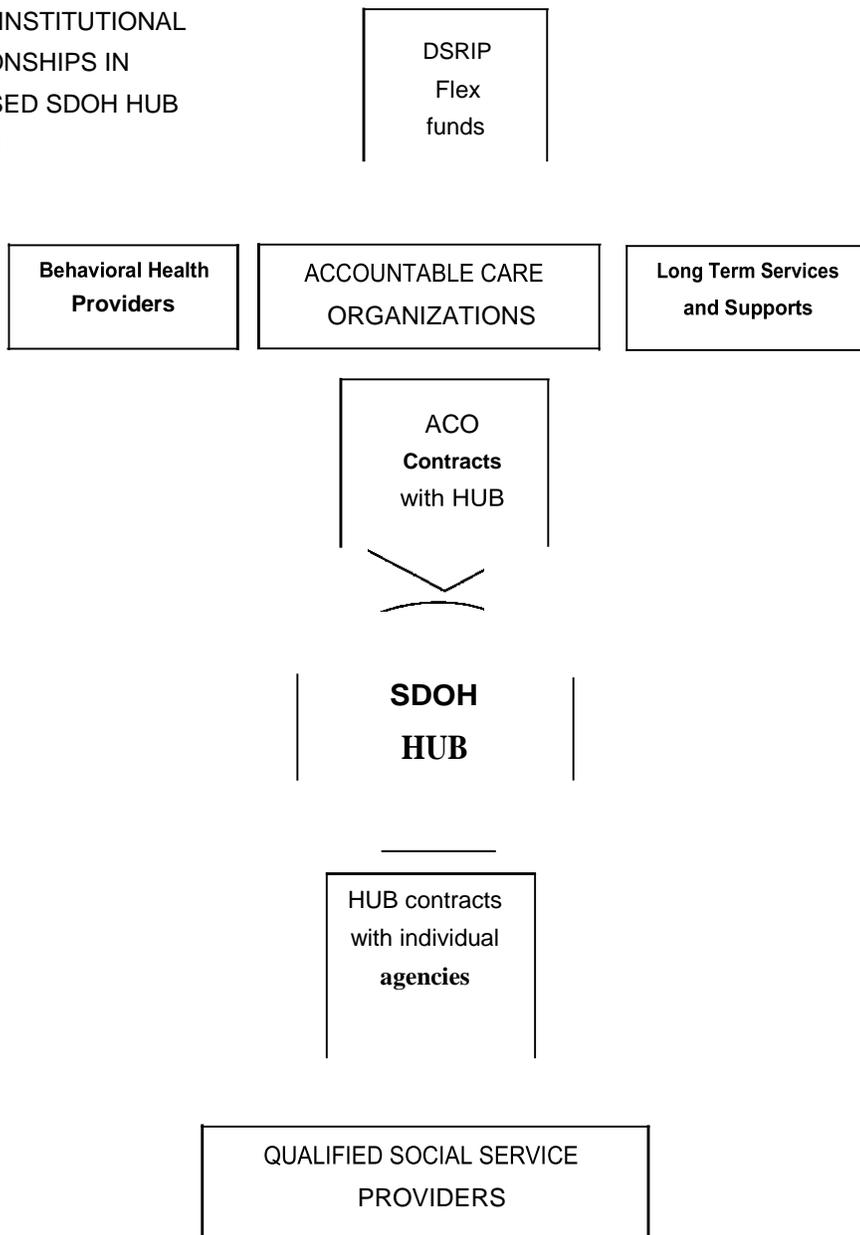
Such a Hub model can offer clinicians and their patients the widest possible range of social services supports which have documented health impacts. A Hub structure is ideally suited to providing access to medically beneficial, evidence-based programs in each geographic region, without the need to construct new service networks. It can readily incorporate specialized organizations uniquely capable of work with underserved populations.

A Hub model creates significant efficiencies for ACOs. It eliminates the complexity of contracting with multiple partners. It can offer integration with the ACO and its agents through the Care Coordination Team, and deliver patient services including needs assessment, eligibility review, information and referral, navigation and follow-up services in a coordinated and cost-effective way. A Hub is capable of working with multiple ACOs to bridge medical and social service systems-leveraging the full range of existing high-quality community services through a single source.

The Hub model supports increased accountability and sustainability for the MassHealth system. The Hub structure is both scalable and capable of responding flexibly to the needs of populations and ACOs. A key element of the model is the expectation that the Hub shares in both risk and benefits with the ACO, building both accountability and sustainability. Initial costs for startup can be covered by DSRIP, while recurrent costs can be structured on a shared risk/benefit basis with the ACO (through risk corridors or caps on profit and loss.) By providing a context in which to conduct analysis of avoided costs and ROI, a Hub system can establish the base of data needed for investment in non-medical services, while fine-tuning the array of services provided for maximum impact.

We strongly believe that the SDOH Hub concept is a viable solution to providing care which is genuinely coordinated and integrated-and that it will strongly support the long-term goals of the MassHealth Delivery System Restructuring initiative.

Figure 1: INSTITUTIONAL
RELATIONSHIPS IN
PROPOSED SDOH HUB
SYSTEM



II. SYSTEM NEEDS

The MassHealth Delivery System Restructuring is driven by the need to transform a siloed, unsustainably costly and medically inefficient program into one that can reduce fragmentation and focus on "value rather than volume"¹.

The Commonwealth recognizes the importance of systematically linking medical services with resources "not traditionally reimbursed as medical care, to address health-related social needs." The system reform effort envisions incentives for Accountable Care Organizations (ACOs) to build linkages with social services. It also incorporates access to Delivery System Reform Incentive Payment (DSRIP) funds in order to address the social determinants of health. Like other DSRIP funding, such resources are not permanent, but intended as a bridge to "support development of scalable new capabilities and capacity2."

As a consequence of this focus, the emerging MassHealth system, and its constituent partners, need a social services linkage strategy that has the following qualities.

It must:

- Be responsive to the characteristic unmet needs of High Utilizers and other MassHealth populations.
- Be capable of demonstrating added value, measurable in terms of avoided costs and improved health outcomes.
- Reduce barriers and streamline access-not add new layers to existing systems.
- Be capable of rapid deployment.
- Be sustainable after the phase-out of DSRIP funds.

The proposed Social Determinants of Health Hub (SDOH Hub) model has the potential to meet these requirements.

III. MODEL ELEMENTS

The SDOH Hub model is predicated on the deployment of system elements for which there is established or emerging evidence of efficacy.

¹Executive Office of Health and Human Services. April 14, 2016. *MassHealth Delivery System Restructuring: Additional Details*.

² *ibid.*

Hub and-spoke structure. The proposed SDOH Hub seeks to radically simplify the process of connecting patients with social services. Instead of adding a new layer of social service coordination and subcontracting within each ACO, multiple ACOs can utilize one provider portal, the Hub. The Hub, in turn, brokers referrals, and follow-up through a very broad field of social service resources that can be accessed by all patients. This model builds on the experience of several states (notably, Tennessee³ and Ohio⁴), in establishing hub-and-spoke models of non-medical service delivery. In addition to creating simpler structures for contracting, referral, reimbursement and data aggregation by ACOs, the Hub structure makes assurance of HIPAA compliance easier because only the Hub must be HIPAA-compliant, as opposed to multiple social service partners with separate contracts.

Effective service integration through Care Coordination Team. The one-stop connection mechanism of the Hub model provides an ideal tool for planning and integration of services through Care Coordination Teams. It allows Hub and ACO representatives to jointly engage in data-driven planning around the services needed by individual consumers.

Focus on services with established ROI. An extensive literature demonstrates that "nonmedical factors play a substantially larger role than do medical factors in health", and that "...increased investment in selected social services...can confer substantial health benefits and reduce health care costs for selected populations." The proposed Hub concept will focus on non-medical inputs for which there is a strong research base suggesting positive impacts on health outcomes and avoided costs, including those referenced below in *Table 2*, below. Initially, the model will prioritize services for which the evidence base is strongest, and for which positive ROI can be demonstrated readily.

Leveraging of multiple existing funding sources. The Hub model is capable of creating substantial leverage for ACO funds by helping consumers access state, federal and local resources which are revenue-neutral for MassHealth. The Hub can readily screen consumers for eligibility for multiple programs and services, both reducing the effective cost of services requested by the ACO, and providing a range of wrap-around services which can enhance health and well-being. This "resource multiplier" effect allows the Hub to minimize MassHealth costs while maximizing consumer benefits.

Utilization of existing infrastructure. More generally, the Hub model can build on existing networks of connection and collaboration among nonprofit organizations-including not only larger organizations, but smaller groups that may be linguistically and culturally specialized to serve hard-to-reach populations. The proposed Hub model can also build on existing tools and structures, now utilized by leading social services providers, to ensure a consistent, seamless consumer experience. These elements include needs

³ State of Tennessee Application for State Innovation Model (SIM)

⁴ Governor's Office of Health Transformation, January 2016. Transforming Payment for a Healthier Ohio, at www.HealthTransformation.Ohio.gov

⁵ Taylor, L.A., Coyle, C.E., Ndumele, C., Rogan, E., Canavan, M., Curry, L., and Bradley, E.H. June 2015. *Leveraging the Social Determinants of Health: What Works?* Yale Global Health Leadership Institute.

assessment using standardized rubrics; standardized referral, service navigation, and follow-up procedures; and client tracking and data warehousing systems.

Robust basis for sustainability. Any mechanism for social services delivery must be largely self-sustaining, because new funding associated with the MassHealth restructuring process will be insufficient, in itself, to meet the social service needs of MassHealth populations (or to build new service delivery entities). The proposed SDOH Hub structure features a high degree of sustainability and builds upon existing infrastructure. Many of the core Hub services (social service needs assessment, eligibility screening, information and referral, application assistance, systems navigation, and follow-up) are core activities now being undertaken by social service providers capable of hosting an SDOH Hub. As noted above, the array of consumer services potentially available through the Hub is also underwritten by multiple State, Federal and local funding sources. The critical capacity-building and start-up costs for which DSRIP resources will be needed are strikingly front-loaded; they include, for example, building contractual relationships, establishing standardized processes for calculating and reporting ROI and avoided costs, building out existing data warehouse structures and ensuring systems interoperability, and training staff.

Capacity to measure and report impacts. Metrics for social service outcomes and service quality, such as those itemized in *Table I*, below, will be established, and reported on regularly by the Hub to ACOs. The Hub operator will be responsible for collecting and compiling this data. Data sharing between ACOs and Hub operators will allow for the calculation and analysis of avoided Medicaid costs. ACOs will also establish baselines for consumer costs, satisfaction, and health status. Changes with reference to these baselines, as they pertain to services rendered through the Hub, are also a basis of measurement as to the efficacy of the model, and lend themselves to the eventual shared risk and shared benefit. Establishment of metrics is supported by the experience of a variety of program models in which increased access to social supports has been associated with improved health outcomes and health cost reductions⁶.

Risk-sharing contracting structure. The Hub structure has been informed by, among other sources, the Center for Medicare & Medicaid Innovation (CMMI) *Accountable Health Communities* initiative, which has begun to clarify effective practices in establishing decision-making processes and the financial roles of integrator organizations, as well as issues and costs associated with service integration⁷. Resources flow through two sets of contracts: one links multiple ACOs to a coordinating entity which hosts the Hub; the second links the Hub manager to multiple social service agencies. The Hub model provides considerable flexibility in balancing risks and benefits for ACOs, Hub agencies, and local social service providers. Payments to the Hub from ACOs will be on a capitation basis. Contracting between the Hub and social service providers may be handled through a variety of mechanisms, with established standards for minimum outcomes and service quality.

⁶ Bachrach, D, Pfister, H., Wallis, K., and Lipson, M. May 2014. *Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment*. Manatt Health Solutions.

⁷ Heider, F., Kniffin, T., and Rosenthal, J. May 2016. *State Levers to Advance Accountable Communities for Health*. National Academy for State Health Policy.

Table 1:SELECTED OUTCOMES FOR AN SDOH HUB

<i>Reduced Unmet Needs</i>
Reductions in modifiable health risks (physical inactivity, smoking)
Improved housing quality
Improved housing stability
Improved food security
Improved nutritional quality
Improved ability to maintain safe temperature in home
Increased adequacy of income relative to household needs
<i>Reduced Barriers to Care</i>
Increased ability to attend scheduled appointments
Increased ability to fill prescriptions in a timely way
Increased adherence to treatment plans
<i>Improved Health Outcomes</i>
Reduced incidence of chronic disease modalities
Reduced number of days of limitation of physical activity
Reduced number of days of school or work missed
Improved quality of life as measured by standard scales
Improved key health markers (glucose levels, hemoglobin)
<i>Reduced Utilization and Costs</i>
Reduced average total number of emergency department visits (compared to baseline)
Reduced average number of hospital admissions (compared to baseline)
Reduced average total number of inpatient days (compared to baseline)
Reduced readmissions for targeted conditions (compared to baseline)
Reduced average hospital charges (compared to baseline)
Overall Medicaid cost savings (compared to baseline)
Overall positive ROI

Table 2: SELECTED SOCIAL SERVICE INTERVENTIONS THROUGH SDOH HUB

EXCERPTS FROM EVIDENCE BASE	SAMPLE OF EXISTING SERVICES CAPABLE OF COORDINATION THROUGH SDOH HUB
<i>Interventions with Documented Impacts</i>	
<p>CASE MANAGEMENT. Care coordination and case management can have a significant impact on health outcomes and health costs, as demonstrated by a number of recent demonstration projects, including Oregon Coordinated Care Organizations (CCOs)', Minnesota's Hennepin Health ⁱⁱ, Medicare Pioneer ACO programs such as Montefiore Medical Center in New York ⁱⁱⁱ, Franciscan Alliance ACO in Indiana", and Banner Health Network in Arizona and patient-centered medical home (PCMH) programs such as that operated by Blue Cross Blue Shield of Michigan. Care coordination mechanisms appear to work both for broad patient populations and for targeted groups. With respect to specific populations, positive return on investment has been demonstrated for at-risk infants ^{vi} and dually-eligible elders ^{vii}, as well as low-income asthmatic children ^{viii}, obese children, disabled elders' and high-need patients being discharged from hospitals".</p>	<p>Needs assessment Service plan development Information and referral Service navigation Follow-up</p>
<p>HEALTH EDUCATION AND WELLNESS INTERVENTIONS. Modifiable health risks have significant impact on health outcomes and costs' . Education and self-care programs addressing these factors have demonstrated impact in diabetes prevention ^{xrn} and in improving glucose control in diabetes"'. Well-studied evidence-based programs for smoking cessation have also demonstrated short-term clinical and economic benefits ^{xv}, as well as lifetime health cost savings ^{xvi}. More broadly, approaches which seek to increase physical activity in general are directly related to lower health charges at a level which justifies investment ^{xvii}.</p>	<p>Smoking cessation Chronic disease prevention programs Evidence-based self-care programs for chronic disease management Exercise programs</p>
<p>HOUSING SUPPORT. There is evidence from multiple studies demonstrating a direct relationship between housing interventions and health care cost reductions in low-income populations. Net savings range from \$9,000 per person per year to nearly \$30,000 per person per year for some defined populations ^{xviii}. The 10th Decile Project found that \$1 of spending on housing generated \$2 in reduced spending in the following year and \$6 in reduced spending in subsequent years ^{xix}.</p>	<p>Housing safety and quality assessment Connection to housekeeping services, pest extermination, repair services, appliance replacement Sanitary code enforcement Tiered legal advocacy with respect to housing-related needs Hoarding interventions Eviction prevention Foreclosure prevention Reasonable accommodation</p>

	<p>Safety-and-disability-based transfers</p> <p>Non-discrimination</p> <p>Rapid re-housing for homeless families/individuals</p> <p>Housing vouchers</p> <p>Housing search assistance</p>
<p>NUTRITIONAL ASSISTANCE. A robust evidence base for the impacts of nutritional support includes lowered infant mortality and higher average birth rates for WIC recipients , as well as significant avoided costs among WIC-recipient high-risk women, infants and children. There is also strong evidence for Medicaid cost reductions and declines in nursing home admissions associated with home-delivered meals for frail elders xxi. Research shows a strong association between limited food resources among diabetic patients and acute hospital admissions for hypoglycemia ;, and specialized food bank programs offering diabetes-appropriate food have been shown to improve glycemic control xxiii</p>	<p>SNAP applications</p> <p>Tiered legal advocacy with respect to SNAP denials and barriers</p> <p>Food pantries</p> <p>Home-delivered meals (Title IIB and others)</p> <p>Congregate meals (Title IIB and others)</p>
<p>FUEL ASSISTANCE. As early as 2006, significant declines in hospital use were reported among vulnerable families and individuals with access to the Low-Income Energy Assistance Program (LIHEAP) ".</p>	<p>LIHEAP</p> <p>Utility discount programs</p> <p>Weatherization and other energy conservation programs</p> <p>Tiered legal advocacy with respect to shut-off protections</p> <p>Appliance repair and replacement</p>
<p>INCOME SUPPORTS. Receipt of the Earned Income Tax Credit has been associated with lowered infant mortality 'and improved overall health status among children, including reductions in obesity'. For elderly and disabled individuals, receipt of higher levels of Supplemental Security Income has been linked to reduced rates of disability. xxvii</p>	<p>SSI/SSDI application assistance</p> <p>Earned Income Tax Credit (EJTC)</p> <p>Financial capacity education and coaching</p> <p>Assessment of eligibility for other public resources</p> <p>Employment and job training assistance</p> <p>Tiered legal advocacy with respect to income support barriers and denials</p>
<p>HEALTH CARE ACCESS SUPPORTS. Nonfinancial barriers to health care have been recognized as significant factors in patient noncompliance, as well as in unmet need for care and delayed care xxvm. Among nonfinancial barriers, "structural" issues including lack of transportation and scheduling conflicts with work and child care are prevalent in low-income populations xxix. Transportation barriers have been linked to poorer health outcomes=, and specialized transportation services have been assessed as effective in reducing barrier to care xxxi. Legal barriers, notably immigration status, are associated with higher rates of health disparities, and use</p>	<p>Child care for appointments, other health care needs</p> <p>Transportation for appointments, other health care needs</p> <p>Assistance with immigration status</p> <p>Guardianship assistance</p>

<p>of costlier health care settings xxx i_ Assistance in normalizing immigration status has been associated with reduced use of high-cost care options and increased preventative care xxltiii. Lack of a defined legal decision-making arrangement for older and disabled individuals with complex medical conditions has been seen as increasing delays in care and suboptimal care. Access to assistance in establishing guardianship appears to reduce the incidence of these issues.</p>	
<p>IPV SERVICES. Intimate partner violence (IPV) is linked to extremely high medical cost burdens for survivors xxxiv. Survivors experience increased risk of chronic disease and behavioral health issues, reduced capacity to manage chronic disease, and elevated rates of complications of pregnancy xxxv. Children of survivors also experience increased rates behavioral and physical health problems=;. Early identification of IPV and assistance in addressing the issue appear to reduce health risk and health care cost xxxvii,xxxvm</p>	<p>Screening Counseling Legal support Assistance with relocation, housing</p>
<p>EDUCATION. Longitudinal observational studies have tied participation in high-quality early care and education by low-income children 0-5 years to better adult health outcomes, including lower blood pressure and lower risks of metabolic syndrome=;. Higher educational attainment among adult consumers has been associated with greater use of preventative services x¹ reduced risky behavior xn, and lower levels of coronary heart disease xm.</p>	<p>Access to Early Intervention Early Head Start and Head Start Subsidized child care vouchers Access to SPED services Out-of-school-time learning programs Alternative high schools Transition to college programs Reasonable accommodation</p>

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**Action for Boston
Community Development; Inc.**

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Section 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai:

Action for Boston Community Development, Inc. (ABCD) supports MassHealth's submission of an 1115 DSRIP waiver proposal to the federal Center for Medicare and Medicaid Services, and offers these additional suggestions to refine the proposed waiver, especially for those MassHealth members being referred to health-related social services.

Since its founding in 1961, ABCD has sought to be a catalyst for empowerment and opportunity, providing hands-on assistance to those in need and responding promptly to emerging issues. ABCD is the anti-poverty, community action agency for Boston and, as of last year, for Malden, Medford and Everett too. We also reach beyond these municipalities into Newton, Brookline, Stoneham, Winchester and Woburn. Within these towns and cities, ABCD has some 40+ neighborhood locations, offering uniquely accessible services to low-income communities which are too often isolated and disenfranchised.

ABCD's capacity to bring about positive change impacts more than 100,000 low-income households every year in these communities; most of these households participate in MassHealth. ABCD has developed a broad spectrum of programs to reach out to people in need and equip them with the skills they need to move forward in their lives. These include SNAP and other public benefits application assistance, housing services, Head Start and child care voucher assistance, elder nutrition, job training, youth career development, fuel assistance and many other supports.

ABCD wishes to thank you for putting much time into listening to input from a wide range of MassHealth constituents, and for your thoughtful consideration of the way MassHealth delivers health care to the low-income residents of our state.

MassHealth General Membership.

MassHealth has thoughtfully addressed ways in which a redesign can meet the needs of people with chronic diseases and those needing long term services and supports. This is good and welcome. ABCD would ask that the final waiver proposal also explicitly address the responsiveness of the redesign to the needs of all members. Specifically, we would ask that Accountable Care Organizations (ACOs) be required to permit social service referrals for *all* members. A healthcare provider should not be prevented from referring a family to fuel assistance or other services simply because the member does not have a qualifying "disease" other than poverty and need.

SDOH Service Hub.

ABCD and our many social service partners welcome the recognition by MassHealth of the key role social services play in helping low-income people maintain and regain their health. ABCD believes the redesigned MassHealth healthcare delivery system needs a central nexus, a Hub where ACOs and Social Service organizations can meet. ABCD and its partners have collaborated to develop a Social Determinants of Health Service Hub model we propose be adopted by Massachusetts as the mechanism for connecting patients to social services. Such a Service Hub can offer a single point of coordinated access to a wide range of social services for all MassHealth populations and reduce the costs of care.

A Hub would work with multiple ACOs to bridge medical and social service systems- providing culturally and linguistically competent services, engaging multiple (often small) social services agencies, and providing access to medically beneficial, outcome-informed programs in each geographic region. The Hub manager would hold contracts with ACOs and subcontract with local nonprofit service providers. The SDOH Hub thus permits "one stop social service shopping" on part of the ACO and its MassHealth patients.[ABCD and its regional/statewide service delivery organizational partners have submitted, under separate cover, an SDOH Service Hub concept proposal.]

Demonstrating Cost Effectiveness of Social Services.

While a select set of specific social service interventions, including some housing and nutrition studies, have received the imprimatur of "Evidence-Based Best Practices," many interventions have been less rigorously studied, yet demonstrate well-documented outcomes and long-standing recognition as effective, value-based programs. ABCD joins many other organizations and coalitions in urging MassHealth to make certain the social service referrals it permits are not artificially limited.

In general, we urge you to conceptualize social services broadly. Childcare and Head Start, (free) tax preparation, programs which counter social isolation (such as Foster Grandparents) and other services should be as much part of a toolkit of referrals as housing, nutrition and utility supports. Similarly, MassHealth members may be eligible but unaware that they qualify for many existing social services.

Community Health Workers.

ABCD applauds MassHealth's inclusion of Community Health Workers (CHWs) in its waiver. They are one of the most cost effective means by which ACOs can work with individuals and families, and should be integrated with members' Interdisciplinary Care Teams.

In addition, many social services agencies and programs, such as ABCD's health services and neighborhood-based programs, employ community health workers for their unique ability to reach specific, often marginalized populations, explain complex social and health issues, and assist in navigating social and health care systems. MassHealth should explicitly recognize the value and service-delivery effectiveness of CHWs in community-based settings.

Fuel Assistance.

ABCD is particularly pleased that MassHealth recognizes the value of connecting MassHealth members to Fuel Assistance and related utility supports. ABCD's Low-Income Home Energy Assistance Program (LIHEAP) covers 10 cities and towns in Greater Boston and is part of a statewide coverage net-one which also ensures access to other related programs, such as weatherization, utility discounts and heating system repair. Fuel Assistance is only one example of many social service supports which are revenue-neutral to MassHealth, and for which the vast majority of MassHealth members will qualify. Such no-cost referrals represent an important source of leveraged supports for MassHealth members, which could be readily facilitated through a structure such as the SDOH Hub, as described above. Such referrals should be permitted-and encouraged-in the design for social service access.

Recovery High Schools.

ABCD operates the William J. Ostiguy Recovery High School. We were pleased to see, in MassHealth's waiver proposal, the request to bring Recovery Coaches under MassHealth covered services.

In conclusion, we wish to thank you again for including social services in your development of MassHealth's health care and payment delivery systems redesign. ABCD is pleased to have had the opportunity to be involved in this process over the past year. We hope that, as these system

redesigns are operationalized over the coming months and years, we and other social service agencies will continue to have a place at the table. The Social Determinants of Health underlie much of the ill-health which MassHealth members disproportionately experience in our society. Social Services, as MassHealth has recognized, are key to reversing that and enabling its members to live healthy, stable lives.

Sincerely,

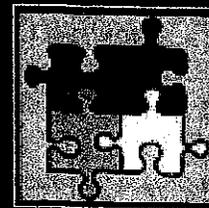
A handwritten signature in black ink, appearing to read "John J. Drew". The signature is fluid and cursive, with a large initial "J" and "D".

John J. Drew

President/CEO



ADVOCATES FOR AUTISM OF MASSACHUSETTS



June 23, 2016

Daniel Tsai, Assistant Secretary and Director of MassHealth
Executive Office of Health and Human Services
Office of Medicaid, Attn: 1115 Demonstration Comments
One Ashburton Place 11th Floor
Boston, MA 02108

RECEIVED

JUN 27 2016

OFFICE OF MEDICAID

RE: Comments on Demonstration Extension Request -Restructuring of MassHealth and its Impact on the Delivery of Physical and Behavioral Healthcare and LTSS to People with Autism

Dear Assistant Secretary Tsai:

As Chair of Advocates for Autism of Massachusetts (AFAM), I am writing about our feedback about the proposed restructuring of MassHealth and its impact on the delivery of physical and behavioral healthcare and long term services and supports to people with autism. AFAM is a Massachusetts statewide grassroots organization, consisting of 12 member organizations, advocating on behalf of individuals on the autism spectrum.

With our specific community in mind, we have reviewed the documents describing the proposed restructuring of MassHealth posted at www.mass.gov/hhs/masshealth-innovations (the Summary, Overview and Additional Material).

We understand that MassHealth must undergo restructuring to improve the delivery of medical and behavioral healthcare and long-term services and supports in a way that improves quality and is fiscally sustainable. We appreciate the complexity of the challenge you face.

It is heartening that the proposed restructuring is not "one-size-fits-all," and that there are different options and approaches that reflect the needs of MassHealth members and the range of provider capabilities. We appreciate the major focus on integrating the delivery of healthcare to better meet members' physical health, behavioral health (BH) and long-term services and support (LTSS) needs, as well as the proposal to strengthen linkages to social services. We applaud the proposed upfront investment in BH/ LTSS community capacity, investments to better meet health-related social needs, and investments to improve accommodations for members with disabilities.

We also recognize that--as is the case with major changes to any complex system-- the devil will be in the details. At this point in the review, we have the following *deep concerns*:

- There is a current statewide dearth of primary care physicians and specialists (including psychiatrists and psychopharmacologists) who are experienced in delivering medical and behavioral healthcare to children and adults with autism and other developmental disabilities. These patients often pose challenges and they encounter barriers that limit access to quality, effective care in the existing system. The shortage of qualified physicians available to treat people with autism and other developmental disabilities is exacerbated by the fact some will not accept

Health due to reimbursement rates. Our concern is that this shortage will grow worse. Exceptions/referrals need to be made for individuals with specialized needs.

- If members are required to choose an ACO based on their PCP's membership in the given ACO network, accommodation must be made if they receive LTSS (e.g., day hab services) from a provider in another ACO network. Again, there is a very limited number of providers in Massachusetts who have experience in delivering acceptable, quality services to people with severe autism and significant behavioral challenges. These LTSS are often only one piece of the services on which the person relies. For example, the person may receive residential services under the Home and Community Based Waiver, and these services are not currently proposed to be subject to the ACO-based system. The selection of a coordination of all of these services (some of which may never become a part of the restructured MassHealth services) must make sense for the individual. It must ensure real, meaningful access, and must ensure choice and ensure adequacy of services and supports. Flexibility must be built into the restructuring. Flexibility will further the goal of improving the quality of physical, behavioral and long-term supports and services and the quality of care coordination. Therefore, much more operational detail will need to be developed to determine if this desired outcome can be achieved.
- We strongly recommend an "opt-out" choice for all clients as this restructuring takes place. It is also imperative that an "opt-out" choice be made available to clients in an ACO if that ACO does not meet clients' needs. We further urge an extended waiting period of an additional year before individuals with ASD/ID/DD must be included in the rollout of the MassHealth restructuring. This will allow shortcomings and problems for this particular population to be adequately addressed, and details of solutions proposed.

Based on these concerns, we have additional, outstanding questions about the operation of the new models:

- How will the requirements for Certified Community Partners mesh with the reality that there are few BH and LTSS providers with knowledge of how to effectively deliver health care and other long-term supports and services to people with autism and other developmental disabilities?
- What standard will be used to determine that ACOs have sufficient understanding of the complex needs of these challenging clients?
- Assuming Massachusetts is successful in obtaining the federal DSRIP dollars to provide for the required upfront investments in this new system, will adequate funding exist as the DSRIP period winds down to ensure its continued operation in an effective way?

We appreciate your continued efforts to ensure the delivery of quality healthcare and long term services and supports to people with autism and other developmental disabilities, and we look forward to further opportunities to be helpful on the detail as the restructuring process evolves.

Very truly yours,



Michael J. Borr, Chair of AFAM

Cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services
Robin Callahan, Deputy Medicaid Director for Policy and Programs
Commissioner Elin Howe, Massachusetts Department of Developmental Services

Hello,

My name is Catherine Boyle, and I am the president of Autism Housing Pathways, a 501(c)(3) organization that educates Massachusetts families about housing options for their adult family members with developmental disabilities. I am writing to provide comment on MassHealth's Section 1115 Demonstration Project Amendment and Extension Request.

Housing stabilization and support, search and placement

In my work with families across the state, I have found that, in general, individuals, their families, and teachers of transition-age youth generally have little to no a priori understanding of existing housing programs, or of MassHealth State Plan options, such as Adult Family Care/Adult Foster Care. To expect them to take the further leap of understanding the rules governing the interactions of these programs without assistance is, frankly, assuming the impossible.

As a result of this experience, I am happy to see specific mention of "Housing stabilization and support, search and placement" as a category of flexible services in 5.3.2.3 of the Amendment and Extension Request. I hope that the category is broadly construed to encompass the range of elements that help individuals and their families to develop and execute a sustainable, self-directed housing strategy. These include (but are not limited to):

- Education about the range of subsidized and/or affordable housing programs, and identification of appropriate programs for the individual;
- Education about the existence and requirements of MassHealth State Plan services, and identification of the service that will best support the individual in housing;
- Hands on assistance in filling out applications for Section 8 housing vouchers;
- Education of the individual in what is expected of a housemate, a neighbor, and a tenant;
- Assessment of living skills;
- Assessment of and funding for appropriate assistive technology; and
- Evaluation of housing for appropriateness and developing recommendations for environmental modifications to ensure success.

The last four are particularly important for individuals with autism, who now constitute almost half of the DDS Turning 22 class. Otherwise, it is all too easy for individuals to fail to maintain tenancy. For this reason, in some instances, training of landlords, property managers, and housing authority personnel in how to interact with tenants with autism is also advisable.

All of these elements need to be embedded in a person-centered process that identifies the relationship of housing to transportation and employment/day activities to create a sustainable model.

State plan services

While not directly addressed in the Demonstration Extension Request, there are certain features of existing State Plan services that negatively impact the ability of MassHealth members to obtain and maintain safe, healthy, and sustainable housing arrangements.

Adult Family Care is the primary way for families to provide LTSS to an individual in the home. However, it is currently limited to a care provider who is not a guardian. This creates a genuine hardship for single parents, who are frequently most in need of support, and increases the likelihood an individual will need a far more expensive group home placement. Allowing single parents who are guardians to be AFC caregivers would improve the care of eligible MassHealth members, provide a relief to families, and save money.

The Adult Family Care and Adult Foster Care (AFC) stipend level is determined by the level of care an individual needs. Level II of AFC requires an individual need physical assistance with three or more Activities of Daily Living (ADLs), or with two if a maladaptive behavior is present. (ADLs include bathing, dressing, toileting, transferring, ambulating, or eating; maladaptive behaviors include: wandering, being verbally or physically abusive, socially inappropriate/disruptive or resisting care.) Many individuals with autism have more than one maladaptive behavior present and require only cueing to perform ADLs. Despite having intensive support needs, these individuals are only eligible for Level I AFC. It would be appropriate to add cueing to the Level II requirement, so that Level II funding can be received if the member requires physical assistance or cueing with 3 ADLS; or 2 ADLs and the management of the behavior. This would provide individuals with more appropriate supports, preventing or slowing caregiver burnout, and hopefully delay the need for more expensive residential services.

Group Adult Foster Care (GAFC) can be used to provide up to two hours a day of drop in services for individuals who need cueing for at least one ADL. It differs from AFC, in that the individual does not require a support provider to live in the same unit. However, it can only be used in assisted living facilities and subsidized (i.e., project-based) housing. The result is that people for whom this is an appropriate level of service can only receive it in these settings. For instance, someone living in a project-based Section 8 setting can receive it, but someone with a portable Section 8 voucher cannot. This means there is currently no State Plan service for someone who needs cueing only, unless they are living in these very limited settings. Changing the setting requirement to a simple requirement that a GAFC provider agency be willing to provide services in a given location would increase the ability of individuals to live independently in the community.

Thank you for the opportunity to comment.

Sincerely,

Catherine Boyle

President, Autism Housing Pathways

617-893-8217

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www.autismhousingpathways.org

building roads to home

Dear Secretary Sudders,

The Alliance of Massachusetts YMCAs is pleased to present written comments regarding the demonstration extension request. We appreciate the creativity and progressive thinking of the Department in finding a balance between concern for controlling costs and the need to improve the health of some of our most at risk residents of the Commonwealth.

The Alliance represents the 30 YMCA nonprofit associations in the state with over 400 service locations. We serve over one million people each day, are collectively the largest provider of early learning and out of school services, and provide over \$40 million annually in direct support to the communities we serve. In our focus areas of Youth Development, Healthy Living, and Social Responsibility, many of our Ys are located in low wage earning communities where we provide housing, access to healthy food, job training assistance, and coordinate with local providers for access to health services, including behavioral health and long term service supports, with an emphasis on chronic disease and its prevention. No one is ever turned away from a Y due to lack of ability to pay.

In reviewing the demonstration extension request, we are pleased to see the inclusion of social service supports. In our role as a community partner we believe these services to be essential to achieving the desired results of the request, specifically to reduce costs and improve health outcomes for vulnerable populations suffering from one or more chronic illnesses. We know from experience that having access to supports that provide safety and security are a prerequisite for individuals seeking healthcare. Additionally, we also know that the inclusion into a community of others, as the Y has historically and uniquely done so well, provides immeasurable benefit for the chronically ill. When combined with evidenced based chronic disease prevention programs, these supports and programs create the opportunities necessary for this request to succeed.

We also recognize the new territory being created in designing a system that includes social services from community providers not traditionally reimbursed by or accountable to the Department. To that end, while in general support of the request, we believe that once approved there is the need to define and describe how these community supports will interact with ACOs, become sustainable, and be accountable. We believe that the groundwork for this necessary structure has been accomplished through the work of the Department as well as the Department of Public Health, lacking only refinement for implementation. Specifically, we further offer that community responsive hubs which connect to local agencies offering services impacting social determinants of health and are partnered with ACOs in data collection, risk stratification, and shared risk are the most efficacious model to implement.

The Alliance had the privilege of serving on the MassHealth Health Homes Work Group. The identification through that process of the important and integral role of medially beneficial services offered through community-based organizations that are not traditional health providers was a key part of that work. The discussions and suggestions through that work group regarding the integration of social service supports is essential to the ultimate success of this effort.

We believe social services to broadly encompass population health components and while including supports such as childcare, transportation and housing, we understand the intent of the Department is to not limit itself to that narrow a definition. Based on the work with Health Homes, we recognize social services to include that which not only assist a person in accessing medically beneficial services, but also to include specific evidenced based programs which, when offered through a community based organization, further reduce costs and improve health outcomes. Current research has proven this assertion of costs savings and health benefit through investment in social services to be true. Locally, this has already been proven through the Prevention and Wellness Trust Fund, whose process serves as a template for inclusion of social services and associated population health impacts for this extension request.

Therefore, we believe it is essential that as the plan is implemented, for MassHealth to specifically provide incentives for ACOs to engage in and provide evidenced based chronic disease prevention and mitigation programs as well as essential safety and security supports. In most cases these services will most efficaciously be offered through community based organizations that can provide the necessary ongoing supports required to achieve success for those served.

We believe that the flexible spending component of the proposed plan allows for this work. What we believe to be necessary is to create a structure for ACOs to directly partner in a shared risk and shared benefit process with social service providers. However, rather than build something completely new and untested, we believe building off of existing infrastructure will provide the desired results more quickly and more cost effectively. We offer a preferred method of a social service hub that is a contractual part of the care planning team with the ACO and then subcontracts with local providers for services as being the most effectual mechanism to create partnership, sustainability, cost effectiveness, and improved health status. This process allows for immediate community alignment and flexibility to the unique needs and resources of a community, while not forcing an ACO into an unfamiliar role, and while creating a bridge between clinical services and community supports, also allows for accountability and sustainability through shared resources, risk and benefit. It creates a model of an interactive connected value based care continuum focused on the needs and desired outcomes of the individual.

Again, we appreciate the work of the Department and believe it to be an appropriate step in serving some of our most vulnerable people. The Alliance looks forward to working with the Department in defining the incentives and processes for the inclusion of social services in this effort.

Sincerely,

Peter R. Doliber

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Peter R. Doliber, MHSA, MPH

Executive Director

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ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE

July 12, 2016

Daniel Tsai, Assistant Secretary for MassHealth
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Attn: 1115 Demonstration Comments

Dear Assistant Secretary Tsai:

As you know, the Association for Behavioral Healthcare (ABH) is a statewide association representing more than 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 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people.

On behalf of our membership, ABH thanks the Baker Administration, the Executive Office of Health and Human Services, and MassHealth for a proposal that recognizes the need for better care integration among physical health, behavioral health, long-term services and supports and health-related social services and includes significant design elements to move toward this goal.

ABH offers comment on many elements of the Request for Amendment and Extension of the Commonwealth's Section 1115 Demonstration. Many of our comments focus on the following:

- **Community Partners.** ABH strongly endorses the Behavioral Health Community Partner (BH CPs) concept. We offer additional comment on the need for a "high bar" for certification with a strong focus on community connectedness and population expertise and we reiterate the importance of direct member assignment to CPs.
- **Community Expertise.** ABH recommends strengthening the proposal to include requirements and incentives for ACOs to partner with community providers and also recommends that MassHealth increase investments in the current system of community-based care;
- **Integration.** ABH recommends inclusion of behavioral health representation on ACO governing structures to help promote care integration at both institutional and practice levels; and,
- **SUD Expansion.** ABH strongly endorses the proposed service expansion and coordinated care framework and applauds the Baker Administration for its leadership in this area.

The following sections offer recommendations relevant to the Section 1115 amendment and extension request as well as considerations for design and implementation of new care and payment models. Design and implementation details will be crucial to systems transformation.

Community Partners

ABH is deeply appreciative that MassHealth has recognized the care coordination expertise of community-based providers in the design of the Community Partners (CPs). The plan to **directly invest** in community organizations to better coordinate care for individuals with behavioral healthcare needs is unprecedented. This combination of system design and targeted investment will significantly improve health outcomes for MassHealth members with complex behavioral health needs. **ABH strongly supports the Behavioral Health CP design and direct investment.** We offer additional comments on design specifics and operations beginning on page 8 below.

Behavioral Healthcare Services

ABH **strongly endorses the proposed expansion of Substance Use Disorder (SUD) services** and is pleased that the demonstration application was developed jointly with the Department of Public Health, the Single State Authority on SUD treatment. The proposal to expand SUD coverage to additional 24-hour levels of care for MassHealth members (ASAM Levels 3.1 and 3.3), to increase access to Medication Assisted Treatment (MAT), and to create access to care management and recovery supports will expand access to proven treatment and recovery services and supports and provide the Commonwealth with critically needed tools in the fight against opiate addiction. ABH offers more comments and questions beginning on page 15 below.

Relative to the role of services and supports to individuals with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED), ABH encourages MassHealth, in partnership with the Department of Mental Health, the Single State Authority for Mental Health to refine operational details, such as the selection and role of Community Partners and consumer/member protections and choice in provider.

In terms of more broad-based access to behavioral healthcare services, ABH deeply appreciates that MassHealth's overall accountable care approach will seek to preserve access to treatment by maintaining the policy of not requiring referrals for outpatient behavioral health services (see Executive Summary of the demonstration extension request document). There are numerous barriers to accessing appropriate levels of behavioral healthcare services, including stigma, psychological barriers, prior authorization and administrative constraints, and siloed care. In order to maximize service access, ABH believes all behavioral healthcare services should be excluded from the new copays that are under consideration as indicated in Section 4.4. The state should not create yet another hurdle to care by instituting new copays.

ABH continues to be concerned about insufficient access to community-based outpatient services for MassHealth members. Both Community Partner organizations and ACOs will struggle to access these services without a significant investment by MassHealth in the community-based system. ABH offers more comments on page 17 below.

Finally, the waiver proposal does not specify how the ACO construct will address the unique needs of children and families. Family is critical to accessing services and managing care for

children. All ACOs should have sufficient connections to community-based behavioral healthcare providers with expertise in serving children and families. The ACO's partnership with the CP/Community Service Agency (CSA) is vital, because these entities have extensive experience serving and coordinating care for children with SED who may be involved with an array of services and supports (schools, social service agencies, state agencies, social clubs, faith communities, etc.). The ACO initiative should also incorporate lessons from the Children's Behavioral Health Initiative (CBHI), which has embraced non-medical staff such as family partners to help families achieve better outcomes for their children and piloted an alternative payment model (APM) for the CSA services.¹ In addition, the initiative has required that the MCEs be uniquely aligned in terms of services offered and access to these services. This approach has improved experience and outcomes for families.²

Transparency

During systems transformation and payment reform, it will be important to have numerous indicators against which to measure current and future states. ABH recommends the following reporting and transparency requirements be mandated for ACOs and/or MCOs, as appropriate.

1. Report annually in a public document its spending, in total and as a percentage of total expenditure, on MassHealth members for:
 - behavioral health services;
 - primary care;
 - acute care costs;
 - emergency services;
 - pharmacy; and,
 - other specialties that MassHealth deems appropriate.

These data should be broken down by levels of care:

- inpatient (e.g., inpatient psychiatric hospitalization, Acute Treatment Services, Clinical Stabilization Services, etc.);
- diversionary/intermediate (e.g., 24-hour community-based care and recovery-oriented services like ESP, PACT and CSP); and,
- outpatient.

ACOs should be required to categorize services in a standardized manner (e.g., Level III detox is uniformly categorized as diversionary, not inpatient, or vice versa, etc.) to enable comparative analysis. MassHealth should provide data to establish a pre-ACO participation baseline using expenditure data on those members attributed to each ACO.

2. Report in a public document on demographic information collected under the Health Policy Commission's ACO Certification Criteria "Assesses needs and preferences of ACO patient population" domain – with the additions of disability status and recent incarceration - and

¹ CSA services include Intensive Care Coordination and Family Partner services. ABH understands that early APM pilot data show better staff morale, greater staff retention, and increased focus on quality/clinical service delivery.

² There is no reason why some of these same approaches could not be taken with adults as well.

detail how this information is used to inform operations and care delivery;³

3. Document to all ACO participating providers how shared savings will be distributed among participating providers and make a summary publicly available;
4. Detail in a public document its methods and processes to coordinate care throughout an episode of care and during level-of-care transitions both inside and outside the ACO, with documentation verifying the non-ACO partnerships. For example:
 - transition from inpatient behavioral health unit to community-based and outpatient services; and,
 - transition from inpatient detox to intermediate and outpatient services.

This plan should be updated on a scheduled basis.

5. Detail in a public document its plan to incorporate behavioral health into its care management of members. Verify the participation of community-based partners and update this plan on a scheduled basis;
6. Detail in a public document its number and percentage of members eligible for Community Partner coordination services and the number and percentage assigned to a Community Partner for care coordination. Also report the percentage of members receiving coordination services provided by the ACO, primary care providers, and Community Partners; and,
7. Detail in a public manner its plan to prevent disparities in care, including matching members to appropriate community-based providers and resources.

Finally, ABH recommends that MassHealth convene additional stakeholder feedback sessions on the ACO and MCO procurements. Based on the Pilot ACO Request for Responses, ABH would have a number of questions and comments.

Cross-Model Consistency

The proposal envisions MCOs and ACOs as complementary, with MCOs “working with ACO providers to improve care delivery and coordination” and helping “determine which care management functions are best done” by providers vs. MCOs (See proposal Executive Summary). The proposal also states that “MCOs may also help ACOs determine how best to integrate behavioral health (BH) and long-term services and supports (LTSS) Community Partners into care teams.” Because of the potential for a proliferation of arrangements, ABH believes that the Commonwealth should have sufficient standardization to minimize confusion among MCO-contracted providers, ACO-affiliated and unaffiliated providers, and MassHealth members.⁴ This would be consistent with the Center for Health Care Strategies (CHCS) recommendation for states to establish consistently defined standards across core activities to

³ The referenced HPC domain requires ACOs to collect and evaluate the following data on members: race, ethnicity, language, culture, literacy, education, gender identity, sexual orientation, income, housing status, access to transportation, interpretation/translation needs, food insecurity, history of abuse/trauma and “other” as appropriate.

⁴ In its MCO reprocurement, MassHealth should seek greater consistency across plans. For example, the PCC plan via the Massachusetts Behavioral Health Partnership (MBHP) along with One Care plans pay for highly effective, evidence-based Program of Assertive Community Treatment (PACT) services, but the MCEs do not. There is no logical reason why MassHealth member access to this medically necessary service is contingent upon plan enrollment.

simplify ACO administration and monitoring, while also making it easier for MCOs to administer and less expensive for non-primary care providers, i.e., specialists that might participate in multiple ACOs, to participate. CHCS notes that States clearly “defining ACO and MCO roles, implementing the program effectively, and aligning ACO activities across Medicaid payers are crucial aspects of ACO success in a managed care environment.”⁵ This will also be important in helping the state avoid duplication of functions and services.

Designated Behavioral Health Representation in ACO Governance

There is extensive national and state data correlating behavioral health disorders with higher health care costs and/or unnecessary Emergency Department (ED) utilization.⁶ Beyond the financial costs, the human costs are catastrophic. 1,379 Massachusetts residents lost their lives due to opiate overdose in 2015.⁷ Data show that individuals diagnosed with Serious Mental Illness (SMI) have an average age of death at 53,⁸ and the risk of early death is due largely to preventable conditions.⁹

In implicit recognition of this stark reality, two of the five proposed Demonstration goals relate directly to behavioral healthcare:

- improve integration among physical health, behavioral health, long-term services and supports, and health-related social services (#2); and,
- address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services (#5).

Average Life Expectancy of Adult with SMI

53

Percentage of Preventable Premature Deaths in Individuals with Schizophrenia

85%

MA - Unintentional Opiate Overdose Deaths 2014

1282

MA - Unintentional Opiate Overdose Deaths 2015

1379

Required Behavioral Health Expertise in ACO Governance

0

⁵ [The Balancing Act: Integrating Medicaid Accountable Care Organizations into a Managed Care Environment](#), Policy Brief, Center for Health Care Strategies (November 2013).

⁶ See e.g., *Health Policy Commission (HPC) 2013, 2014 and 2015 Cost Trends Reports* (noting significantly increased spending for individuals with both behavioral health and chronic medical conditions; avoidable ED visits for behavioral health conditions have grown sharply, about 5% annually, and finding a strong negative correlation between numbers of behavioral health providers in each region and rates of behavioral health-related ED visits.)

⁷ Massachusetts Department of Public Health [Data Brief: Opioid-related Overdose Deaths Among Massachusetts Residents](#) (May 2016) (1379 unintentional opioid overdose deaths, estimating 146 additional deaths not yet confirmed.)

⁸ Colton CW, Manderscheid RW. 2006. “Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states.” *Prev Chronic Dis.* 3(2):A42.

⁹ See e.g., Olfson, Mark, et al., Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry* 72.12 (2015): 1172-1181 (Showing individuals with schizophrenia are 3.5 times more likely to die than the general population, losing an estimated 28.5 years of life. Eighty-five percent of the premature deaths were due to largely preventable conditions such as high blood pressure, high cholesterol, diabetes, and heart disease.)

However, changes are needed not only at the practice level but also within institutional and governance structures in order for transformation to occur. The Health Policy Commission's final ACO certification standards did not include designated behavioral health representation in governance, as they did for patient representation. As ABH noted in prior correspondence, the final standards reflect a retreat from the draft standards which required behavioral health representation in ACO governance. ABH believes this belies a deeply entrenched commitment to the status quo and continued disregard for these patients and the services they require by entities likely to become ACOs.

Given the vast impact of behavioral health conditions on human and financial cost, the substantial behavioral health investment MassHealth is making through Behavioral Health Community Partners and SUD service expansion, and the stated focus of the Demonstration on improved care integration, **ABH strongly encourages MassHealth to require designated community-based Behavioral Health representation within MassHealth ACO governance structures.** It is unclear how an entity could adequately devise strategies relating to behavioral healthcare - an area with a known and substantial impact on total cost of care - without content expertise represented in governance and leadership. Finally, MassHealth may wish to consider requiring each ACO to identify an executive team member who is responsible for behavioral healthcare services, integration and interface with the BH CPs, similar to its requirement that all MassHealth MCOs have a Behavioral Health Director.

Member Choice: BH Service Provider

MassHealth members' choice of primary care clinician (PCC) will drive how they receive care and how their care is coordinated. Section 4.1.8 states that "while special attention will be paid to maintaining primary care relationships in assignment and attributions, members will need access to accurate information about the full range of health services offered." ***Preserving the treating relationship between a MassHealth member and his or her behavioral healthcare provider is as important as preserving primary care relationships***, and for some MassHealth members, it will be more important. MassHealth, its MCOs and its ACOs must make similar efforts to maintain these relationships.

Specifically, we recommend:

- ***Informed Member Choice.*** Section 4.1.8 indicates that ACOs and MCOs will be required to make information about their plan(s) readily accessible, and that MassHealth will enhance its own member-facing customer service, website, publications, and community engagements. Although most individuals will be assigned to an ACO through their primary care doctors, as opposed to individuals affirmatively selecting an ACO, patients must understand that they are committing to the MCO/ACO's network and they need to ensure that their specialty providers are network participants. To the maximum extent feasible, a member should be able to learn with a single phone call or website visit whether his/her providers – including primary care, behavioral health, and other specialty – participate in his/her ACO and/or MCO. Assistance in determining provider participation should also be widely available to members so they can make informed decisions about provider, plan and ACO selection.

- **Interdisciplinary Care Teams.** The ACO procurement should specify that ACOs adopt a care team planning approach.¹⁰ The procurement should also specify that the care team include participation by the attributed MassHealth members' behavioral healthcare clinician (and other providers) of choice, regardless of ACO or CP affiliation, provided they are in the MCO network. If the member is eligible for a CP, the BH CP care manager should hold responsibility for authorizing the care plan.
- **Continuity of Care.** To ensure stability for MassHealth members and providers during a time of significant transition, ACOs should be required to demonstrate that their networks include providers who delivered at least 80% of the last 12 months' non-hospital behavioral health spend for the ACO's attributed members in the preceding year or another recent 12-month period that MassHealth can use to make this calculation (see page 14 for inclusion in ACO Accountability). It is crucial during this period of significant transformation in the delivery system that continuity of treatment be maintained for this vulnerable population.
- **No Artificial Barriers.** ABH was pleased to see that Model B ACOs will not be permitted to impose additional referral requirements for providers not included as preferred providers. All ACOs should be explicitly prohibited from imposing additional requirements for accessing providers that are not part of the ACO or partner CP(s).

Community-Based Service Expertise

ABH has substantial concerns about the lack of mandates that would **require Accountable Care Organizations (ACOs) to partner with community-based provider organizations for service delivery**, not just as Community Partners for care coordination. Without meaningful incentives or formal requirements, existing community service expertise that MassHealth has developed in its provider network over several decades may be lost, and/or unnecessary and costly service duplication may result. This is especially true for specialty or niche services provided by smaller community-based organizations who have developed decades of expertise serving subsets of MassHealth members with chronic behavioral health conditions, including cultural and linguistic minorities and others already experiencing significant disparities in access to care.

The waiver request indicates the following will be required of ACOs relating to behavioral healthcare *service delivery*:

- Evidence of cross continuum care: coordination with BH, hospital, specialist, and long-term care services (Section 4.1.1. - Health Policy Commission ACO Certification criterion);
- Integration of physical, behavioral health, oral health, social determinants of health and long-term services and supports (Section 4.1.1 - ACO procurement process expectation);
- Interdisciplinary care teams that include BH Clinicians and for members with complex BH needs "community-based BH providers with expertise across the entire care continuum of

¹⁰ MassHealth should consider investing in and mandating universal person-centered care planning training for ACOs and CPs as occurred with the CSAs. Further, this is consistent with the proposal to adopt an ASAM-based assessment tool across SUD levels of care and coverage types.

BH treatments and services, from emergency and crisis stabilization through intensive outpatient, community-based service”¹¹ (Section 4.2.1 – source of expectation not clear).

While ABH understands that the waiver request lacks a high-level of operational detail,¹² we believe that the requirements above are insufficient to ensure that existing behavioral healthcare services are not replicated within ACOs at higher cost to the Commonwealth. Further, it is not clear that the unique needs of cultural and linguistic minorities and other subpopulations will be met or that those already experiencing significant disparities will experience a reduction in those disparities.

As ABH has previously commented, the Health Policy Commission’s Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment Program lacked any requirements or significant incentives to partner with community-based organizations for service delivery. When ABH surveyed its membership about CHART grantees leveraging community expertise for funded behavioral health projects, responses indicated that in the majority of instances grantees either did not partner with community organizations or did so in a cursory fashion. In numerous instances, services were duplicated by the hospitals, an approach that represents potential new, unnecessary costs to the care system.

Based on the experience of our members, ABH believes that there must be **explicit requirements that ACOs partner with existing community-based behavioral health service providers**. Specifically, ABH recommends that ACOs be required to have partnerships across the continuum with community-based behavioral health organizations pursuant to the HPC certification criteria and submit affiliation agreements, referral agreements, and/or subcontracts with community-based behavioral health providers for the provision of behavioral health services as evidence of these partnerships. For Models A (if an existing MCO) and C, the MCO should be required to ensure care continuity by demonstrating that their networks includes a **minimum threshold of those provider organizations that provided 80% of the last 12 months’ non-hospital behavioral health spend for the ACO’s enrolled members**.

Behavioral Health Community Partner Certification

MassHealth members with complex needs require interdisciplinary care teams with cross-continuum expertise, and CPs will be essential team members. CPs need a relatively stable, critical number of members with complex needs in order to effectively coordinate care in a sustainable manner. ABH continues to caution MassHealth that any certification process must be sufficiently rigorous to ensure that geographies are not oversaturated. This will help ensure that BH CPs have sufficient numbers of MassHealth members to serve members effectively and that DSRIP funding is optimally distributed.

¹¹ ABH interprets the latter BH provider partner to be the BH CP care coordinating entity.

¹² The Pilot ACO RFR requires applicants to detail proposed TCOC/Quality Management models that “take into consideration” goals of integrating physical, behavioral health and other health domains as well as investment in community providers and community-based organizations. If the applicant’s proposal entails the “use of team-based care” and coordination and integration with “providers of mental health and/or substance use disorder services” and others, the applicant must detail its approach. However, these do not appear to be required elements. ABH recommends that the final ACO RFR be far more explicit as to expectations, particularly around care teams and partnerships across the continuum.

If the Commonwealth certifies multiple CPs in a specific geography, MassHealth will have empowered ACOs to select winners and losers among BH CPs. By allowing ACOs to select which BH CPs they partner with and which members they assign to CP services, ACOs will control the flow of patients to their favored entities without an evidence basis. Because no baseline BH CP data exists that the ACOs may use to guide BH CP partner selection, the Commonwealth must not put barriers in place for the BH CPs certified or procured by MassHealth to succeed. This will undermine MassHealth's own commitment to the role of CPs in care coordination for members by allowing DSRIP investment to be wasted on unsuccessful CPs.

Relative to BH CP certification domains, ABH agrees with those identified by MassHealth.¹³ In addition, any certification process should ensure:

- statewide access to CP services;
- demonstrated community embeddedness;
- demonstrated competencies in serving individuals with complex BH needs;
- strong cultural and linguistic competence in serving the target population(s); and,
- sufficient MassHealth member participation for sustainable services.

ABH offers the following competencies that any applicant for BH CP certification should be required to demonstrate:

- **State Services and Supports.** Provider organizations that are contracted with state and local governments to deliver services will have knowledge of non-MassHealth services and eligibility criteria, relationships with local and administrative agency personnel, and the ability to leverage this knowledge and relationships to obtain resources and support for MassHealth members.
- **Intersystem knowledge, planning, and affiliation.** In addition to service-purchasing partners, BH CPs must have knowledge of and ability to access critical non-healthcare community systems such as schools, housing assistance agencies, cultural organizations, immigration services, legal services, reentry services, recreation programs, food pantries, police, etc.
- **Community-based.** BH CPs that are embedded in local communities are better able to attract staff who are representative of populations served, outreach to individuals in need more easily, and have knowledge of services and providers that allow for consumer choice. Knowledge of local stakeholders and services is essential to person-centered care coordination and promotes access to services in the individual's home community, wherever possible and desired.

¹³ MassHealth proposes in Section 4.2.3.3 CP competencies in six Health Home services, outpatient mental health and SUD services, including outreach & home-based services, and assessment domains of Infrastructure and systems (e.g., ability to collect, analyze and share information electronically), care management and coordination, staff expertise and training, relationships with social service providers and local and public agencies, quality measurement and reporting, and cultural competency. The BH CP must also be a Community Service Agency or have agreements with one.

- **Care Planning and Care Team Expertise.** BH CPs should have competence in care planning teams, Wraparound care planning, or other models and approaches, and should be required to detail approaches to community- or home-based assessments, development and facilitation of the care team, including a Peer or Family Partner, individual patient-centered care plan development and follow-up.
- **Recovery-Oriented Supports.** Integration of recovery supports such as peer specialists into its operations is a core competency that should be expected of a BH CP and is a competency which community providers have been developing for several years in partnership with the Commonwealth.
- **Individual and Family Voice.** BH CP must solicit and prioritize individual, family and youth values and preferences during the care planning and coordination process.
- **Cultural and linguistic competence.** BH CPs must be able to work with MassHealth members in a culturally aligned manner that recognizes, among other things, the member's chosen identity, norms, values, beliefs, preferred language and mode of communication.
- **Levels of Care.** BH CPs must be knowledgeable about and know how to leverage community-based outpatient, intermediate/diversionary, and inpatient mental health and substance use services. BH CPs must have relationships with the providers of those services in order to ensure effective consultation and referral processes and seamless transitions and coordination of care.
- **Diversion.** BH CPs and ACOs share a common goal of diverting individuals from more restrictive settings when that setting is not necessary, effective or desirable for the person in crisis, particularly hospital EDs and inpatient psychiatric care. BH CPs can help reduce inappropriate use of acute care settings and shift care provision to alternatives in the community, near the MassHealth member's natural supports whenever feasible and appropriate.

Finally, the document notes some alignment between the Certified Community Behavioral Health Clinic (CCBHC) initiative and the Section 1115 strategy. ABH **strongly opposes** deeming CCBHC certification as adequate BH CP certification. ABH repeatedly raised concerns about needing to make that approach transparent to potential CCBHC applicants during the application process if the Commonwealth opted to align the initiatives. Alignment was never formally communicated. It would be **unfair to providers that elected not to apply for CCBHC certification** to align these initiatives after that certification process has closed. Moreover, the CCBHC criteria, more narrowly focused on outpatient services, do not fully align with Mass Health's goals and CP responsibilities.

Community Partner Member Assignment

Section 4.2.3.1 indicates that in addition to member self-referral, rating category and/or claims data will be used to identify members who might benefit from Community Partners (CP) services. Information on these members will be provided "to the CPs as well as the ACOs to facilitate outreach to the member and *subsequent* participation in a CP." CP services are different than

psychotherapy services or primary care in that these are a package of care coordination activities that most people will not seek out in the way that they might contact a therapist to treat depression or a doctor to diagnose recurrent headaches. Because of the nature of the service and the vulnerability of the populations to be served, ABH believes that **direct assignment by MassHealth of members to a CP is the most efficient and effective approach** to ensuring that eligible members will be given a meaningful opportunity to benefit from CP services. The CP would then reach out to engage the assigned members, which is more likely to result in effective engagement of eligible participants.

It is unclear from the documentation exactly how member enrollment in CP services will be achieved, e.g., ACO referral, affirmative enrollment, etc. Given the targeted populations (individuals diagnosed with SMI, SED or SUD), a significant number of whom will have complex, co-occurring BH conditions, the outreach and engagement process can sometimes take weeks or even months. Direct assignment will allow providers to create and sustain the necessary infrastructure to undertake this work. ACOs will have MassHealth members directly attributed to them. It is unclear why a direct attribution process is appropriate for these entities, but direct assignment is not appropriate for BH CPs, which will have a significant role in reaching highly vulnerable individuals and families. Our concerns about the sustainability of CP services are amplified if members must be referred to CPs by ACOs or if there are multiple CPs in an area who are simultaneously outreaching to the same members. This approach could undermine the effectiveness of the CP system while also overwhelming some of MassHealth's most needy members.

Health Disparities and Specialty BH CPs

The waiver request includes limited discussion of the specialized needs of cultural or linguistic minority populations and the specific mechanisms through which ACOs will be held accountable for addressing behavioral health disparities, particularly the specialized needs of cultural or linguistic minority populations. MassHealth should establish minimum requirements for all ACOs and CPs, including:

- Sharing of required ACO demographic data collection and analysis pursuant to HPC ACO Certification Criteria (Required Supplemental Question #2) with CPs;
- Establish selection criteria and scoring for ACOs and CPs that address providers' capacity to meet the needs of underserved racial, ethnic and linguistic populations; and,
- Require cultural competence training of all patient-facing staff and ensuring that hiring practices focus on recruitment from the populations and communities that the ACO and CP serves.

Additionally, ABH recommends that MassHealth consider multiple specialty BH CPs for identified cultural and linguistic minority populations, similar to the procurement of specialty CSAs under CBHI.

The ACO-BH Community Partner Relationship

All ACOs should be required to partner with BH CPs throughout the five-year DSRIP period. The draft submission is somewhat confusing on this point. Sections 4.1.3 through 4.1.5 provide more detailed overviews of the ACO Models. However, only Model B includes an express statement that this model will be required to partner with CPs. Verbiage elsewhere in the

document suggests that all ACOs will be required to have formal agreements with Behavioral Health Community Partner organizations. We respectfully request clarification.

In Section 4.2.3.2, MassHealth indicates that MassHealth will establish a framework for ACO and CPs to formalize their partnerships, i.e., MOUs, and that MassHealth will define mandatory agreement domains, including roles and responsibilities in care coordination and management, shared decision-making and governance, performance management and reporting, clinical, IT and systems integration, approach to address cultural competency and health literacy, and workforce development and training. ABH recommends the following additions:

- Identification and specification of criteria and processes used to refer and enroll additional patients in the BH CP beyond those automatically identified or enrolled by MassHealth;
- Required shared savings in total cost of care for CP-enrolled members with their CP partners in light of the key role of care management in reducing cost growth;
- Prohibition of mandates for the use of a particular EHR by CPs; rather, MassHealth should mandate interoperability/data exchange options;
- ACO provision of real-time access to the ACO's client records with no cost to the CP;
- ACO provision of necessary clinical, claims and total cost of care data on CP members to the CP;
- Delineation in the role of the CP as care coordinator and as treatment provider; and,
- ACO-CP dispute resolution process

ABH recommends that ***MassHealth issue a template MOU that covers core requirements and that could be modified as appropriate to the needs and strengths of the signatories.*** This would be consistent with MassHealth's inclusion of a model contract with its Pilot ACO RFR and with proposed use of DSRIP funds for legal services.

The ACO-BH Community Partner Relationship: Care Plan Authorization

Section 7.2.6 indicates that individuals with significant SUD will be assessed, participate in service plan development, receive ongoing support and service coordination, and health and social service referrals through the Community Partner. These services are overseen by the Community Partner's Care Manager who will approve the member's recovery plan. **MassHealth should make explicit that the CP Care Manager will approve care plans for all CP populations**, not just members with SUD.

ACO-BH CP Relationship: Flexible Supports

ABH is concerned about the assignment of roles and responsibilities between ACOs and BH CPs relative to flexible supports to assist with health-related social services and social determinants of health (SDH). It appears that CPs are charged with making linkages to social services agencies, formulating care plan recommendations, generating referrals, and providing navigational assistance. There appears to be overlap with ACO responsibilities. However, Section 5.3.2.3 indicates that only ACOs receive distinct flexible services funding. Given their essential role in care coordination, ***CPs must be able to access flexible services funding to enhance their***

ability to provide wrap-around services. This is important for two reasons: administrative efficiency and relationship building. First, requiring the CP to do the groundwork to solve a problem and then requiring it to navigate an administrative process to secure funds to resolve the issue is a poor use of staff time and resources and becomes a barrier to the appropriate use of funds. Further, the proposed structure makes it challenging for CPs to develop and maintain credibility with MassHealth members and social service agencies with whom the CP partners. The example provided in the waiver document of a member needing to complete a utility assistance application and pay an electric bill is exactly the type of situation in which a CP should have direct access to flexible funds. Trust cannot be built with the MassHealth member if they are forced to wait for resolution of an administrative process to have their electricity restored. It will also be important for CPs to access these supports for non-managed care eligible individuals whom they serve, if they are ultimately eligible for CP services.

Finally, MassHealth should establish CP and ACO standards for competency in identifying and addressing social determinants, including cultural competency, engagement of members with significant adverse social determinants, and skill at supporting peers to assist with engagement.

ACO Total Cost of Care: Cliff Effect Mitigation

Relative to BH CP costs and functions, Section 5.4.2.2 of the document states that “Health Homes funding will taper off in years 3 through 5 of DSRIP with the expectation that the care coordination services will be increasingly supported by the ACO’s total cost of care budget.” In order to mitigate the “sticker shock” and potential financial cliff effect that could impact CP services at the end of year 5, ABH recommends that **the costs of BH CP services for ACO-attributed members be included in each ACO’s total cost of care budget as they come online, but excluded from the ACO’s overall accountability.** ABH assumes that the costs associated with the ongoing Community Service Area (CSA)-delivered care coordination services will be built into the TCOC budget, as they are included in TCOC calculations now. It may make sense to have these costs excluded from overall accountability during the five-year period, along with the CP costs. This approach will help ensure that ACOs consider how to support CP functions after DSRIP and Health Homes funding winds down and also builds in consistency in approach.

Delivery System Reform Incentive Payments (DSRIP): Allocation

Given the historic underfunding of community-based behavioral healthcare organizations and their exclusion from many Health Information Technology (HIT) capacity and infrastructure grants and funding, BH CPs are further behind in readiness for systems transformation than hospital systems and health centers. As such, ABH recommends that **approximately 25-30% of DSRIP funds be targeted to BH CPs** to ensure sufficient investment and readiness as opposed to the 20-25% projected in the waiver proposal.

DSRIP Funding: Development and Capacity

Start-up funding for CPs will be critical to their success. ABH requests clarification on the availability of infrastructure development and capacity funding for CPs. The document can be read to suggest that funding is available only on a retrospective basis or that it will be paid through a per member per month (PMPM) – based on member enrollment. BH CPs will need significant investments in HIT, staffing, performance management, etc. before service delivery can begin. Retrospective funding — or even PMPM funding that starts small – alone will make

this model unworkable. CBHI CSAs suffered from lack of initial start-up funding which the Commonwealth acknowledged and rectified post-implementation by belatedly providing “ramp-up” funding. It will be important to avoid this same mistake in the establishment of CPs.

In addition, ABH requests clarification as to the rationale for requiring BH CPs to submit DSRIP work plans for approval while ACOs do not appear to be subject to a similar requirement.

DSRIP Funding: Technical Assistance

The proposal states that MassHealth will procure “high quality” vendors that all ACOs and CPs can access and that “providers will be required to contribute 30 percent of the overall TA costs.” ABH believes that this percentage is significantly too high for BH CPs given their current capacity and the proportion of DSRIP funding they are scheduled to receive. Ten percent is more realistic.

DSRIP Funding: CSAs

To the extent that a CSA is not a BH CP, the CSA should also be able to access DSRIP funding for the same purposes as the BH CP since their needs will be similar, if not identical.

ACO Accountability

The document indicates in Section 5.3.5 that ACOs will be evaluated annually and receive a composite “DSRIP accountability score” to determine how much of the at-risk DSRIP funds will be released. This composite score will include:

- 1.) utilization reduction in avoidable admissions and re-admissions;
- 2.) spending reduction;
- 3.) quality; and,
- 4.) progress toward integration, which will include process and outcome measures.

Relative to specific metrics for at-risk DSRIP funding, the proposal indicates in Section 4.2.2 possible measures for both ACO and BH CPs including “ED utilization rate for SMI/SUD/SED population, percent of BH CP members who receive care from a BH community-based provider, penetration rates for primary and medical care access for members with SMI, SED and/or SUD.” As additional components of the DSRIP accountability score for at-risk DSRIP funding, ABH recommends that ACOs be measured on:

- the percent of ACO members with BH diagnoses that receive care from community-based providers; and,
- whether their utilized network includes community-providers that collectively provided 80% of the last 12 months’ non-hospital behavioral health spend for its attributed members.

These metrics are important not only to measuring progress toward integration but also in monitoring reduction in avoidable inpatient and emergency department utilization. In addition, they support MassHealth member satisfaction in maintaining treating relationships during a time of transition.

Regardless of inclusion as an accountability component, ACOs should be required to report on these metrics.

BH CP Accountability

The document indicates in Section 5.4.5 that “some portion of DSRIP funds will be at risk based on how ACOs and CPs perform on specific quality and/or process metrics.” ABH believes that **downside risk is not initially appropriate for BH CPs** due to decades of historic below-cost funding of community-based services. Even with sorely-needed DSRIP investment, infrastructure and capacity will take time to develop. The **at-risk component to DSRIP funds should be phased-in over time, beginning no earlier than Year 3**. Further, the proposal indicates in Section 5.4.5 that a phasing-in of risk will increase to 20% of DSRIP funds. ABH believes this percentage is too high and should be no more than 15%.

The proposal also indicates in Section 5.4.5 that CPs will be evaluated for at-risk DSRIP funding using composite accountability scores that include “process measures, quality measures, and ACO/MCO evaluation of CP performance, with various measures phasing in over time.” ABH has concerns about quality and ACO/MCO performance evaluation given that the BH CP as currently constructed has no ability to pay for flexible services and limited control over managed care authorization processes.

SUD Expansion

ABH is extremely pleased about and strongly supports the proposed expansion of SUD services and care coordination and recovery supports. This expansion will provide MassHealth members diagnosed with SUD a stronger opportunity to sustain recovery in clinically appropriate, less restrictive settings. In addition, the Commonwealth will benefit from reduced acute care usage. As the document notes, individuals who receive Residential Rehabilitation Services in Massachusetts are less likely to have inpatient and emergency department (ED) usage after treatment than those who do not complete this treatment.

ABH requests clarification and continued dialogue as to the following:

- **BSAS Wrap of ASAM Level 3.1 Services.** It is ABH’s understanding that the Department of Public Health will wrap continued Transitional Support Services and Residential Rehabilitation Services around MassHealth members after exhaustion of MassHealth-reimbursed care. **The availability of extended services is vitally important to many individuals in attaining and maintaining recovery.**
- **Standardized ASAM-based Assessment.** Relative to the standardized ASAM-based assessment tool, ABH requests the opportunity to have further discussion with MassHealth about the tool. ABH also recommends that MassHealth integrate this tool with other assessment and care planning processes associated with the ACO and CP initiative to ensure planning is person-centered and not duplicative.
- **SUD Workforce.** Finally, in Section 7.2.8, the proposal states that “[i]n addition to developing the workforce, it will be essential to align financial incentives across the workforce to provide care that treats the whole person.” ABH is unclear as to the meaning of this statement, particularly in relation to the workforce; clarification is requested.

Member Choice: PCC Plan Benefit and Cost-Sharing Changes

ABH supports the proposed elimination of copays for members below 50% FPL. However, we join our colleagues at Health Care For All in **opposition to proposed increases to copays and benefit eliminations within the Primary Care Clinician Plan, which will disproportionately impact individuals with disabilities and those with complex care needs.** Members should be encouraged to participate in managed care options which best meets their individual healthcare needs.

As the Massachusetts Medicaid Policy Institute recently noted, “MassHealth members with disabilities and other medically complex care needs are disproportionately represented in the Primary Care Clinician (PCC) Plan” when compared to the MCOs.¹⁴ The report further notes “adults and children with disabilities represent more than double the proportion of the PCC population as their counterparts in the MCO program.” The PCC Plan has been an appropriate preference for many MassHealth members with behavioral healthcare needs. The measures proposed will unfairly force a particularly vulnerable population into a terrible dilemma. These members should not have to choose between seeing their preferred providers and securing needed eyeglasses and hearing aids. Further, while copays are styled as “nominal,” research shows that “premiums and cost sharing can act as barriers in obtaining, maintaining and accessing health coverage and health care services, particularly for individuals with low incomes and significant health care needs.”¹⁵ In addition, copays in many instances will likely manifest as bad debt to providers unable to collect them from the low-income individuals they serve.

Finally, the request document states in Section 4.4 that “MassHealth will also expand the list of services to which copayments may apply.” **ABH strongly opposes new copays for behavioral healthcare services.** There are numerous barriers to accessing appropriate levels of behavioral healthcare services, including prior authorization and administrative barriers, siloed care, and stigma. Any additional barriers will impede care access by the individual.

Emergency Services Programs and ED Boarding

MassHealth data clearly show that community-based Emergency Services Programs (ESPs) divert individuals from Emergency Departments (EDs) and inpatient admissions and do so at a rate greater than hospitals that are subcontracted with their ESPs to conduct crisis assessments themselves. Because of the significant focus on reducing avoidable ED use and hospitalizations, **each ACO should be required to utilize the Emergency Service Program(s) that operate within the ACO’s catchment area(s).** This is consistent with MassHealth’s Pilot ACO RFR which requires ACOs to “[f]acilitate Attributed Members’ immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week.”¹⁶ EOHHS and MassHealth should consider ways to strengthen ACO-ESP partnerships as it seeks ways to address the ED boarding crisis. Section 5.5.4 indicates that some DSRIP funding may be available to address ED boarding. ABH believes that the service models considered for

¹⁴ [MassHealth: The Basics. Facts and Trends](#). Updated June 2016. Massachusetts Medicaid Policy Institute (MMPI).

¹⁵ [Premiums and Cost-Sharing in Medicaid: A Review of Research Findings](#). February 2013. Kaiser Commission on Medicaid and the Uninsured (summarizing research on the impact of Medicaid premiums and copays on coverage, access and savings).

¹⁶ EOHHS Request for Responses for the Accountable Care Organization Pilot, Attachment A, Section 2.4.H.

development or expansion in the waiver proposal will help address this human crisis when part of a statewide strategy.¹⁷

Access and Workforce

Shortages in professional and paraprofessional staff are impacting access in all areas of the healthcare sector. ABH looks forward to ongoing, cross-continuum dialogue about workforce and access, and we recognize that workforce development is one important component to a longer-term strategy to address a significant factor in ongoing systems transformation. ABH strongly supports MassHealth's proposal for dedicated DSRIP Workforce Funding as outlined in Section 5.5. We make the following recommendations:

- **Student Loan Repayment Program.** ABH greatly appreciates the inclusion of behavioral health professionals in this program. Behavioral health professional shortages impact access to a wide variety of programs including outpatient services, court-mandated CBHI services and many others. This program should be made available to staff of all MassHealth member-serving provider organizations, not just ACOs or CPs. ABH further recommends that the program be expanded beyond Medically Underserved Areas, as we understand that definition to be limiting.
- **Primary Care Integration Model Grants.** Bi-directional integration is important to serving MassHealth members, particularly those who access services primarily through their behavioral healthcare provider. This grant program should be available to organizations seeking to integrate primary care into behavioral healthcare settings.
- **Workforce Development Grants.** The description of this program suggests this program is open only to ACO or CP participants. ABH recommends that this program be made available to any provider seeking to invest in its workforce in a manner consistent with the Section 1115 proposal.
- **SUD Workforce.** The SUD proposal envisions development of new roles within MassHealth (recovery coaches and recovery support navigators) as well as significant training in evidence-based practices and cultural competence. ABH seeks clarification as to whether there is distinct funding dedicated to the SUD workforce, and if so, to whom it is available.

Service Investment

Outpatient services are the bedrock of community-based behavioral healthcare services. Care coordination and care management will not be effective if treatment services cannot be accessed within a reasonable period of time. ABH understands that the DSRIP initiative is not intended to be a rate increase for providers. However, we remain concerned that without a sustained **investment** in outpatient behavioral healthcare services for safety net providers,¹⁸ access issues will grow worse for MassHealth members. Low reimbursement rates make it difficult if not impossible to attract and retain staff, both professional and paraprofessional level, and vacancies

¹⁷ ABH seeks clarification as to whether the referenced Clinical Stabilization Services is a reference to Community Crisis Stabilization proposed for possible expansion. Both could be appropriate responses to ED boarding.

¹⁸ 90% of ABH respondents report a third-party payer mix that was at least 63% publicly funded (MassHealth and Medicare). For half of our members, MassHealth and Medicare accounted for 90% of third-party revenue.

can cause access delays.¹⁹ A recent ABH member survey indicated challenges to broad access to sustainable outpatient services including lengthening assessment wait times, reduced capacity and financial instability. MassHealth recognized this reality with its recent investment in MCO behavioral healthcare services, and ABH is extremely appreciative of this. **ABH recommends that MassHealth make additional, sustainable investment in outpatient behavioral health services.**

Accommodations for Members with Disabilities

ABH **strongly** endorses making DSRIP funds available to assist providers in purchasing necessary items or making adjustments to accommodate persons with disabilities. As with other dedicated funding streams, ABH recommends that these grants be open to all providers, not only ACOs and CPs. Providers who have patient mixes with larger numbers of disabled members should be prioritized for grant funding.

Provider Ombudsman

ABH supports the creation of an ombudsman for MassHealth members who participate in an ACO or MCO. The documentation states that MassHealth expects “that the ombudsman will play a crucial role in ensuring a successful rollout of our payment and care delivery reforms.” ABH recommends the **creation of a provider-facing ombudsman** for these same reasons. For example, providers have struggled in recent years to resolve issues impacting managed care enrolled members such as recoupments relating to retroactive eligibility changes and resolving service authorization and payments for members with duplicate member IDs. As responsibility for service authorization, care coordination, and other functions will be allocated across and within MCOs, ACOs and CPs, the ability to resolve problems will be critical.

Conclusion

The draft waiver submission outlines what are potentially transformative proposals to meet the needs of MassHealth members with significant behavioral health needs. EOHHS and MassHealth have been transparent and proactive to an unprecedented degree throughout this process. Proper attention to the details of design and implementation will be crucial to how successful we ultimately are as a Commonwealth in achieving this transformation. ABH is committed to working with EOHHS and MassHealth to ensure our collective success.

Thank you for the opportunity to comment. If you have any questions or comments, please feel free to contact me.

Sincerely,



Vicker V. DiGravio III
President/CEO

¹⁹ A 2013 Massachusetts Behavioral Health Partnership/PCG Health analysis to determine whether MBHP’s outpatient rates covered the cost of a range of outpatient services showed that almost all outpatient services were paid at rates significantly below cost. It is important to note that MBHP rates, still below costs, typically *exceed* the MassHealth fee-for-service schedule, where a comparable service exists.



Association of Developmental
Disabilities Providers

Community for Living. Community for Life.

July 15, 2016

Marylou Sudders
Secretary
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02115

Dear Secretary Sudders

On behalf of the 133 member agencies of the Association of Developmental Disabilities Providers, we wish to provide the following feedback and recommendations regarding the Commonwealth's proposed Section 1115 Waiver Demonstration Project Amendment and Extension Request ("the Waiver").

We commend EOHHS and MassHealth for the inclusive manner in which input was actively sought by the Administration to develop a proposal that reflects the contributions of MassHealth members, stakeholders, providers and a diverse representation of interested parties. We hope to be able to continue the dialogue on an ongoing basis as MassHealth moves forward on the implementation of the Waiver Demonstration Project.

We believe that many features of the Waiver Demonstration Project are innovative and provide unique opportunities to enhance quality outcomes, as well as effective use of limited fiscal resources through effective coordination as DSRIP funding is used to build effective Certified Community Partners.

Thus, we wish to renew our recommendations for inclusion in the program definition and operational details of the Demonstration Project.

1. Certified Community Partners, our recommendations include:

- Certified Community Partners (CPs), be determined and certified by the specific state agencies that are expert in the specific populations served, such as the Elder Affairs, Department of Developmental Services, Massachusetts Rehabilitation Commission, Department of Mental Health, or Department of Children & Families, determining qualifications and competencies and providing certification to serve these specific unique populations in partnership with MassHealth.
- CPs, in the execution of care coordination, will be held accountable by the certifying agency for compliance with all CMS requirements and regulations specific to the Americans with Disability Act, the U.S. Supreme Court Olmstead decision and the Final Rule on Home and Community Based Settings, defined by CMS and adhered to in the Massachusetts/CMS HCBS Final Rule Plan; and the CMS Managed Care Rule.

- CPs, ACOs, and MCOs will be prohibited from contracting with service providers and contractors that fail to adhere to these regulations and will be required to provide assurances of their understanding and compliance with these aforementioned CMS regulations.
- ACOs and MCOs will be required to demonstrate network adequacy for long term services and supports as determined by the relevant state agency that determines certification requirements for CPs.
- CPs will be critical members of the individual's care team.
- CPs will be the key decision makers, in accordance with an individual's Individual Support Plan where applicable, for ensuring that services and supports are provided consistent with the specialized need of the individual and delivered by providers licensed or certified by the state for specialized knowledge and expertise related to the individual including behavioral healthcare and long term services and supports.
- CPs need to play a role, in collaboration with the ACO/MCO in coordinating services across LTSS, behavioral health as well as health care.
- Eligibility standards for LTSS services, coordinated by CPs, will be set by the specialized agencies through current Massachusetts Administrative procedures, which are inclusive of public notice, public comment and the opportunity to be heard through oral and written testimony.

2. CP/ACO/MCO

Consumer Protections

- MassHealth members, ACO, MCO, and CP members shall have the right to choose service providers from service provider licensed and certified by Commonwealth of Massachusetts who agrees to accept state set service rates. The standards for network adequacy need to be established by the relevant state agency in collaboration with MassHealth to ensure member choice is not compromised.
- Enrollees should be attributed to LTSS providers using methodology which assures that CPs, ACOs, MCOs shall continue current service settings and contractual obligations for a period a minimum period of two years after the inclusion initiation of ACO or MCO enrollment, in order to provide stability of LTSS services and sustain community health and wellness programs needed to achieve the long term goals of the Waiver; if at a later date HCBS services are included in the ACO or MCO, current service settings and contractual obligations shall be extended for a period no less than two years.
- EOHHS, CHIA and other state agencies who currently set rates will continue to perform this service consistent with the intent of existing state and federal rate laws and regulations including but limited to Chapter 257 and other Medicaid rate regulations; ACOs will obligated to pay providers no less than state set rates. ACOs may pay rate higher than state set rates as an incentive for service and ACO goal implementation.
- Mass Health members must be provided with the opportunity to choose their ACO, and the right to change their ACO within an administratively reasonable period of time. We do have concerns about a 12 month lock in with no or limited opportunity to switch ACOs, particularly for those individuals with I/DD with significant and complex health care needs.
- EOHHS should establish an Ombudsman Office and process similar to, or expand the scope of the One Care Ombudsman Office to include services provided under the Waiver, in order to assure that enrollees have access to an independent entity which can resolve enrollee complaints and/or disputes with ACO's, MCO's, or providers.
- The CMS/Mass Health agreement should provide access to the State's Disability and Protection program to have the right to receive documentation and investigate concerns consistent with the recommendation of the federal government's National Council on Disability and CMS.

3. Payment and Financial Concerns:

- The CMS/Mass Health Agreement should obligate ACO's and MCOs to pay rates which are equal to or greater than rates established by Chapter 257 or the Medicaid State Plan fee for service system for the same services by Massachusetts laws and regulations.
- Rates established by the ACO for Service Coordination and all other provider services should be appealed to the Commonwealth's Center for Health Care Information, should a provider be able to demonstrate insufficiency of rates.
- Rates established for the CPs need to take into consideration the complex needs of members with I/DD.

4. CMS/MassHealthPublicTransparency:

- The CMS/Mass Health Agreement shall require ACOs to report monthly on the utilization of all major service codes, inclusive of health care, long term service and supports, Medicaid and Medicare Acute Care, emergency room services, hospital stays and specialty utilizations.
- The CMS/Mass Health Agreement should report monthly on an array of quality measures, including enrollee experience (such as the Medicare Advantage rating system), process measures (including HEDIS), real world outcomes (percentages of populations in housing , employed) and the range of outcomes specific to specific enrollee populations (IDD, Autism, ABI, SMI, Frail Elders) and aggregate totals of the entire population served by the agreement.
- EOHHS should establish an Advisory Council with a constituency of consumers, advocates and providers, and, similar to the One Care Implementation Council, charge this entity with public reviews of specific financial performance, utilization, and quality data, and recommending policies and practices which will support and guide the successful implementation of the Waiver. This information should correspond with existing state service, health and support codes, including LTSS codes.

5. DSRIP Funding : Direct Support of Certified Community Partners:

- ADDP supports the proposal to provide a substantial amount of DSRIP funding directly from MassHealth to CPs, in order that they may develop the infrastructure to provide care coordination and information and data sharing needed for all components of the system to work effectively on behalf of enrollees.
- EOHHS shall ensure that the transparent reporting of use of DSRIP funds occurs in a manner which allows public review of the proportion of funds used across entities and their relations with quality metrics and outcomes.

Again, thank you for the extensive efforts and steps your team has taken to develop this process in a transparent and inclusive manner.

Sincerely,



Jean Phelps
Chair, ADDP Board of Directors



Gary Blumenthal
President & CEO

Hello,

My name is Catherine Boyle, and I am the president of Autism Housing Pathways, a 501(c)(3) organization that educates Massachusetts families about housing options for their adult family members with developmental disabilities. I am writing to provide comment on MassHealth's Section 1115 Demonstration Project Amendment and Extension Request.

Housing stabilization and support, search and placement

In my work with families across the state, I have found that, in general, individuals, their families, and teachers of transition-age youth generally have little to no a priori understanding of existing housing programs, or of MassHealth State Plan options, such as Adult Family Care/Adult Foster Care. To expect them to take the further leap of understanding the rules governing the interactions of these programs without assistance is, frankly, assuming the impossible.

As a result of this experience, I am happy to see specific mention of "Housing stabilization and support, search and placement" as a category of flexible services in 5.3.2.3 of the Amendment and Extension Request. I hope that the category is broadly construed to encompass the range of elements that help individuals and their families to develop and execute a sustainable, self-directed housing strategy. These include (but are not limited to):

- Education about the range of subsidized and/or affordable housing programs, and identification of appropriate programs for the individual;
- Education about the existence and requirements of MassHealth State Plan services, and identification of the service that will best support the individual in housing;
- Hands on assistance in filling out applications for Section 8 housing vouchers;
- Education of the individual in what is expected of a housemate, a neighbor, and a tenant;
- Assessment of living skills;
- Assessment of and funding for appropriate assistive technology; and
- Evaluation of housing for appropriateness and developing recommendations for environmental modifications to ensure success.

The last four are particularly important for individuals with autism, who now constitute almost half of the DDS Turning 22 class. Otherwise, it is all too easy for individuals to fail to maintain tenancy. For this reason, in some instances, training of landlords, property managers, and housing authority personnel in how to interact with tenants with autism is also advisable.

All of these elements need to be embedded in a person-centered process that identifies the relationship of housing to transportation and employment/day activities to create a sustainable model.

State plan services

While not directly addressed in the Demonstration Extension Request, there are certain features of existing State Plan services that negatively impact the ability of MassHealth members to obtain and maintain safe, healthy, and sustainable housing arrangements.

Adult Family Care is the primary way for families to provide LTSS to an individual in the home. However, it is currently limited to a care provider who is not a guardian. This creates a genuine hardship for single parents, who are frequently most in need of support, and increases the likelihood an individual will need a far more expensive group home placement. Allowing single parents who are guardians to be AFC caregivers would improve the care of eligible MassHealth members, provide a relief to families, and save money.

The Adult Family Care and Adult Foster Care (AFC) stipend level is determined by the level of care an individual needs. Level II of AFC requires an individual need physical assistance with three or more Activities of Daily Living (ADLs), or with two if a maladaptive behavior is present. (ADLs include bathing, dressing, toileting, transferring, ambulating, or eating; maladaptive behaviors include: wandering, being verbally or physically abusive, socially inappropriate/disruptive or resisting care.) Many individuals with autism have more than one maladaptive behavior present and require only cueing to perform ADLs. Despite having intensive support needs, these individuals are only eligible for Level I AFC. It would be appropriate to add cueing to the Level II requirement, so that Level II funding can be received if the member requires physical assistance or cueing with 3 ADLS; or 2 ADLs and the management of the behavior. This would provide individuals with more appropriate supports, preventing or slowing caregiver burnout, and hopefully delay the need for more expensive residential services.

Group Adult Foster Care (GAFC) can be used to provide up to two hours a day of drop in services for individuals who need cueing for at least one ADL. It differs from AFC, in that the individual does not require a support provider to live in the same unit. However, it can only be used in assisted living facilities and subsidized (i.e., project-based) housing. The result is that people for whom this is an appropriate level of service can only receive it in these settings. For instance, someone living in a project-based Section 8 setting can receive it, but someone with a portable Section 8 voucher cannot. This means there is currently no State Plan service for someone who needs cueing only, unless they are living in these very limited settings. Changing the setting requirement to a simple requirement that a GAFC provider agency be willing to provide services in a given location would increase the ability of individuals to live independently in the community.

Thank you for the opportunity to comment.

Sincerely,

Catherine Boyle

President, Autism Housing Pathways

617-893-8217

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www.autismhousingpathways.org

building roads to home



**Beacon Health Options' Response to
the Commonwealth of
Massachusetts' Executive Office of
Health and Human Services' Request
for Public Comment on the
MassHealth Section 1115
Demonstration Extension Request**

July 17, 2016

INTRODUCTION

Thank you for the opportunity to provide our perspective on the Massachusetts Executive Office of Health and Human Services’ request to amend and extend the MassHealth Section 1115 Demonstration to the Centers for Medicare and Medicaid Services. Based on our extensive experience in Massachusetts—working with four MassHealth managed care organizations, managing the Primary Care Clinician Plan, and administering mental health and employee assistance services for the Group Insurance Commission—as well as across the country and in the UK, Beacon Health Options (Beacon) bears much expertise in achieving successful outcomes on behalf of approximately 1.5 million members across the Commonwealth.

Behavioral health is an important, yet often overlooked component to integrated care delivery. Despite clear evidence that individuals with medical and behavioral health issues have a high prevalence of co-morbidities, more thought can be given to the role that behavioral health plays in an Accountable Care Organization (ACO) model and how it can contribute to better outcomes and lower costs. The overall cost of care is disproportionately weighted to medical expense. This imbalance is a result of individuals with treated psychiatric or substance use disorders typically costing two to three times more than those without a behavioral health condition, on average across all market segments. Financial incentives and reimbursement models must be organized in a different way to address total medical expense.

Additionally, individuals with complex behavioral health needs (e.g., serious mental illness [SMI] and chronic substance use disorders [SUD]) often receive insufficient or uncoordinated care. When their issues are not addressed appropriately, they can interfere with daily functioning, self-care, and adherence to medical and behavioral health treatments. While there continue to be improvements in the health care industry toward the integration of medical care and behavioral health care, much of health care delivery remains fractured, particularly for those who face personal and systemic barriers to access (including financial issues, transportation barriers, and lack of ongoing supports to maintain treatment adherence). The risks of poorly coordinated care include exacerbation of chronic medical conditions and negative behavioral health outcomes. And those with SMI and chronic medical conditions face an increased risk of premature death.

An integrated approach in which primary care and behavioral health providers work together to address the medical and behavioral health needs of an individual is therefore necessary to improve his or her overall health. With access to appropriate care and support through well-designed systems of care, individuals with SMI conditions and/or chronic SUD are able to become contributing members in their community.

Beacon has reviewed the Waiver document in extensive detail. In order to achieve the results EOHHS has outlined in the Waiver, Beacon recommends EOHHS be extremely clear and targeted in their requirements, as outlined in the following table:

Relevant Waiver Section	Beacon Response
Overall Comment	At its core, the ESP system has expanded the core definition of emergency services from assessment and disposition (“hospital screening”), to full-service crisis assessment, intervention, and stabilization, particularly in a community-based setting. While some circumstances may necessitate a behavioral health crisis evaluation in an emergency department (ED), there are many times when an individual can best be served by having a crisis evaluation conducted at a community-based location, such as his or her primary care clinician’s office. While we acknowledge a need for a potential redesign to contemporize this critical safety net service, it is still an important component to not only

Relevant Waiver Section	Beacon Response
	<p>primary care clinicians, but also the system of care in Massachusetts and should therefore be referenced prominently in the Waiver document.</p>
Overall Comment	<p>For many individuals, specifically those with mild-to-moderate behavioral health conditions, primary care is the de facto location of care for mental health and/or SUDs. However, despite their best efforts, primary care clinicians sometimes have trouble providing the right care to meet these patients' needs and are challenged with accessing qualified behavioral health services due to shortages and lengthy waitlists among local providers. As such, strengthening behavioral health integration within primary care practices is key. It is not only more efficacious, but, in a world in which psychiatry access is an increasingly scarce resource, it is critical that primary care clinicians are operating at the top of their licenses, and the specialty network is focused on higher need and more complex behavioral health cases.</p> <p>At Beacon, when we refer to integration, we mean systematically applying the principles of the Collaborative Care Model. While many models for integration exist, the Collaborative Care Model, pioneered through research at the University of Washington, has the strongest evidence base for integration. Integrated primary care practices that operate under this model deliver better outcomes for individuals with behavioral health conditions, and, in particular, those with co-morbid behavioral health and chronic medical illnesses. However, achieving this form of practice transformation is not as simple as co-locating a behavioral health clinician within a primary care practice. Further, many well-intended primary care clinicians that are aiming to accept greater accountability for member care do not fully integrate behavioral health for their members. A recent <i>Health Affairs</i> article documented these facts, where a review of BCBS of Massachusetts' pioneering Alternative Quality Contract (AQC) program revealed that few of the AQC providers were integrating behavioral healthcare, and those that were did not demonstrate meaningful improvements over those that did not.¹</p> <p>The most widely used and perhaps the simplest way to integrate behavioral health into the primary care setting is to incorporate behavioral health screenings. The Collaborative Care Model prescribes that behavioral health screening is a core responsibility of the primary care provider, and one of their key care coordination duties. However, screening is not a stand-alone solution to ensuring holistic, person-centered care. In order to be effective, screening must be followed up by warm handoffs and connections with specialized behavioral health resources. A truly innovative program not only screens for behavioral health needs in primary care, but also creates mechanisms that facilitate access to specialized care and linkage to that care.</p> <p>With these considerations in mind, the Waiver should define what true behavioral health integration in the primary care setting means for individuals with mild-to-moderate behavioral health conditions and what the steps necessary to really achieve it. Beacon recommends leveraging key elements of the Collaborative Care Model, such as co-locating a licensed Care Manager for screening and triage within the primary care site, facilitating access to same-day walk-in appointments, providing scaled and timely access to psychiatrists for clinical consultation to primary care clinicians, and introducing registries for tracking outcomes on key metrics. Further examples and</p>

¹ <http://content.healthaffairs.org/content/34/12/2077>

Relevant Waiver Section	Beacon Response
	<p>additional detail on the Collaborative Care Model can be found in Beacon’s Integration White Paper, which is available at https://www.beaconhealthoptions.com/integration-white-paper/.</p>
Overall Comment	<p>The Waiver provides great detail on integration, mainly from the perspective of integrating behavioral health with physical health to treat members holistically. However, it does not address integrating care for individuals with co-occurring mental health and SUD. This omission could potentially perpetuate silos in care delivery across the mental health and SUD systems of care.</p> <p>While the waiver does specifically focus on expanding SUD treatment, there needs to be a recognition that many individuals with a SUD also have a mental health condition, and some also have a SMI. For example, approximately 50 percent of Beacon members that have an opiate addiction also have a mental health diagnosis. Therefore, Beacon recommends the inclusion of more explicit requirements to ensure SUD providers receiving funds have the systems in place to properly coordinate care with mental health providers.</p>
Overall Comment	<p>Beacon applauds the efforts by both the Centers for Medicare and Medicaid Services and the Commonwealth of Massachusetts in developing the One Care Program. We support the original purpose and design of the program and its specialty recognition around individuals with SMI. Beacon is supportive of efforts to improve components of a rejuvenated One Care Program in the Commonwealth.</p>
4.1. Overview of ACO Models	<p>Individuals with SMI are among the most vulnerable members of our society, displaying dramatically reduced lifespans compared to the population norm. Untreated SMI conditions have a pronounced impact on a person’s executive functioning and self-care ability. This impact often results in several related-health deficits. Appropriate treatment resources and supports have far too often remained unavailable, inaccessible, or disorganized. The unintended consequences include criminal justice recidivism, increased rates of homelessness, unemployment, and higher use of avoidable ED and hospital admissions, or in the worst case, tragic community events.</p> <p>Patterns of accessing care differ as well. A comparison of health care utilization in Massachusetts reveals that people with SMI access ED care six times more often, and primary care half as often, when compared to people without SMI.² When asked why, individuals with SMI report they have trouble getting to appointments; feel uncomfortable disrobing in front of doctors; feel doctors do not really listen to them; and crowded waiting rooms make them nervous. Compounding these circumstances is that many primary care clinicians do not feel confident managing people with SMI. Primary care clinicians also may not recognize the early signs of mental illness, and if they do, lack opportunities to discuss shared care plans with specialty mental health colleagues.</p> <p>Despite ongoing efforts to achieve integration and reduce stigma, people with SMI remain the most likely group to receive suboptimal care in primary care settings.² Even when people with SMI are engaged with care, as few as seven percent actually receive evidence-based practices.³ Such individuals continue to live on the fringes of our communities, families, and society more broadly.</p>

² Reardon, C. Integrating Behavioral Health and Primary Care – The Person-Centered Healthcare Home. Social Work Today. 2010;10(1):14.

³ Summergrad, P, & Kathol, RG. (2014). Integrated Care in Psychiatry. New York, NY: Springer.

Relevant Waiver Section	Beacon Response
	<p>Without a specific targeted approach from a health care perspective, they are disconnected from the larger system of care.</p> <p>Additionally, although individuals with SUD are not always qualified as SMI, illicit drug dependence or abuse co-occurs in a significant percentage of adults with SMI. While the primary focus for treatment of SMI conditions has focused on bipolar, schizophrenia, and major depression, the strong presence of co-occurring SUD for 27 percent of the same individuals demands a solution. Within the context of integrated care, failure to provide adequate treatment and recovery resources for individuals with both SMI and SUD conditions can cause poor outcomes. Because the historical state funding structures and oversight divisions may segregate treatment resources for these conditions, there needs to be targeted strategies and programs to overcome these structural barriers and provide holistic treatment.</p> <p>To fully address these issues in the Waiver, Beacon recommends inclusion of the following:</p> <ol style="list-style-type: none"> 1. A clear definition of SMI – The Waiver is an opportunity to be prescriptive in defining what SMI means as this has been historically ill-defined in Massachusetts. While typically focused only on mental health conditions, Beacon strongly advocates for the inclusion of individuals with chronic SUD in this definition, including both individuals with co-occurring SMI and SUD, as well as those individuals with chronic SUD as the primary driver of their condition (e.g., no SMI diagnosis). 2. A separate cohort and rating category for SMI – The Waiver should be flexible enough to address populations differently and include specific requirements and programs that target individuals with SMI separately from the larger population. These individuals need something different and there should be clear mechanisms in place to identify them and fund their care separately. 3. A separate SMI rate cell for individuals with SUD as Primary - Given the criticality of the opiate crisis in Massachusetts today, we believe that individuals with a primary SUD diagnosis (with or without a co-occurring mental health condition) require an intensive level of intervention similar to a complex mental illness and SMI designation. We advocate that a separate rate cell be created for the primary SUD population to demonstrate where a SUD is the driver of a mental health diagnosis, and vice versa. <p>Many other states have acknowledged SMI as a distinct category and developed targeted programs to manage and fund these individuals separately. For example, New York created two new high intensity health plans last year as part of their redesigned behavioral health system of care—the Health and Recovery Plan (HARP) for Medicaid adults with select SMI and SUD diagnoses and a HIV Special Needs Plan (SNP). The HARPs offer access to an enhanced benefit package comprised of home- and community-based services (HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan Medicaid services.</p>
4.1. Overview of ACO Models	Beacon understands that by organizing care around providers in the form of Models A, B, and C, the ultimate goal is to get better value on total outcomes and total cost of care. However, this approach does not necessarily lead to

Relevant Waiver Section	Beacon Response
	<p>lower administrative costs. For individuals with complex behavioral health needs, to get this right, real reform will require an upfront investment to ensure delivery of care in the right time, at the right intensity, in the right setting. This may come in the form of building out existing infrastructure and adding people, services, and activities to fill the gaps in care that exist today. This may require a redistribution of funds to solve for these issues and increase access to diversionary and community-based services. However, this will ultimately mean fewer ED visits and fewer inpatient admissions, among other things, which will ultimately lead to better outcomes for members and lower total cost of care.</p>
<p>4.2.3. Community Partners</p>	<p>Beacon views the role of Behavioral Health Community Partners as more than just “care managers.” For individuals with SMI, they will most likely be the primary location where members receive care—similar to a health home. Because the ACOs will need to organize around the member’s primary location of care, Beacon advocates for a more clearly defined role of the Behavioral Health Community Partner and strict selection criteria, including:</p> <ul style="list-style-type: none"> • Minimum experience and expertise in caring for individuals with SMI • Adherence and fidelity to evidence-based care approaches • Comprehensive care management capabilities that embrace real integration of physical and behavioral health services • Demonstrated processes for coordinating care with primary care clinicians • Demonstrated linkages with other local providers to manage the full continuum of behavioral health care <p>That being said, many Community Partners may not have all of the required infrastructure and experience to operate in a larger organization and coordinate with larger systems. Therefore, we believe it is essential to include a specialty behavioral health focus to provide the technical assistance, infrastructure building, and training for providers that will be targeted by the ACOs to participate in this program.</p>
<p>4.2.2. MassHealth’s Role in Improving Integrated Care Delivery</p>	<p>Beacon is fully supportive of the proposed continuation of CBHI services and views the role of Behavioral Health Community Partners in delivering these services as essential. Beacon’s comments are based on extensive experience collaborating with the MassHealth Managed Care Entities in developing and implementing these home- and community-based services for children, youth, and families, as well as developing the respective medical necessity criteria and performance specifications. While the Waiver specifically states continuing CBHI services in the ACO model, it does not specifically address what happens to a CBHI enrollee. From our perspective, CBHI capitation should be held as a separate capitation so that EOHHS and the court monitor can be assured all designated CBHI funding is being spent on CBHI services.</p> <p>Additionally, it is important to consider children involved with the child welfare and juvenile justice system, or other agency-affiliated and program-involved children and adolescents. This population requires a strong focus on care coordination and increased access to home- and community-based services and family/parent peer supports services to improve health outcomes, an increase in resiliency among youth and their families/caregivers, and ultimately to spend dollars more effectively. Therefore, Beacon advocates for a more prominent role of specialty behavioral health care to provide wraparound services, ensure accessible and responsive treatment is available, and fill gaps in continuum of care that results in a strong system of care for these members.</p>

Relevant Waiver Section	Beacon Response
<p>5. Delivery System Reform Incentive Program Investments</p>	<p>As stated above, to really accomplish the goals outlined in the Waiver, there will be a need to build on and expand the current system of care to increase access to flexible supports and fill existing gaps in the care continuum, especially for individuals with complex behavioral health needs. To account for this, Beacon recommends adding a fifth level of DSRIP funding/separate line item that is used exclusively for this purpose. While we acknowledge that infrastructure may be lacking in specific geographic locations, infrastructure building should be funded separately from filling gaps in care and systems investments that drive connectivity.</p> <p>Additionally, building and maintaining a high quality system requires clear and specific metrics that are monitored, measured, and reported to ensure ACOs and Community Partners are meeting requirements and spending funds appropriately. As such, there should be mechanisms in place to ensure ACOs and Community Partners are accountable to and transparent with EOHHS regarding their spending of DSRIP funds.</p>
<p>5.5.4. Emergency Department Boarding</p>	<p>Beacon is fully supportive of the proposed strategies outlined in the Waiver document to address the ED boarding challenges in Massachusetts. These strategies—specifically the use of community-based, diversionary services—are consistent with our approach and subsequent proposal to Massachusetts and in other states to combat this issue. However, there are additional strategies we feel that should be considered and potentially added for consideration. These include:</p> <ul style="list-style-type: none"> • Additional investment in building inpatient capacity and strengthening the existing community-based diversionary system of care • Adding in community-based flexible supports, including expanding Programs for Assertive Community Treatment (PACT) teams, which are currently available for the DMH population • Enforcing a no-reject policy, requiring the ACOs that have attributed members stuck in an ED to find a bed or fund the person receiving services elsewhere
<p>7. Enhanced Services for People with Substance Use Disorder</p>	<p>In general, the SUD Waiver is a critical component of the current efforts to redesign the MassHealth program, especially given the current opiate crisis that Massachusetts, like the rest of the nation, is facing. Unfortunately, our health care system is currently organized to treat SUD with acute services with the hope of abstinence upon discharge. Evidence tells us that this approach typically leads to treatment failures and readmissions to acute detoxification services. In short, this results in expensive care that delivers poor outcomes.</p> <p>The Waiver is an opportunity to reinforce the evidence base of treatment for opiate addiction by providing a strong focus on diversion, prevention, and ensuring proper connectivity between inpatient levels of care and outpatient medication-assisted treatment (MAT). While the Waiver does propose expanding MAT, carving in Residential Rehabilitation Services (RRS) and Transitional Support Services (TSS), and circumventing the IMD exclusion for these services, these system improvements merit prominence in any redesign efforts.</p> <p>Beacon strongly urges EOHHS to view SUD as a chronic illness. Like many medical chronic conditions that are treated in a community-based setting, so too should SUD conditions be treated in the community, focusing on providing individualized, member-centric care. This then provides an evidence-based</p>

Relevant Waiver Section	Beacon Response
	<p>framework to increase the quality of care, reduce costs, and improve outcomes. It also highlights the role and need for primary care to assume a key position in the treatment continuum, with extensive specialty mental health/SUD support.</p> <p>Further recommendations to create a well-functioning SUD system of care include:</p> <ul style="list-style-type: none"> • Focusing more on prevention, education, and intervention to prevent individuals from becoming chronic substance users • Emphasizing more connectivity between inpatient levels of care and maintenance in the community, including strengthening direct access to community-based care • Increasing access to MAT, which is the only evidence-based care in the whole SUD continuum for long-term treatment • Allocating DSRIP funds for expanding SUD community-based and diversionary services, including ambulatory levels of care and infrastructure building in community-based detox locations • Proposing incentives to transition acute care dollars into chronic care dollars and change the ratio • Developing alternative or value-based payments for SUD providers to support total cost of care for individuals with chronic SUD <p>While Beacon strongly advocates for expanding SUD services, primarily in the community, it will not be effective unless services are provided at the right time, by the right team, in the least restrictive setting. As such, we recommend EOHSS mandate the use of American Society of Addiction Medicine (ASAM) criteria⁴ to determine treatment and appropriate lengths of stay and monitoring to it to ensure there is recovery orientation and progress is being made. More than 30 states require the use of ASAM criteria to validate evidence-based best practices, including the use of medication-assisted treatment for individuals with an opiate addiction.</p>
7.2.4. Levels 3.1 and 3.3 Treatment Services	<p>The Waiver document proposes a continuation of CBHI services and views the role of Behavioral Health Community Partners as essential in delivering these services to children and adolescents. However, with a recognition that special considerations will be made for individuals with complex needs, there is no clear connection between community-based flexible supports for individuals with SMI and the Community Partners who will deliver those services. Today, the community-based flexible supports remain carved-out of managed care. Earlier in our comments, we advocated for a stronger, more prescriptive definition of Community Partners, which would offer a way to properly define who a Community Partner in the ACO model can and should be (e.g., tying DPH and DMH services together), and ask that formal communication protocols be established by EOHHS.</p>
7.6. Quality Measurement and Evaluation Design	<p>As stated above, we strongly advocate for a shift in the focus of treatment for individuals with chronic SUD from 24-hour levels of care to more of a community-based, diversionary, prevention strategy. As such, we recommend including alternative metrics and prioritizing the metrics based on level of importance. Based on our expertise, the three most important measures should be focused on:</p>

⁴ <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria>.

Relevant Waiver Section	Beacon Response
	<ol style="list-style-type: none"> 1. Increasing access and use of MAT 2. Longevity and adherence to MAT programs 3. Success in connectivity from 24-hour levels of care to diversionary outpatient services in the community
9. Budget Neutrality	<p>The delivery of care in and of itself, as well as the cost to deliver those services, will vary depending on geography. In some areas, the costs will be less, but the needs may be greater. This is due to a number of exogenous factors that impact how someone accesses and receives the care they need. For example, some areas will lack reliable public transportation or the distance between areas of service are far too great. Therefore, Beacon suggests applying an additional level of risk adjustment to account for these differences and ensure funds are distributed appropriately based on need. This should apply to both the PMPMs going to the ACOs, but also to the funding streams that are going to the Community Partners, which will differ.</p> <p>Additionally, these safety net services (such as transportation) are not typically considered during a budgeting process, nor when funds are distributed, because there is no CPT code attached to them. However, funding should be inclusive of such services to ensure someone receives the full array of wraparound support they need to access services, regardless of their geographic location.</p>

Thank you for the opportunity to provide our comments on this important, transformational Waiver to redesign the MassHealth Program in Massachusetts. Should you have any questions or require additional information, please do not hesitate to contact me.

Sincerely,



Christie L. Hager, J.D., M.P.H.
Senior Vice President, National Client Partnerships, New England Region
Beacon Health Options
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Boston Accountable Care Organization (BACO)

July 15, 2016

Secretary Marylou Sudders
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02108 Dear

Secretary Sudders,

On behalf of the Boston Accountable Care Organization (BACO), we are pleased to submit this letter of support for the Commonwealth of Massachusetts' Section 1115 Medicaid Waiver Request. With a history of twenty years of experience providing collaborative, integrated exceptional health care to all that began under Boston HealthNet, we fully endorse the move to accountable care for our patient population. BACO includes:

- Codman Square Health Center
- DotHouse Health
- Greater Roslindale Medical and Dental
- Mattapan Community Health Center
- South Boston Community Health Center
- South End Community Health Center
- Faculty Practice Foundation at Boston Medical Center and Boston University Medical School
 - Evans General Internal Medicine Group
 - BU Family Medicine, Inc.
 - Child Health Foundation
 - Specialty Practices (medical and behavioral health)
- Boston MedicalCenter

Many of our community health centers (CHCs), along with BMC and the BMC HealthNet Plan, were active participants in the robust stakeholder working groups. Through those groups, our clinical and administrative representatives had the opportunity for direct input into the development of the request. Beyond the working groups, the Executive Office of Health and Human Services (EOHHS) convened numerous additional meetings with us to allow for ongoing dialogue to prepare for this transition. This collaborative process illustrates the strong partnership that EOHHS has cultivated with key Medicaid providers such as BACO.

The Commonwealth's 1115 Medicaid Waiver request is aligned with our vision to bring high-quality, cost-effective, coordinated care to our patients. As the largest safety net provider system in Massachusetts, BACO was created to better serve the needs of our patients through an ACO that allows for full integration of patient care and health information as well as an enhanced focus on outcomes related to patients' quality of care across the continuum.

The Massachusetts waiver request is centered on the restructuring of care for the MassHealth population under these types of ACO models. Additionally, it allows for financial reimbursement that places prudent management of the total cost of care dollar at the ACO level. Such a model will allow ACOs, such as BACO, to support services that are most beneficial to the patient including some that are not reimbursable under today's fee for service system. We welcome and support this plan.

While BACO is prepared to assume full responsibility of the total cost of patient care in conjunction with our affiliated BMC HealthNet Plan, we realize that not all providers in the state are in the same position. We therefore also support the Commonwealth's plan to offer different models that suit the needs and readiness of providers who care for the MassHealth patients. Massachusetts is fortunate to have some of the highest NCQA-ranked Medicaid Managed Care Organizations (MCOs) providing coverage to MassHealth patients. We believe that their valuable expertise can play an important role with providers who are at various stages of ACO readiness.

The Massachusetts waiver request includes \$1.8 billion to support ACO transitions through the Delivery System Reform Incentive Program (DSRIP) funding. This funding will ensure partnerships between ACO's, Behavioral Health (BH) and Long Term Support Services (LTSS) Community Partners. BACO has a keen appreciation for the importance of strong partnerships with BH and LTSS providers as key to effective care for the MassHealth population. We also applaud the Commonwealth's efforts to use this funding for statewide investments in areas such as Emergency Room boarding and other important, beneficial services. Too often, we have struggled with finding a resolution for patients who have been "stuck" at the emergency room while we look for acceptable options. Funding to provide those options would be of great benefit to the patients.

Our system is better positioned to make this transition as a result of the efforts supported under the current Delivery System Transformation Initiative (DSTI) waiver. With the support of DSTI funding, we have developed our ACO, implemented focused efforts to reduce readmissions, designed and implemented targeted strategies aimed at the reducing the cost of care for the highest utilizers and enhanced our focus on quality improvements in key areas. The DSTI Community Based Care Delivery and Integration project ensures that we have identified the key community partners who will play a critical role in the ongoing care of our patients under an ACO model.

The Safety Net Care Pool (SNCP) is an important mechanism to the financial support of systems such as BACO. Our community health centers and Boston Medical Center, the state's largest safety net hospital, rely on SNCP funding, as do our patients. It provides important resources that benefit the unique needs of providers who disproportionately care for the low-income population including not only those on Medicaid but also the residually uninsured. While this provision includes changes to some of the payments under the SNCP, it is well aligned with the ACO strategy of the Commonwealth and BACO. The CHCs, BMC and our patients rely on this associated funding. Most importantly, the SNCP request will allow for the continuation of nearly full health insurance coverage across our state.

Substance Use Disorders have reached a critical stage in Massachusetts and throughout the country. Our BACO providers have seen the devastating impact this has had on our patients and their families. While we have been a visible leader in the development of strategies to address the crisis, current

resources have not been able to keep up with the demand. The Commonwealth is to be commended for its efforts to expand coverage in this area and to address the opioid crisis.

In closing, we hope that CMS will approve the waiver proposal from the Commonwealth of Massachusetts. We believe it has the potential to have a very positive and lasting impact on the Medicaid financing and delivery system. Your approval will allow BACO and the Massachusetts provider community to continue to work in partnership with the state to the benefit of our patients.

Sincerely,

Codman Square Health Center



Sandra Cotterell
Chief Executive Officer

DotHouse Health



Michelle Nadow
Chief Executive Officer

Mattapan Community Health Center



Azzie Young, PhD.
Chief Executive Officer

South Boston Community Health Center



William J. Halpin, Jr.
Chief Executive Officer

Greater Roslindale Medical and Dental Center



Barbara Lottero
Executive Director

South End Community Health Center



William Walczak
Chief Executive Officer

Boston Medical Center and the Faculty Practice Foundation at BMC and the Boston University School of Medicine



Kathleen E. Walsh
President and Chief Executive Officer



By email: masshealth.innovations@state.ma.us

Daniel Tsai
Assistant Secretary for MassHealth Executive
Office of Health and Human Services One
Ashburton Place, 11th Floor
Boston, MA 02108

July 17, 2016

RE: Draft Medicaid 1115 Demonstration Waiver Extension Request

Dear Assistant Secretary Tsai,

Thank you for the opportunity to offer our comments on the proposed Medicaid Waiver Extension Request. As the health department for the city of Boston, the Boston Public Health Commission provides a wide range of services to residents and visitors of Boston, including emergency medical services, substance use disorder treatment services, shelter and case management for homeless individuals and home visiting programs that span the life course. In addition, our agency provides infectious disease surveillance, health data analysis and healthcare navigation services in collaboration with the city's robust healthcare provider network.

As the largest local health department in Massachusetts, BPHC has been advocating for better integration of traditional healthcare, behavioral health and community-based care for a number of years, understanding that medical care is an important but relatively small part of what it takes to keep individuals healthy. As is becoming increasingly obvious, social determinants – quality housing, transportation, and income supports – have a far greater influence on health and well-being than the provision of medical care. In addition, we know from our own patient population that mental health and substance use disorders are primary drivers of healthcare consumption and that more effective, integrated care is needed to keep people well and out of high cost emergency department care. We are encouraged by the tremendous progress that MassHealth has made in just a short time toward laying out a blueprint for a more fully integrated healthcare system. Below are recommendations that we hope you will incorporate into your plans moving forward.

Healthcare Access:

As a longtime member of the ACT!! Coalition, we echo the comments of the Coalition regarding the importance of maintaining affordable, quality coverage for the most vulnerable residents of the Commonwealth. We appreciate MassHealth's commitment to prioritizing this goal, and

support the proposals that are intended to increase access to services for low-income residents:

- Eliminating copays for MassHealth members with income at or below 50% FPL;
- Assuring the sustainability of the CommonHealth program for working disabled adults aged 65 and older;
- Ensuring the sustainability of the ConnectorCare program; and
- Providing continuous eligibility through the duration of the Student Health Insurance Plan period for enrollees receiving Premium Assistance for SHIPs.

At the same time, we are concerned about potential changes to the MassHealth program that would limit access to care for members including:

- Eliminating coverage for chiropractic services, eye glasses, hearing aids, orthotics and other services in the Primary Care Clinician (PCC) plan;
- Increasing copays for members enrolled in the PCC plan, in relation to MCO members;
- Expanding the list of services to which copays apply; and
- Increasing premiums for enrollees with incomes at or above 150% FPL.

We are particularly concerned about the push to limit services offered through the PCC plan. While we understand that MCOs may be a good option for many patients, the PCC plan remains an important option for many medically complex patients who wish to maintain the relationships with longstanding providers who are not part of an MCO network. These patients, many of whom have disabilities, should not be forced to make a choice between services and their providers.

Oral Health: We applaud the inclusion of dental services in MassHealth's vision for a modernized payment and delivery system and is pleased to see that dental services will be phased in to ACO accountability over time. There is increasing evidence to suggest that the provision of dental care actually lowers overall health care costs while granting consumers a higher quality of life.^{1,2,3} Through ACOs, there is a significant opportunity to both address the unmet health needs of the Commonwealth while leading the broader movement toward comprehensive whole-person health nationally. We believe that this is a major win for both MassHealth enrollees and the state.

In order to more thoroughly rectify the arbitrary separation between oral health and overall health, we urge MassHealth to consider oral health as a component of primary care. ACOs should offer incentives, including adequate reimbursement and training, for primary care settings to incorporate oral health into routine care. This approach capitalizes on PCP access to

¹ Cigna. (2010). *Improved health and lower medical costs: why good dental care is important [white paper]*. Retrieved from http://www.cigna.com/assets/docs/life-wall-library/Whygooddentalcareisimportant_whitepaper.pdf

² UnitedHealthcare, Optum, (2013). *Medical Dental Integration Study*. United HealthCare Services, Inc. Retrieved from http://www.uhc.com/content/dam/uhcdotcom/en/Private%20Label%20Administrators/100-12683%20Bridge2Health_Study_Dental_Final.pdf

³ Jeffcoat, M.K., Jeffcoat, R.L., Gladkowski, P.A., Bramson, J.B., Blum, J.J. (2014). *Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions*, American Journal of Preventive Medicine, 47: 174-182.

individuals as well as primary care's expertise in care coordination and prevention education, and will help ACOs achieve cost-savings.

Safety Net Providers:

We appreciate the acknowledgement in the draft waiver extension of the important role that safety net providers play in the MassHealth ecosystem. Caring for the most vulnerable patients in the Commonwealth and achieving the quality goals cited in the waiver will require not only an infusion of DSRIP funds but also reimbursement rates that make it possible for providers to continue to serve these patients. We urge MassHealth to continue to prioritize the viability of safety net providers as you move forward with system transformation and creation of risk-adjustment formulas.

Community-based partnerships and linkages to social services:

We were hopeful that this waiver application would provide an opportunity to truly address the social determinants of health – those factors that influence health but are outside of the healthcare system – by integrating primary care, behavioral health and access to community-based services that help manage and prevent chronic disease. We fear that the current proposal falls well short of achieving this goal.

We support the concept of direct DSRIP funding for community partners to support existing community based care providers rather than leaving these funds in the control of the ACOs, which could lead to the creation of new, duplicative hospital-based care providers. However, we are concerned that the waiver, in providing DSRIP funds only to ACOs and to Behavioral Health/LTSS Community Partners, misses the opportunity to build-out a system of community-based care that would help keep MassHealth members healthy in their communities. The waiver seems to limit community supports to those with behavioral health or disability-related issues (see page 6). Though these patients may make up a percentage of those who could be defined as high-need, there are many more patients whose social experiences, including poverty, homelessness and emotional trauma, create barriers to maintaining their health and managing chronic disease. While some of these patients may ultimately find a way into the care of the narrowly defined behavioral health/LTSS category, we fear that others will be left out of these enhanced services.

Moreover, while the 5-year DSRIP funds will be available to help these patients, without greater definition for how the “flexible funds” will be used, it is entirely possible that they will not be used to build infrastructure to better address the social determinants, but instead will be used as short-term relief of larger problems. Thus, when the one-time “flexible funds” are discontinued at the end of five-year period, there is a risk that there will not be a sustainable system in place for addressing social needs.

Behavioral Health Integration

We are supportive of provisions that require further integration of ACOs and Behavioral Health/LTSS care providers through the establishment of formal relationships. At the same time, we remain concerned about whether there will be sufficient financial support to build the infrastructure and systems necessary for care providers to manage risk and effectively share information with ACOs. We know from our experiences coordinating the Prevention and Wellness Trust Program in Boston that linkages between clinical and community-based care must be built and this takes both a commitment of staff time as well as funding for infrastructure. The responsibility for building this infrastructure should not rest solely on the community partners when the entire system will benefit from this investment.

We also hope that certification of community partners (CPs) is flexible enough to accommodate the many community-based organizations that are currently serving under-resourced communities in Boston. While it is critical to ensure that CPs meet minimum standards, we remain concerned that some existing organizations, for example those that provide services to special populations such as homeless individuals, will not meet all of the criteria for certification. In setting the bar too high, we risk excluding providers that have intimate knowledge and experience in serving vulnerable populations.

Substance Use Disorders (SUD):

We applaud MassHealth's commitment and proactive approach to addressing the opioid crisis in the Commonwealth by extending Medicaid to cover additional services and requiring greater integration of behavioral health and primary health care services. As the draft waiver request notes, MassHealth patients are disproportionately impacted by opioid-related morbidity and mortality and would benefit significantly from increased investment in the SUD continuum of care. In our SUD navigation program (PAATHS), we often see individuals who successfully complete detox but are unable find a placement that helps them maintain their sobriety and serve as a bridge to longer-term recovery programs. Thus, we support the decision by MassHealth to expand coverage to for MassHealth patients to include TSS and other services available to individuals who are in need of post-detox services. This proposed change will not only increase access to these critical services, but will also improve continuity of care by ensuring proper hand-off between providers. At the same time, we ask that you take care in implementation to ensure that reimbursement rates are sufficient to enable providers to operate successful programs. As a provider of TSS services, we struggle to maintain high quality care at the rates offered through MDPH's Bureau of Substance Abuse Services. If the MassHealth rate falls below what is currently offered by MDPH, it will drive down the quality of services provided and have the unintended consequence of reducing rather than increasing the number of providers.

Statewide Investments

We appreciate the plan to invest some DSRIP funds in a statewide system that benefits providers across the state and helps to prepare for the transition to ACOs. In particular, the planned investments in PCP workforce development, training and retention as well as the targeted TA for CHCs to help prepare for ACO participation and execution are critical to ensuring an integrated system.

Primary Care:

While we are strong supporters of the move to alternative payment models that pay for improved health instead of volume of care, we are concerned that ACO activities/initiatives will be driven by the financial goals and objectives of hospitals who will lead most MassHealth ACOs in Boston at the expense of Boston's unusually robust workforce of providers who provide primary care to MassHealth-insured residents. This could result, for example, in PCPs due to attrition or to movement to clinics that do not serve MassHealth patients. To counter this, we recommend that MassHealth consider stronger inclusion of primary care and prevention metrics (i.e. vs. tertiary care-centric metrics) in the quality measurements, ACO rules which require a strong leadership role for primary care providers and perhaps a requirement that promotes inclusion of providers that are certified Health Homes in the ACO network.

We appreciate the chance to offer our thoughts on a member-centered health delivery system that includes attention to the social determinants of health and better linkages to behavioral health supports. We thank you for your consideration and your leadership on this matter and are eager to collaborate with you to help ensure members have access to integrated, comprehensive, and accessible whole-person care.

Sincerely,

A handwritten signature in black ink, appearing to read 'MLL', with a long horizontal flourish extending to the right.

Monica Valdes Lupi, JD, MPH
Executive Director

To Whomever It May Concern:

It is with great regret that I was unable to attend any of the formal listening sessions that you had going on during the month of June, due to other commitments that I had to attend to, however, there are comments that I would like to submit at this time.

First of all, as it relates to behavioral health, as said before, for those who are blind or have other transportation related matters due to the fact that one, through no choice of their own cannot obtain a driver's license due to a disability that prevents them from doing so, as it relates to behavioral health and transportation to and from psychiatric/psychology appointments, including psychotherapy, and medication management appointments, as it is at the time, under the current Pt1 system for medical transportation, people on MassHealth or CommonHealth can only get medical transportation when prescribed by a doctor to a MassHealth or CommonHealth provider, who accepts either one of these insurances, however, if someone who is transportation disabled goes to a provider who does not accept MassHealth or CommonHealth, but, only accepts Medicare or some other insurance, than even through a pt 1 such person cannot get medical transportation to and from the facility. This rule has to change to allow for an exception to this policy in order to allow for those who are blind or have other disabilities that prevent them from getting an automobile license to be allowed to get pt 1 medical transportation coverage to and from behavioral health facilities when a blind person or a disabled person who cannot get a driver's license is either enrolled in MassHealth or CommonHealth. The reasons following dictate so. 1. To take a taxi to and from such behavioral health facility such as a psychiatrists office or a psychologist office can be quite expensive, and you and I know that people who receive MassHealth are on fixed incomes, but, yet, an automobile is required to get to these appointments, as often times public transportation is either unavailable in the vicinity of the area of the appointment or is in conflict in schedule to the time the person has to arrive at the appointment and wait to either leave or go back. 2. The issue of paratransit requires that one who needs to go to said facilities requires one to book the trip either one day in advance or several days in advance. Now this obviously includes round trips, and said paratransit does not allow for "will calls," when an appointment is completed. Instead, said complementary paratransit will either have the patient schedule a drop off time or a pick-up time, thus, depending on the time when the appointment starts and end, can incur long wait times. This does not put someone on an equal playing field to those who do not have any disabilities that would preclude them from full enjoyment of the privilege of having a driver's license, thus, meaning, while a blind person cannot drive a car, a person with let's say, a certain type of walking problem, with the appropriate accommodations would be able to obtain and enjoy the privilege of being able to maintain full autonomy via a driver's license. Thus, making exceptions to the Pt 1 rules, policies and regulations, would otherwise allow for those with transportation related disabilities such as blindness or deaf/blindness to be able to have full autonomy just the same as other non-transportation handicapped individuals in the Commonwealth of Massachusetts do enjoy, and doing such would greatly enhance the quality and quantity of life, as also you and I both know, failure for one to obtain a driver's license, due to its privilege nature does not in itself deem someone to be incompetent to take care of themselves and maintain full autonomy.

As to other issues related to behavioral health, while I am not a psychiatrist or a psychologist and don't even pretend to be, given all of the mass shootings that had taken place most recently, MassHealth, CommonHealth and also Medicare, also need to provide better quality mental health services. Even if such means paying for voluntary or involuntary commitment to a psychiatric hospital inpatient care for a thorough psychological and psychiatric evaluations or re-evaluations for periods of up to 30 days and that mental health services need to be covered based upon those treatment plans that had been made

while the person was in hospital for first evaluation or subsequent re-evaluation. As it is, our right to be safe, it is also our responsibility to tend to situations that may make it unsafe for self or others in our community. Thus, to extend beyond just mass shootings, as you are aware, you have elders living longer, and in some cases, some elders do experience dementia, such as Alzheimer's disease. Although I am neither a doctor or an expert on the topic, the researched literature that I had looked into even web M.D do suggest that for some people in the middle stages of the progression of the disease can become aggressive or even hostile and violent, but, yet, the caregiver calls the doctor of the patient or loved one so being affected by the disease and tells the doctor of the aggression, hostility or other changes in behavior, such as from calm to violence, these professionals do advise the caregivers of their loved ones to keep them home with them and have the caregiver observe the violent behaviors themselves.

Common sense alone tells me to be weary of such advice and practice as one must also factor in that the caregiver may also be the parent of a minor child who is too little to understand what is going on or why the little one may had become, let's say for example, permanently disabled as a result of the patient's hostility or violent behavior that had resulted from said dementia. It is at this point that I urge that both MassHealth and CommonHealth also engage in lobbying activity that would place a law on the books in Massachusetts that says that when a patient suffering from dementia's doctor becomes aware of such hostility or violence taking place, that such doctor must have involuntarily committed to a psychiatric hospital or facility, a patient with such dementia for a period of no more than 20 days and that upon such evaluation or re-evaluation, said clinicians performing said psychiatric and psychological evaluations at said psychiatric hospital or facility must give a report to the patient's doctor, their caregiver and the patient's healthcare proxy as at that point in dementia, said patient does not even know that he/she is acting aggressively and violently or in a hostile manner. Contained in such reports should also include a treatment plan to deal with such troublesome behaviors and or whether or not any treatment plan will be capable of working, and if a treatment plan is working, outline in said reports situations that may trigger the hostility, aggression or violence. This can be observed in a psychiatric facility just as well as at home, by having a psychiatrist and psychologist and a mental health specialist who is more professionally trained in dealing with such situations as to what triggers the behaviors and what does not based on different situations and scenarios.

With this information, the caregiver can better predict and better be able to prevent or have such situations avoided or call a family meeting to decide whether or not it is time to put such patient with dementia into a long term facility, such as an assistive living program specializing in patients with Alzheimer's disease or even a nursing home. If a long term care facility outside of the community is warranted for said person with dementia, this brings to mind the estate recovery act so mandated by the federal government that compels states to recover the costs of such long term care, such as nursing home care. In commenting on this issue, I'd like to comment and suggest that this estate recovery act be reviewed and updated to make some exceptions as to the changes or exceptions that may need to be made to the rule. Let's say for instance, the demented patient and their son owns real property together as joint owners, and let's say it is the son's mother. She is the one affected by the dementia, which in turn affects in a harmful way her son who is caring for her, his wife or even their children. Now, the mother passes away. Even though the mother may have not known what she was doing while she was alive and suffering from the middle stages of Alzheimer's disease, and it was said upon evaluation by all clinicians involved, that it would be in the son's and mother's best interest to place the mother in a nursing home. The exception should be here, that said estate recovery for the long term care should come from any assets that she has besides the house that she owns with her son and that when all assets, with the exception of the house has been collected for recovery of the long term care has been done, this shall be deemed to be as long term care expenses has been recovered. If the deceased

mother has no assets at the time of her passing, n estate recovery for such long term care should take place, unless, during her care, the son who was caring for his mother acted abusive and in a violent way towards her while he was taking care of her.

I hope that you will take a serious look at these comments here as you deliberate as to what policies and procedures that you may put in place. If you have any questions, please do not hesitate to contact me at 508 265-5099. I look forward to what comes out of your careful deliberations as you proceed forward. Have a nice day.

With Warm Regards,

Brian J. Coppola

Brian J. Coppola

From: May, John (EHS)
Sent: Tuesday, June 28, 2016 10:22 AM
To: Tierney, Laxmi (EHS)
Subject: FW: Information for tomorrow's MCAC and PPAB meeting

Hi Laxmi,

FYI – Here is some feedback on the waiver proposal from an MCAC member.

John

From: Upshur, Carole [<mailto:Carole.Upshur@umassmed.edu>]
Sent: Monday, June 27, 2016 9:34 AM
To: May, John (EHS)
Subject: RE: Information for tomorrow's MCAC and PPAB meeting

Hi John,

I went through the materials sent last week. Sorry I missed the hearing. I am not enough up on the financials issues from vendor perspectives to discuss the downsides, but I will say that the conversation about created better integration and more management of care has been going on for years. I have always been in support of that, including more behavioral health integration since my whole career has been spent in documenting evidence based interventions for behavioral health integration in primary care.

I do hope the waiver moves forward in the direction outlined and I do believe it will result in cost savings and more efficiencies in the Medicaid program.

Carole

Carole Upshur, EdD, Professor, Director of Research Training and Development
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From: May, John (EHS) [<mailto:John.May@MassMail.State.MA.US>]
Sent: Thursday, June 23, 2016 3:13 PM
To: Tsai, Daniel (EHS); Dunbar-Hester, Anna (EHS); Elizabeth Funk (BettyFunk@rcn.com); 'Joanne.Cox@childrens.harvard.edu'; Kate Holahan; Spooner, Paul; Richard Dropski; Suzanne Curry; Upshur, Carole; Vicker V. DiGravio (vdigravio@abhmass.org); McHale, Dan; Matteo, David; Sherman,

Elissa; Nordahl, Kate; Kramer, Marilyn (CHIA); Mark Reynolds (MReynolds@rmf.harvard.edu); Edraos, Pat; Kelleher, Patricia; raymond.mccarthy@baystatehealth.org; Robert LeBow (robertlebow@yahoo.com); Robert Moran (moran87@charter.net); Lit, Susan; Gregorio, Tara
Cc: Cassel Kraft, Amanda (EHS); Tierney, Laxmi (EHS); Newman, Dennis (EHS)
Subject: Information for tomorrow's MCAC and PPAB meeting

Dear MCAC and PPAB members,

Attached are the slides we will be using for our presentation at the meeting tomorrow at 2:30 at 1 Ashburton Place, 21st Floor. Also attached is a summary of the waiver. You can find this document and other information about the waiver at <http://www.mass.gov/hhs/masshealth-innovations>.

The waiver proposal lays out a restructuring of the MassHealth care delivery and payment system through Accountable Care Organizations (ACOs), and includes a significant expansion of substance use disorder treatment services in an effort to address the opioid epidemic. Your input will be particularly helpful given the breadth and depth of your collective expertise and experience. If you have any questions or if you want to discuss aspects of the waiver proposal in advance of the meeting, please let us know.

Following the presentation, you will be invited to comment on the waiver proposal. After MCAC and PPAB members provide their comments, we will invite comments from anyone else who attends the meeting. As this meeting is part of the public comment process for the waiver, we will not respond to any of comments during the meeting, but we will carefully consider all of the input during the public comment review process.

We look forward to seeing you there and will very much appreciate your participation. If you have not yet rsvp'd, please let me know whether you plan to attend. If you send you reply tomorrow, please copy Dennis Newman. If you cannot attend the meeting but would like to send written comments, please send them to us.

Best regards,

John

John May

Senior Legislative Policy Analyst
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108
617-573-1763

July 17, 2016

Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Attn: 1115 Demonstration Comments

Dear Assistant Secretary Tsai:

Casa Esperanza, Inc. is a bilingual/bicultural behavioral health agency that specializes in serving the Latino community in Massachusetts. **Casa's mission is to help men, women and children overcome homelessness and health disparities; recover from addiction, mental illness, and chronic disease; gain the skills they need to be self-sufficient, contributing members of society; and to repair and strengthen families torn apart by trauma and abuse.** Casa Esperanza offers a range of treatment and support services including Residential Recovery Home services for adult men and women, including pregnant and postpartum women, and women reunifying with their children; outpatient mental health and addictions treatment, including the only Spanish language Structured Outpatient Addictions Program in Greater Boston, and an OBAT program that prescribes both Vivitrol and Suboxone with wraparound culturally-focused support services; 37 units of Supportive Housing; and the Commonwealth's first bilingual/bicultural Clinical Stabilization Services program, which is currently under development. Each of these programs is part of our larger CasaCare model that provides integrated behavioral health and primary care services across our continuum.

As an active member of the Association for Behavioral Healthcare, Casa would like to fully endorse the comments and recommendations submitted by ABH on the Request for Amendment and Extension of the Section 1115 Demonstration; and respectfully submits these additional comments at this pivotal moment in health systems transformation in the hopes of strengthening mechanisms that can support the eradication of health disparities.

On behalf of our clients, staff, and Board of Directors, I would like to thank the Baker Administration, the Executive Office of Health and Human Services, and MassHealth for an 1115 waiver proposal that recognizes the need for: 1) better care integration among physical health, behavioral health, and long-term services and supports; 2) services and resources that address the social determinants of health; and 3) evidence-based interventions that meet the unique needs of cultural and linguistic minorities, and other vulnerable subpopulations. We believe that this proposal provides a framework that helps the Commonwealth move toward these goals as it seeks to manage costs and improve both the quality and experience of care.

We strongly support the Commonwealth's stated intention to "reference national best

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OUTPATIENT SERVICES
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practices to advance wellness, prevention, cultural competency and care integration and...build these expectations and standards into the ACO procurement and contractual requirements,” and we applaud the current administration for its vocal, public support for the elimination of health disparities. While we firmly believe that these commitments, along with the goals stated above, will advance care for vulnerable populations and promote the reduction of health disparities, **Casa recommends the addition of explicit language that states the Commonwealth’s intention to significantly reduce or eliminate health disparities through the systems transformation described in the 1115 waiver proposal.** We believe that setting the elimination of health disparities as a specific goal of the waiver will help to guide the development of critical components of this system that have yet to be finalized.

We would also like to acknowledge the truly collaborative process that MassHealth has facilitated to ensure broad stakeholder input into this waiver proposal. We believe that active stakeholder engagement is essential to the development of a proposal that is both aspirational and achievable. We are particularly pleased to see that “MassHealth will continue to seek input from technical advisory groups on key topics, e.g., certification criteria for Community Partners, quality and member experience measurement approach, and ACO model details.” **Casa recommends that the waiver include a stated intention to actively engage stakeholders with demonstrated expertise in serving/researching the needs of cultural and linguistic minorities, homeless individuals, individuals recently released from incarceration, and other vulnerable subpopulations, for the express purpose of commenting on critical operational components that will drive the reduction of health disparities.** We believe that stakeholder engagement in clarifying these operational details is essential to ensure that specific mechanisms for identifying and targeting the elimination of health disparities are both required and incentivized, to promote the assertive engagement of hard-to-reach populations.

Finally, we are extremely appreciative of the comprehensive way in which the waiver addresses the needs of MassHealth members living with Substance Use Disorders. We are continuously grateful to the Baker Administration and EOHHS for their commitment to those affected by SUDs, and the waiver is just another example of this commitment at work. In addition, we appreciate the specific attention paid to the needs of cultural and linguistic minorities throughout the SUD sections of the proposal, and we are extremely honored to be referenced as a model program.

Further, Casa firmly supports the measures outlined on page 76 of the waiver proposal, including the use of NOMS; however, we would caution the Commonwealth that success with key measures such as “increased housing” are often largely dependent on systems and conditions outside a provider’s control, specifically the availability and accessibility of affordable, stable housing. Particularly in the City of Boston, affordable housing is extremely difficult to secure, while a lack of stable housing continues to be a primary catalyst of both relapse and recidivism. Given that housing stability is a “social determinant of health” that impacts such a broad array of

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MassHealth members, **Casa recommends that MassHealth consider including a stated commitment to the development of an interagency plan to increase the availability and accessibility of affordable housing, for the express purpose of improving the health outcomes of MassHealth members affected by housing instability.**

Once again, we thank EOHHS and MassHealth for the chance to participate in this stakeholder process and the opportunity to comment on this historic waiver proposal. If you have any questions or concerns regarding these comments and recommendations, please contact me directly.

Sincerely,



Emily Stewart
Executive Director
Casa Esperanza, Inc./Nueva Vida, Inc.

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Hello,

My name is Catherine Boyle. I have already submitted comments in my professional capacity. These comments are in my capacity as the mother and legal guardian of a MassHealth member.

My son has severe autism, accompanied by aggression and self-injurious behavior when he is stressed. One of the things he finds most stressful is blood draws, which he must have done regularly. While he attended a residential school in NH, these were done at his residence by a visiting nurse. Having these done in his residence, before breakfast, greatly reduced his stress, and he generally had few difficulties compared to his previous experiences going to a lab.

He is now an adult, and resides in a group home in Mass. He is currently not able to get blood drawn at his residence because his need for a house call is due to behavioral reasons, not medical ones. Instead, he must go to a blood lab, where a restraint is performed by several staff members from his residence. I was actually told by Mass General that, were he to go to Mass General for labs, they could only see him in the emergency room, as that is where the security team is.

This situation is not only extremely stressful for my son, it endangers other patients and medical personnel at the lab. Additionally, it incurs the cost of multiple staff having to accompany him to the blood draw. I know he is not the only individual in this situation. I believe every resident of my son's home requires labs regularly. It would be far safer, more efficient, cost effective, and less stressful to have a visiting nurse perform labs at the residence periodically.

Thanks for your consideration.

Catherine Boyle



The Honorable Marylou Sudders
Secretary of Health & Human Services
Executive Office of Health & Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108
Submitted via Electronic Mail: masshealth.innovations@state.ma.gov

July 15, 2016

RE: Comments on Demonstration Extension Request

Dear Secretary Sudders:

Thank you for the opportunity to submit comments on the Executive Office of Health and Human Services' (EOHHS) proposed Section 1115 Demonstration Project Amendment and Extension Request ("the Request") to restructure MassHealth to an Accountable Care Organization (ACO) model.

The Center for Health Law & Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. As part of this work, we collaborate with a number of community partners working to address social determinants of health by providing services such as medically tailored meals, housing stabilization services, and employment supports. One of the organizations with which we collaborate is Community Servings, a Boston based not-for-profit that prepares and delivers medically tailored meals to home-bound, critically and chronically ill individuals throughout Massachusetts.

We applaud EOHHS' commitment to prioritizing social determinants of health as part of the MassHealth ACO model. Addressing social determinants of health, especially access to healthy and medically-appropriate food, is vital to patient-centered care because of the significant impact that social determinants can have on health outcomes.

Food insecurity occurs "whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain."¹ In general,

¹David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 353 (1998).

food insecurity is linked to “poor child development, increased hospitalizations, anemia, asthma, suicidal ideation, depression and anxiety, diabetes, and chronic disease.”² By offering nutritional counseling and directly providing healthy, medically-appropriate food, food and nutrition services (FNS) improve these health outcomes. Provision of FNS has been shown to reduce emergency room visits and hospital stays, enhance treatment adherence, and improve disease management.³

Social determinants, such as food insecurity, can also play an important role in efforts to address substance use disorders (SUDs). For example, families with very low food security exhibited 10 times the rate of heroin use in the past 30 days compared to the general population.⁴ Further, individuals with SUDs who are food insecure experience “diminished physical and mental health states ... including obesity, diabetes, heart disease, hypertension, and depression.”⁵

CHLPI and Community Servings therefore encourage EOHHS to take the following steps to maximize the positive impact of the new ACOs in addressing social determinants of health:

1. Clarify the requirements around ACO flexible spending services (FSS).

Under Section 4.2.2 of the Request, EOHHS states that spending for flexible services must satisfy a number of specific criteria, including a requirement that services are “determined to be cost-effective alternatives to covered benefits and likely to generate savings.” We encourage EOHHS to eliminate or clarify this requirement to avoid unnecessary restrictions on ACOs and social service providers.

Many of the examples of FSS described in the Request—such as housing stabilization, physical activity, and nutrition—should not be, in most cases, a substitution for other health care services.

² Mariana Chilton et al., *The Intergenerational Circumstances of Food Insecurity and Adversity*, J. HUNGER & ENVT’L NUTRITION 1-28 (2016).

³ See Su Lin Lim et al., *Malnutrition and its Impact on Cost of Hospitalization, Length of Stay, Readmission and 3-Year Mortality*, 31 *Clinical Nutrition* 345-350 (2012), available at [http://www.clinicalnutritionjournal.com/article/S0261-5614\(11\)00199-3/pdf](http://www.clinicalnutritionjournal.com/article/S0261-5614(11)00199-3/pdf); see also Fact Sheet HIV/AIDS, Food & Nutrition Services Needs, Cmty. Health Advisory & Info. Network (Oct. 2011), available at http://www.nyhiv.org/pdfs/chain/CHAIN%202011-5%20Brief%20Report_HIVAIDS,%20Food%20&%20Nutrition%20Service%20Needs%20Factsheet.pdf; see also Fact Sheet #2 Who Needs Food & Nutrition Services and Where Do They Go for Help?, Cmty. Health Advisory & Info. Network (Aug. 2013), available at http://www.nyhiv.org/pdfs/chain/CHAIN%202013-2%20Brief%20Report_Food%20Insecurity%20Fact%20Sheet_2.pdf; see also Fact Sheet #3 Food & Nutrition Services, HIV Medical Care, and Health Outcomes, Cmty. Health Advisory & Info. Network, available at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_services/chain_factsheet3.pdf (last visited May 31, 2016).

⁴ Craig Gundersen & James P. Ziliak, *Childhood Food Insecurity in the U.S.: Trends, Causes, and Policy Options*, THE FUTURE OF CHILDREN 6 (2014), available at <http://futureofchildren.org/futureofchildren/publications/docs/ResearchReport-Fall2014.pdf>.

⁵ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 *BMC PUB. HEALTH* 2 (2012).

Instead, these services should supplement existing MassHealth benefits and strengthen their effect on overall patient health. For example, nutrition services, such as medically tailored home-delivered meals provide an array of benefits—addressing management of blood glucose, increasing the effect of medication that must be taken with food, managing protein levels for kidney disease, maintaining healthy weight, etc.—that help patients manage their health conditions, adhere to treatment plans, and follow the instructions of their physicians and providers. Over time, these benefits will reduce avoidable hospitalizations and use of emergency care. In that respect, food and nutrition services ultimately provide an inexpensive alternative to the utilization of costly health care services. However, the immediate impact of services that address social determinants of health is improved patient engagement and adherence in routine care. EOHHS should therefore either remove or clarify the requirement that FSS be “alternatives to covered benefits” to avoid creating an unnecessary barrier to the provision of key social services.

We also recommend that EOHHS eliminate or clarify how it will define the term “cost-effective.” The purpose of funding flexible services is to enable delivery of innovative and promising interventions that meet the needs the ACO’s patient population. In order to make the promise of this funding real with respect to patient outcomes and cost, ACOs should be able to draw from a wide array of possible interventions. In some contexts, “cost-effective” is used to indicate that a study has been published examining the return on investment (ROI) or ratio of cost to quality-adjusted life years gained for the intervention. ACOs could therefore interpret the phrase “determined to be cost-effective” to mean that such studies must exist in order for a particular service to be covered under FSS. For many key social service interventions, this level of data may not yet exist despite compelling evidence (e.g., pilot studies and internal data) that the intervention is low-cost and high-impact. We therefore urge EOHHS to eliminate or clarify the requirement that FSS be “determined to be cost-effective.” In the event that EOHHS chooses to clarify the term “cost-effective,” we support the adoption of a broad definition to avoid limiting ACOs’ ability to provide FSS that address the unique and often overlooked needs of their patient populations.

Under the same section, the Request requires that FSS “funding is not available from other publicly-funded programs.” We urge EOHHS to provide clarification on how it will assess situations in which flexible spending may appear to be similar to a preexisting public benefit program, but is actually complementary. For example, ACOs could provide fruit and vegetable vouchers and nutritional counseling as low-cost, high-impact interventions for beneficiaries identified as food insecure. In such cases, MassHealth members should not be precluded from receiving these vouchers if they also, for example, receive SNAP benefits. To do so would inhibit ACOs from effectively using FSS to improve the care of beneficiaries who participate in multiple public programs. Any clarification that EOHHS can provide on how it will assess similar situations in order to avoid excessive limitation of flexible services would be appreciated.

2. Provide a framework to govern the use of flexible spending funds.

In order to maximize the impact of the new ACO model in addressing social determinants of health, we encourage EOHHS to provide a framework for the use of flexible spending funds. Such a framework would both ensure oversight of the flexible spending program and provide additional clarity for ACOs by establishing a uniform process. We recommend that the framework address at least the following elements:

- i. Which parties determine how flexible spending funds will be spent.*

Currently, the Request does not provide guidance on who will decide how funds are spent within the FSS programs. As a result, ACOs may defer to their partner social service organizations to make these determinations. Because such organizations are often focused on specific needs or patients, such a strategy could result in only a portion of the ACO's population receiving access to FSS. In contrast, the ACOs themselves are well-positioned to assess the needs of their entire patient population and to direct the funds accordingly. Therefore, we recommend that the FSS framework require ACOs to be responsible for determining how FSS funds are spent.

- ii. The process that ACOs must use to determine their members' social service needs.*

In order to facilitate appropriate use of flexible spending funds, we also encourage EOHHS to include guidance in the FSS framework regarding how ACOs should determine the social service needs of their members. In developing this guidance, EOHHS could require ACOs to look to existing data sources and recent patient data to assess community needs. For example, in the first year of the demonstration, EOHHS could require ACOs to base their needs assessment on existing data sources such as Community Health Needs Assessments performed by non-profit hospitals in their service area and county-level data related to social determinants such as food insecurity and housing. Moving forward, EOHHS could then require ACOs to screen patients for social service needs during health care visits and use that data to drive allocation of FSS funds.

To help developing ACOs begin to plan for this process, we also encourage EOHHS to clarify how it will calculate the amount of DSRIP funding that ACOs will receive for FSS. By allowing ACOs to better estimate how much funding they will receive for FSS and how that funding will impact their overall budgets, ACOs will be better equipped to begin planning to provide FSS.

- iii. The FSS reporting requirements that ACOs must meet to ensure transparency.*

Lastly, it would be beneficial for EOHHS to establish transparency requirements regarding FSS funds. Specifically we recommend that EOHHS require each ACO to produce an annual public report describing how they determined their members' social services needs and how they are allocated FSS funds to meet those needs. By doing so, EOHHS can create greater oversight of the FSS program and motivate ACOs to carefully tailor FSS funds to member needs.

3. Emphasize the role of food and nutrition services in helping individuals with substance use disorders recover and maintain long-term abstinence.

In the Request, EOHHS demonstrates a strong commitment to enhancing services for people coping with substance use disorders (SUDs). We applaud EOHHS for its efforts to better address SUDs and ask EOHHS to encourage ACOs to consider including food and nutrition interventions as a critical facet of their SUD strategies. Food insecurity among individuals with SUDs leads to poor health outcomes from both individual and public health perspectives (see studies cited below). As a result, food and nutrition services can help these individuals to recover and maintain long-term abstinence.

From a nutritional standpoint, individuals with SUDs are more likely to be food insecure.⁶ Food insecurity for these individuals tends to become “increasingly severe.”⁷ While individuals with SUDs have a greater risk of malnutrition, the risk is greatest for injection drug users.⁸ Vitamin deficiencies experienced by people with SUDs as a result of food insecurity can lead to negative emotions such as “apathy, anxiety, irritability, and depression.”⁹

In addition, because individuals with SUDs who are food insecure tend to make riskier choices, food insecurity also impacts the public health. Several studies indicate that individuals with SUDs who are food insecure have higher chances of engaging in needle sharing¹⁰ and unprotected sex.¹¹ These activities increase the risk of disease transmission. This increased risk of transmission combined with reduced health status of individuals with SUDs means they are more likely to contract disease and to experience rapid disease progression, health complications, and negative treatment outcomes.¹² Given the relationship between food insecurity and SUDs, FNS can play an important role in addressing the impact of SUDs in the Commonwealth and should therefore be included part of ACO strategies on this issue.

In closing, we appreciate EOHHS’s dedication to addressing social determinants of health in its 1115 Demonstration Amendment and Extension Request. The decision to address social

⁶ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 351 (1998); see also Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 6 (2012).

⁷ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 351 (1998).

⁸ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 352 (1998).

⁹ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 7 (2012).

¹⁰ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 1-9 (2012).

¹¹ Kate Shannon et al., *Severe Food Insecurity is Associated with Elevated Unprotected Sex among HIV-Seropositive Injection Drug Users Independent of HAART Use*, 25 AIDS 2037-2041 (2011).

¹² Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 7 (2012).

determinants in the new MassHealth ACO model will positively impact individuals in the Commonwealth living with chronic illness. We believe that by clarifying flexible spending requirements, providing a uniform framework for the FSS program, and emphasizing FNS as a facet of whole-person treatment for SUDs, EOHHS can maximize this impact.

Again, we applaud EOHHS's efforts to provide whole-person accountable care to MassHealth members, and we would be happy to work with the Office to address any of the comments described above.

Sincerely,



Robert Greenwald
Faculty Director, CHLPI
Clinical Professor of Law, Harvard Law School



David Waters
CEO, Community Servings

Together with the following:

Action for Boston Community Development, Inc., Boston, MA

Children's HealthWatch, Boston, MA

Fresh Advantage® LLC, Cambridge, MA

Health Care for All, Boston, MA

Health Care Without Harm, Boston, MA

Massachusetts Law Reform Institute, Inc., Boston, MA

The Greater Boston Food Bank, Boston, MA

The Open Door, Gloucester, MA

Worcester County Food Bank, Shrewsbury, MA

Avik Chatterjee, MD, MPH, Physician, Boston Health Care for the Homeless Program and
Instructor, Harvard Medical School



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Jeanne Pinado

July 15, 2016

Vice President
Charleen Regan

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Joseph Flatley

Clerk
Naomi Sweitzer

Executive Director
Brenda Clement

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place - 11th Floor
Boston, MA 02108

Submitted by email

To Whom It May Concern:

Thank you for this opportunity to comment on the proposed Section 1115 amendment for the MassHealth program. I am writing on behalf of Citizens' Housing and Planning Association (CHAPA). We are a statewide organization that promotes affordable housing and equitable community development through education, research and legislation. We also belong to the On Solid Ground Coalition, a cross-sector group of more than 30 organizations committed to a research-based approach to increasing housing stability and economic mobility. We believe that achieving housing stability and economic mobility requires coordinated housing, workforce development, education, and health and wellness policies; it is more difficult for unstably housed patients to be medically compliant and chronic illness is often a barrier to education and steady employment.

We believe that the proposed Section 1115 waiver amendment, with its emphasis on integrated care, comprehensive needs assessments and funding for traditionally non-reimbursed flexible services offers an important opportunity to improve the health and well-being of Massachusetts' residents. We are very pleased that it will explicitly address social determinants of health and provide funding for flexible health-related social services through DSRIP.

Our comments focus specifically on the proposals regarding health-related social services not traditionally reimbursed by Medicaid. We strongly support Section 5.3.2.3 (on page 42) which proposes to make DSRIP funding available for several categories of flexible services, including housing stabilization and support, search and placement, utility assistance, nutrition and sexual assault and domestic violence. We believe investments in these types of services can play an important role in reducing negative health outcomes and that the benefits are likely to increase over time.

There are a few places where more flexible language might be beneficial. In the Goals section (§2.2.2), we urge you to consider specifying activities (housing, nutrition) that might qualify as health related social services, while clarifying that eligible activities are not limited to the examples of flexible services provided in §5.3.2.3. In addition, since the evidence on the magnitude of cost savings related to housing stabilization is still evolving, we also urge you to add language giving the Commonwealth more flexibility regarding the proposed funding for flexible services. Specifically, we recommend requesting latitude regarding both the proposed flat per member per month allocation for flexible services and the proposal to transfer all unused flexible service funds from ACOs to the statewide fund for technical assistance. We would leaving open the possibility of allowing that funding to roll over at least initially and/or be made available to another ACO for flexible services.

We applaud the proposal to use global measures of success for the SUD demonstration (page 76) - including changes in housing status, education and employment - and hope these types of outcomes

related to social determinants of health (and in particular housing outcomes) will be tracked under the waiver for all members (both those with access to flexible services and those without). We would welcome an opportunity to work with you and community partners on success measures related to the social determinants of health and on ways to provide effective flexible services.

Sincerely,

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Brenda Clement
Executive Director

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108

Submitted via email to MassHealth.Innovations@state.ma.us

Re: Comments on 1115 Medicaid Demonstration Extension Request

Dear Assistant Secretary Tsai,

On behalf of Children's HealthWatch, please accept these comments on the MassHealth Section 1115 Demonstration Project Amendment and Extension Request. We applaud the Executive Office of Health and Human Services' efforts to allow ACOs to address social determinants of health among MassHealth members.

Children's HealthWatch is a Boston, MA-based nonpartisan network of pediatricians, public health researchers, and policy and child health experts committed to improving children's health in America. Every day, in urban hospitals across the country, and here in Boston at Boston Medical Center, we collect data on children ages zero to four many of whom are from families experiencing economic hardship. We analyze and release our findings to academics, legislators, and the public to inform public policies and practices that can give all children equal opportunities for healthy, successful lives. In Boston we collect data at Boston Medical Center

We have included below brief comments on specific aspects of the waiver proposal.

Access to Services and Care Delivery

We strongly support MassHealth's goal to promote member-driven, integrated, coordinated care that includes physical health, behavioral health (BH), Long-term Services and Supports (LTSS), and health-related social services. However, among the vulnerable populations listed (i.e. people coping with behavioral health, substance use disorders, frail seniors, and members with disabilities), we also believe this goal should include very young children under the age of four – a vulnerable and overlooked population. An additional focus on child health will contribute to lowering costs and improving health outcomes.

Community Partners

One of the unique features of MassHealth's proposal is the strong emphasis on ACOs' collaboration with community-based providers. Most of these organizations already serve a high volume of MassHealth members and play a significant role in care coordination and connecting members with non-medical services. We support MassHealth's proposal to connect ACOs with community-based BH and LTSS providers, who can be certified as Community Partners (CPs), including providing direct DSRIP funding to support the capacity-building of CPs. CPs can use these resources to build out the required capacity to work with ACOs in supporting the integration of behavioral health, LTSS and health-related social services. We request more information about the certification criteria which CPs must meet. We also request that, in addition to community-based BH and LTSS providers,

community agencies and service providers that address the Social Determinants of Health (SDOH) can be certified as Community Partners.

Children's Health

Children (especially infants and toddlers) have specialized needs that are not adequately addressed in a system built for adults. However, the waiver proposal does not specify how the different ACO models will address the unique needs of children. ACOs should emphasize prevention and social service interventions with children and their families. Unlike most adult care models, the family plays a primary role in managing a child's care. Family experiences can provide a wealth of useful data and information in shaping some of the core elements of an ACO and achieving its goals. All ACOs that serve children should have the ability to support the family – in addition to the child - and make linkages with other state agencies and with key community resources, such as schools, social service agencies, and others.

Population Health and Prevention

Social Determinants of Health

We are particularly pleased that MassHealth's proposed restructuring framework seeks to incorporate linkages to social services in an effort to address social determinants of health, including designating a portion of DSRIP funds for "flexible services." As part of ensuring meaningful ACO collaboration with social service providers, we seek to better understand how DSRIP funds will reach these providers. While DSRIP funds will clearly be directed to BH and LTSS CPs for infrastructure and care coordination, it appears that social service providers do not receive direct DSRIP funding as they are not "certified" community partners.

In determining the criteria that must be met to pay for such flexible services, we urge MassHealth to take a broad and flexible approach to encourage ACOs to innovate around how to use DSRIP funds to address social determinants of health. One promising idea to ensure members have the broadest access to social service agencies is through a social services "hub." Such a hub can offer a single point of coordinated access to a wide range of social services which have a documented impact on health outcomes and on reducing the cost of care. A hub model could work with multiple ACOs to bridge medical and social service systems, providing culturally and linguistically competent services, engaging multiple social services agencies, and providing access to medically beneficial, evidence-based programs in each geographic region. With any model, MassHealth should work to promote access to all available services, such as the Supplemental Nutrition Assistance Program (SNAP) and housing supports.

Community Health Workers

ACOs have the opportunity to promote public and community health by strengthening the role of community health workers (CHWs) in connecting people to care resources and promoting overall health. Including CHWs as part of health care teams has been shown to contain costs by reducing high risk patients' use of urgent and emergency room care and preventing unnecessary hospitalizations. CHWs also improve quality of care and health outcomes by improving use of preventive services and offering chronic disease self-management support and maternal-child home visiting and perinatal support.

While ACOs will have flexibility in how to structure care teams, including CHWs, we recommend that the role of CHWs be more formally incorporated into the ACO models. MassHealth should require that ACOs demonstrate how they will integrate CHWs into multi-disciplinary teams for high-risk/high need members.

Direct spending for traditionally non-reimbursed flexible services to address health-related social needs

In order to assess the progress of the DSRIP program and ACO models, it is essential to establish specific quality metrics and outcome goals. We support MassHealth's priority domains for quality measurement:

We understand that a portion of ACO DSRIP funds will be dedicated to spending on flexible services, not currently reimbursed in MassHealth, which address health-related social needs. We support MassHealth's prioritized categories of flexible services, which include:

- Housing stabilization and support, search and placement
- Utility assistance
- Non-medical transportation
- Physical activity and nutrition
- Sexual assault and domestic violence supports

Within the category of physical activity and nutrition, we recommend that a clarifying clause be added to ensure that nutrition services do not just cover the important activity of helping educate members about what they should eat for their particular health status and condition, but also include ensuring members can access and afford food (i.e. food security). Moreover, we recommend that within the categories of flexible services, clinical screening for SDOH (i.e. food insecurity, housing insecurity, and energy insecurity) be included as part of the prioritized services (i.e. SNAP/WIC application assistance, housing support, utility assistance).

We appreciate the opportunity to provide feedback on the MassHealth 1115 Medicaid Demonstration Waiver proposal. For additional information, please contact Stephanie Ettinger de Cuba, Research and Policy Director for Children's HealthWatch at sedc@bu.edu or 617-638-5850, or Richard Sheward, Senior Policy Analyst – State Policy at richard.sheward@gmail.com or 518-265-5343.

Thank you for your consideration.

Sincerely,



Deborah A. Frank, MD
Principal Investigator and Founder
Children's HealthWatch
Boston, MA



John Cook, PhD, MAEd
Research Scientist and Principal Investigator
Boston, MA



Megan Sandel MD, MPH
Principal Investigator
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Ruth Rose-Jacobs, ScD
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July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Director of Medicaid
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Scott Taberner
Chief of Behavioral Health and Supportive Care
Office of MassHealth, Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Assistant Secretary Tsai and Chief Taberner:

The Children's Mental Health Campaign (CMHC) welcomes the opportunity to submit comments on the MassHealth application to amend and extend Section 1115 Demonstration to the Centers for Medicare and Medicaid Services (the proposal). The CMHC leadership appreciates that the focus of the application is to increase care integration in a meaningful way for MassHealth members as their coverage is transitioned to Accountable Care Organizations (ACO). We remain concerned that though youth comprise almost 40% of Mass Health members, the proposal does not specify how the system would function to serve children and adolescents.

MassHealth leadership signaled its commitment to youth by including CMHC leadership and many child and adolescent service providers in the recent MassHealth ACO Transformation work groups. However, we are disappointed to see very few of the contributions made by child health leaders included in the proposal. The CMHC is concerned not only about the lack of direct inclusion of pediatrics in the proposal, but also the opportunity cost for youth, given the scope of the proposed undertaking. In the absence of pediatric-specific system planning, MassHealth fiscal and human resources will be focused on developing an integrated care system whose service delivery model aligns with adult outcome measures. In our long experience with the MassHealth program, we have seen that children and adolescents risk being left behind without dedicated internal resources (personnel and otherwise) to assure that they are explicitly included in your planning and implementation process.

As you know, well integrated care for youth is an investment in the future. The cost savings from providing the prevention and early intervention services that are the mainstay of pediatric care may not be realized immediately, but they pay substantial dividends over a lifetime of improved health. It is notable, for example, that the substance use disorder (SUD) focus of the proposal is commendable, but the majority of SUD 'horror stories' start with substance use during childhood or adolescence. The treatment options for youth are particularly limited, and MassHealth arguably has a critical role to play in improving this state of affairs. We know that the expense of not providing early intervention to such children or the savings of doing so is actualized over the course of a lifetime.

We look forward to further exploring these issues with you when you join the Children's Behavioral Health Advisory Council on August 1. We appreciate your commitment to children with behavioral health needs and their families, and to MassHealth providing integrated and well-coordinated care in order to improve outcomes, lower long-term costs, and better care for the kids of the Commonwealth.

Sincerely,

J; (iv--

Courtney Chelo
Children's Mental Health Campaign Manager



Clinicians **UNITED**

for affordable, accessible mental health services

July 17, 2016

Via Electronic Mail to: MassHealth.Innovations@state.ma.us

CliniciansUNITED (CU) is a multidisciplinary group of independent behavioral health clinicians who are associate members of the Massachusetts Human Service Workers Union, SEIU Local 509. We are grateful for the opportunity to provide comments on MassHealth's delivery system and payment methodologies reform.

We applaud the focus on behavioral health integration and encourage you to think deeply about sustainable and realistic systems that can provide care at different levels. Independent clinicians provide a cost effective option for care that is appropriate in the outpatient community setting. We are experts in these services and we encourage you to include clinicians in your decision making processes.

There are many opportunities for MassHealth to re-shape the current system that is frustrating for both providers and patients. Reimbursement rates are notoriously low and many providers cannot afford to sustain their practices while taking MassHealth. With this focus on integration, MassHealth has an incredible opportunity to restructure reimbursement to increase provider participation in MassHealth, and in turn, increase patient access. With payment methodologies that are fair and transparent, MassHealth can create a system that works for clients and providers.

The negotiation and payment process to providers should be transparent and equitable -- and needs to be communicated in those same ways to clinicians. Mental health clinicians working in the community provide critical care and deserve clear and fair payment and negotiation structures. The current carve out system is severely lacking in transparency and respect for providers. Changing this ineffective structure could lead to significant improvements to patient access and provider sustainability.

In addition to the payment restructuring, we urge MassHealth to truly examine the adequacy of their network. By opening up panels, more clinicians will be able to provide more services to this vulnerable population and increase critical access to outpatient mental health care. CliniciansUNITED recently commissioned the University of Massachusetts Donahue Institute to conduct a study of independent mental health clinicians statewide. The goal was to gain a quantitative sense of the challenges clinicians and their clients face. A particularly alarming finding in the Donahue Institute of UMass survey was that of the 662 clinicians surveyed, 81% had to turn away one or more potential clients in a month. Of those clinicians who had to turn away potential clients, 49% noted that this number increased in the past year. This data shows



Clinicians *UNITED*

for affordable, accessible mental health services

that people who are seeking care for mental health issues are not getting it, maybe at all, but definitely not in a timely manner. MassHealth has the opportunity to change that statistic for this vulnerable population.

Additionally, we believe this data also points to the need for opening panels. We strongly encourage MassHealth to continually add therapists to their referral networks -- rather than have a closed network that rarely opens up to new therapists. This would ensure that the MassHealth is committed to mental health clinicians practicing in the community. This would also demonstrate the commitment to addressing the real issue of clients not receiving care because of a lack of therapists who take their insurance, which is the current reality in Massachusetts.

Thank you again for the opportunity to provide feedback. We are looking forward to working with you throughout this process.

Sincerely,
Melody Hugo
Clinicians*UNITED* Director



July 15, 2016

Dear Assistant Secretary Tsai:

Thank you for offering a comment period on the draft 1115 Waiver Proposal to CMS. The work that you, your colleagues and the entire Governor Baker administration has taken with regards to this work is creative, smart, innovative and incredibly focused on the needs of the state's most vulnerable populations. We applaud you for these efforts and we very much look forward to partnering with you to bring this progressive vision to a successful reality.

The table below contains our feedback. Please do not hesitate to reach out for any clarity you need on any of the below.

Best Regards,

Christina Severin
President & CEO

Section Number Page number (of 92 pages)	Waiver Content	CCC's feedback
Executive Summary 5	An MCO must demonstrate competencies and readiness in these areas before it takes on accountability for LTSS	This option should also become available for high-performing Model B ACOs.
Section 3 21	Additionally, MassHealth will establish an advocate and member advisory group to ensure that members will have an appropriate forum to provide input to support design, implementation planning and roll-out.	Can the consumer representative on our board participate in this group for board education and development purposes?
4.1.2 25	All eligible members will enroll in a managed care option and select a primary care provider, as they do today. All eligible members will have the right and opportunity to select their health plan and PCP.	We believe this should read, "All eligible members will have the right and opportunity to select their health plan and/or PCP", since picking a Model B ACO is picking his/her PCP, but not a "heath plan".
4.1.4.1 26	These tools may include options to take on more advanced	We strongly desire for withholds to be available to



	<p>payment models, including forms of prospective payment in which providers may elect to have some of their fee schedule payments reduced or withheld, and instead paid directly to the ACO.</p>	<p>consenting providers upon go-live. This is critical to align incentives and make internal financial architecture work correctly.</p>
<p>4.1.4.2 27</p>	<p>If an ACO designates a referral circle, that MassHealth approves the enrolled member will not need a primary care referral for any services rendered by a provider in that ACO's referral circle, making it easier for members to receive coordinated care.</p>	<p>We do not believe that taking off all referral requirements is a good tool to promote care coordination. Although this might have theoretical merit, in reality, it promotes unnecessary utilization, regardless of the preferred circle. Our PCPs are not in favor of referral circles. Preferred specialists should also be concerned that removing a referral requirement will allow unnecessary care to get to them. You should keep referrals in place for all non-ACO provided services. However, we are very supportive of adding more meaningful administrative requirements for non-preferred providers (eg; prior authorization or ACO generated referrals with unique numerical sequencing), and we encourage you to seek approval to do so in this Waiver Request.</p>
<p>4.1.4.3 27</p>	<p>Model B ACOs must have a repayment mechanism – a line of credit, restricted capital reserve, or performance bond – to ensure they can bear the financial responsibilities of the ACO risk model.</p>	<p>MassHealth must be able to implement withholds upon go-live as this can be an internal strategy to create a reserve fund for funding a portion of repayment obligations (ie: an ACO PCP claims withhold). We would like to be able to select the amount from 1% up to 15%.</p>
<p>4.1.6 28</p>	<ul style="list-style-type: none"> Accelerate the readiness work that ACOs are performing during this period 	<p>We are in full and complete agreement with this statement.</p>



<p>4.1.6 28</p>	<ul style="list-style-type: none"> • Test and refine key systems, operations, and rate-setting functions with a small ACO cohort, to ensure readiness for the full launch in late 2017 	<p>We are in full and complete agreement with this statement.</p>
<p>4.1.6.2 29</p>	<p>A member in an MCO who is attributed to a Model C ACO will have access to the same network as a member in that MCO who is not attributed to an ACO.</p>	<p>Does this mean that members in Model C will have access to the MCO's full network, including Model A networks for that MCO?</p>
<p>4.1.7 30</p>	<p>MassHealth's quality accountability strategy will build on nationally used approaches, including the quality strategies in Medicare's ACO models. Quality scores will be used to determine ACOs' ability to receive shared savings and DSRIP payments.</p>	<p>We understand the methodology for titrating an ACO's percent share/loss based on quality scores. However, we do not agree that DSRIP payments should also be titrated. Doing so will create a real barrier for underperforming ACO's to have the financial ability to improve their performance, leading to a downward spiral. We strongly urge you to reconsider this.</p>
<p>4.2.2 32</p>	<p>For members with the most significant and complex behavioral health and/or LTSS needs, MassHealth will require ACOs to have formal relationships with organizations known as Behavioral Health Community Partners (BH CPs) and LTSS Community Partners (LTSS CPs), which will be certified by MassHealth.</p>	<p>How and when will we know what the statewide network of approved BH and LTSS CP's is? We'd like to begin partnering and contracting as soon as possible.</p> <p>Given the strength and depth of many of our members' behavioral health services, including care integration, we are assuming that many of them will seek and gain CP BH certification.</p> <p>We assume that we need to meet the state's care, service and quality requirements for BH CP's, but that as the ACO, we get to architect what this network looks like and who we choose to contract with across</p>



		the state. As community-based organizations, in addition to BH services we operate today, we may decide to build upon and expand our own model to meet BH CP requirements.
4.2.3.3 35	The MassHealth certification process will also ensure that BH and LTSS CPs have the staffing, organizational structure and expertise to meet a robust set of requirements to qualify as CPs	MassHealth should require that ACO's receive all needed data from CP's to ensure that our warehouse has a full view of services and care provided. This is very critical.
5.3.2.3 43	<p>Categories of flexible services include:</p> <ul style="list-style-type: none"> • Housing stabilization and support, search and placement • Utility assistance • Non-medical transportation • Physical activity and nutrition • Sexual assault and domestic violence supports 	Since it is well known that living in poverty increases morbidity and mortality, these categories of flexible services should be broadened. For example, targeted DSRIP funds should be used for other strategies to address issues of poverty such as strengthening executive function for parents and children, and/or personal financial budgeting skills, goal development and achievement, interpreter services, legal services, etc. Can the categories be broadened and/or can an ACO submit its social health plan, including desired services to spend flexible spending supports on to MassHealth for approval?
5.5.2 50	To this end, Massachusetts will procure vendors to administer technical assistance upon the principles mentioned above, ensuring access to high quality vendors for all ACOs and CPs. Providers will be required to contribute 30 percent of the overall TA costs, which will create an incentive to work diligently with the TA vendor	This should be voluntary only since ACO' will be at different levels of readiness and have different needs that may or may not be met by this TA program.



	and MassHealth to effect change.	
5.5.2 50	Providers may apply for technical assistance in the following categories.	I think this TA program might be good for Model C ACOs. As a Model B, we don't need "TA" as much as contracted vendors to get work into production, get it tested, and get it live. If there was an "approved vendor list" that offered discounts it would be great. Based on what vendors get selected, we might participate in a voluntary program. Recommended vendors would include, Optum, Milliman, Arcadia. We also want to be very careful that a vendor's participation in this state-run sponsored TA program would in no way impede their ability to be a CCC vendor.
7.2.8 75	ACOs and certified Community Partners will be able to fund these trainings with their allotted DSRIP funds, as described in Sections 5.3 and 5.4, and additional support received through DSRIP statewide investments (i.e. technical assistance and workforce development grant programs, see Section 5.5).	This seems like something that the state should have funding for and coordinate and execute on a state-wide basis and not ask the ACO's to do as it will end up to be more expensive and fragmented.



The Honorable Marylou Sudders
Secretary of Health & Human Services
Executive Office of Health & Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108
Submitted via Electronic Mail: masshealth.innovations@state.ma.gov

July 15, 2016

RE: Comments on Demonstration Extension Request

Dear Secretary Sudders:

Thank you for the opportunity to submit comments on the Executive Office of Health and Human Services' (EOHHS) proposed Section 1115 Demonstration Project Amendment and Extension Request ("the Request") to restructure MassHealth to an Accountable Care Organization (ACO) model.

The Center for Health Law & Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. As part of this work, we collaborate with a number of community partners working to address social determinants of health by providing services such as medically tailored meals, housing stabilization services, and employment supports. One of the organizations with which we collaborate is Community Servings, a Boston based not-for-profit that prepares and delivers medically tailored meals to home-bound, critically and chronically ill individuals throughout Massachusetts.

We applaud EOHHS' commitment to prioritizing social determinants of health as part of the MassHealth ACO model. Addressing social determinants of health, especially access to healthy and medically-appropriate food, is vital to patient-centered care because of the significant impact that social determinants can have on health outcomes.

Food insecurity occurs "whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain."¹ In general,

¹David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 353 (1998).

food insecurity is linked to “poor child development, increased hospitalizations, anemia, asthma, suicidal ideation, depression and anxiety, diabetes, and chronic disease.”² By offering nutritional counseling and directly providing healthy, medically-appropriate food, food and nutrition services (FNS) improve these health outcomes. Provision of FNS has been shown to reduce emergency room visits and hospital stays, enhance treatment adherence, and improve disease management.³

Social determinants, such as food insecurity, can also play an important role in efforts to address substance use disorders (SUDs). For example, families with very low food security exhibited 10 times the rate of heroin use in the past 30 days compared to the general population.⁴ Further, individuals with SUDs who are food insecure experience “diminished physical and mental health states ... including obesity, diabetes, heart disease, hypertension, and depression.”⁵

CHLPI and Community Servings therefore encourage EOHHS to take the following steps to maximize the positive impact of the new ACOs in addressing social determinants of health:

1. Clarify the requirements around ACO flexible spending services (FSS).

Under Section 4.2.2 of the Request, EOHHS states that spending for flexible services must satisfy a number of specific criteria, including a requirement that services are “determined to be cost-effective alternatives to covered benefits and likely to generate savings.” We encourage EOHHS to eliminate or clarify this requirement to avoid unnecessary restrictions on ACOs and social service providers.

Many of the examples of FSS described in the Request—such as housing stabilization, physical activity, and nutrition—should not be, in most cases, a substitution for other health care services.

² Mariana Chilton et al., *The Intergenerational Circumstances of Food Insecurity and Adversity*, J. HUNGER & ENV'TL NUTRITION 1-28 (2016).

³ See Su Lin Lim et al., *Malnutrition and its Impact on Cost of Hospitalization, Length of Stay, Readmission and 3-Year Mortality*, 31 *Clinical Nutrition* 345-350 (2012), available at

[http://www.clinicalnutritionjournal.com/article/S0261-5614\(11\)00199-3/pdf](http://www.clinicalnutritionjournal.com/article/S0261-5614(11)00199-3/pdf); see also Fact Sheet HIV/AIDS, Food & Nutrition Services Needs, Cmty. Health Advisory & Info. Network (Oct. 2011), available at

<http://www.nyhiv.org/pdfs/chain/CHAIN%202011->

[5%20Brief%20Report_HIVAIDS,%20Food%20&%20Nutrition%20Service%20Needs%20Factsheet.pdf](http://www.nyhiv.org/pdfs/chain/CHAIN%202011-5%20Brief%20Report_HIVAIDS,%20Food%20&%20Nutrition%20Service%20Needs%20Factsheet.pdf); see also Fact Sheet #2 *Who Needs Food & Nutrition Services and Where Do They Go for Help?*, Cmty. Health Advisory & Info. Network (Aug. 2013), available at <http://www.nyhiv.org/pdfs/chain/CHAIN%202013->

[2%20Brief%20Report_Food%20Insecurity%20Fact%20Sheet_2.pdf](http://www.nyhiv.org/pdfs/chain/CHAIN%202013-2%20Brief%20Report_Food%20Insecurity%20Fact%20Sheet_2.pdf); see also Fact Sheet #3 *Food & Nutrition Services, HIV Medical Care, and Health Outcomes*, Cmty. Health Advisory & Info. Network, available at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_service/s/chain_factsheet3.pdf (last visited May 31, 2016).

⁴ Craig Gundersen & James P. Ziliak, *Childhood Food Insecurity in the U.S.: Trends, Causes, and Policy Options*, THE FUTURE OF CHILDREN 6 (2014), available at

<http://futureofchildren.org/futureofchildren/publications/docs/ResearchReport-Fall2014.pdf>.

⁵ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 *BMC PUB. HEALTH* 2 (2012).

Instead, these services should supplement existing MassHealth benefits and strengthen their effect on overall patient health. For example, nutrition services, such as medically tailored home-delivered meals provide an array of benefits—addressing management of blood glucose, increasing the effect of medication that must be taken with food, managing protein levels for kidney disease, maintaining healthy weight, etc.—that help patients manage their health conditions, adhere to treatment plans, and follow the instructions of their physicians and providers. Over time, these benefits will reduce avoidable hospitalizations and use of emergency care. In that respect, food and nutrition services ultimately provide an inexpensive alternative to the utilization of costly health care services. However, the immediate impact of services that address social determinants of health is improved patient engagement and adherence in routine care. EOHHS should therefore either remove or clarify the requirement that FSS be “alternatives to covered benefits” to avoid creating an unnecessary barrier to the provision of key social services.

We also recommend that EOHHS eliminate or clarify how it will define the term “cost-effective.” The purpose of funding flexible services is to enable delivery of innovative and promising interventions that meet the needs the ACO’s patient population. In order to make the promise of this funding real with respect to patient outcomes and cost, ACOs should be able to draw from a wide array of possible interventions. In some contexts, “cost-effective” is used to indicate that a study has been published examining the return on investment (ROI) or ratio of cost to quality-adjusted life years gained for the intervention. ACOs could therefore interpret the phrase “determined to be cost-effective” to mean that such studies must exist in order for a particular service to be covered under FSS. For many key social service interventions, this level of data may not yet exist despite compelling evidence (e.g., pilot studies and internal data) that the intervention is low-cost and high-impact. We therefore urge EOHHS to eliminate or clarify the requirement that FSS be “determined to be cost-effective.” In the event that EOHHS chooses to clarify the term “cost-effective,” we support the adoption of a broad definition to avoid limiting ACOs’ ability to provide FSS that address the unique and often overlooked needs of their patient populations.

Under the same section, the Request requires that FSS “funding is not available from other publicly-funded programs.” We urge EOHHS to provide clarification on how it will assess situations in which flexible spending may appear to be similar to a preexisting public benefit program, but is actually complementary. For example, ACOs could provide fruit and vegetable vouchers and nutritional counseling as low-cost, high-impact interventions for beneficiaries identified as food insecure. In such cases, MassHealth members should not be precluded from receiving these vouchers if they also, for example, receive SNAP benefits. To do so would inhibit ACOs from effectively using FSS to improve the care of beneficiaries who participate in multiple public programs. Any clarification that EOHHS can provide on how it will assess similar situations in order to avoid excessive limitation of flexible services would be appreciated.

2. Provide a framework to govern the use of flexible spending funds.

In order to maximize the impact of the new ACO model in addressing social determinants of health, we encourage EOHHS to provide a framework for the use of flexible spending funds. Such a framework would both ensure oversight of the flexible spending program and provide additional clarity for ACOs by establishing a uniform process. We recommend that the framework address at least the following elements:

- i. Which parties determine how flexible spending funds will be spent.*

Currently, the Request does not provide guidance on who will decide how funds are spent within the FSS programs. As a result, ACOs may defer to their partner social service organizations to make these determinations. Because such organizations are often focused on specific needs or patients, such a strategy could result in only a portion of the ACO's population receiving access to FSS. In contrast, the ACOs themselves are well-positioned to assess the needs of their entire patient population and to direct the funds accordingly. Therefore, we recommend that the FSS framework require ACOs to be responsible for determining how FSS funds are spent.

- ii. The process that ACOs must use to determine their members' social service needs.*

In order to facilitate appropriate use of flexible spending funds, we also encourage EOHHS to include guidance in the FSS framework regarding how ACOs should determine the social service needs of their members. In developing this guidance, EOHHS could require ACOs to look to existing data sources and recent patient data to assess community needs. For example, in the first year of the demonstration, EOHHS could require ACOs to base their needs assessment on existing data sources such as Community Health Needs Assessments performed by non-profit hospitals in their service area and county-level data related to social determinants such as food insecurity and housing. Moving forward, EOHHS could then require ACOs to screen patients for social service needs during health care visits and use that data to drive allocation of FSS funds.

To help developing ACOs begin to plan for this process, we also encourage EOHHS to clarify how it will calculate the amount of DSRIP funding that ACOs will receive for FSS. By allowing ACOs to better estimate how much funding they will receive for FSS and how that funding will impact their overall budgets, ACOs will be better equipped to begin planning to provide FSS.

- iii. The FSS reporting requirements that ACOs must meet to ensure transparency.*

Lastly, it would be beneficial for EOHHS to establish transparency requirements regarding FSS funds. Specifically we recommend that EOHHS require each ACO to produce an annual public report describing how they determined their members' social services needs and how they allocated FSS funds to meet those needs. By doing so, EOHHS can create greater oversight of the FSS program and motivate ACOs to carefully tailor FSS funds to member needs.

3. Emphasize the role of food and nutrition services in helping individuals with substance use disorders recover and maintain long-term abstinence.

In the Request, EOHHS demonstrates a strong commitment to enhancing services for people coping with substance use disorders (SUDs). We applaud EOHHS for its efforts to better address SUDs and ask EOHHS to encourage ACOs to consider including food and nutrition interventions as a critical facet of their SUD strategies. Food insecurity among individuals with SUDs leads to poor health outcomes from both individual and public health perspectives (see studies cited below). As a result, food and nutrition services can help these individuals to recover and maintain long-term abstinence.

From a nutritional standpoint, individuals with SUDs are more likely to be food insecure.⁶ Food insecurity for these individuals tends to become “increasingly severe.”⁷ While individuals with SUDs have a greater risk of malnutrition, the risk is greatest for injection drug users.⁸ Vitamin deficiencies experienced by people with SUDs as a result of food insecurity can lead to negative emotions such as “apathy, anxiety, irritability, and depression.”⁹

In addition, because individuals with SUDs who are food insecure tend to make riskier choices, food insecurity also impacts the public health. Several studies indicate that individuals with SUDs who are food insecure have higher chances of engaging in needle sharing¹⁰ and unprotected sex.¹¹ These activities increase the risk of disease transmission. This increased risk of transmission combined with reduced health status of individuals with SUDs means they are more likely to contract disease and to experience rapid disease progression, health complications, and negative treatment outcomes.¹² Given the relationship between food insecurity and SUDs, FNS can play an important role in addressing the impact of SUDs in the Commonwealth and should therefore be included part of ACO strategies on this issue.

In closing, we appreciate EOHHS’s dedication to addressing social determinants of health in its 1115 Demonstration Amendment and Extension Request. The decision to address social

⁶ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 351 (1998); see also Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 6 (2012).

⁷ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 351 (1998).

⁸ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 352 (1998).

⁹ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 7 (2012).

¹⁰ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 1-9 (2012).

¹¹ Kate Shannon et al., *Severe Food Insecurity is Associated with Elevated Unprotected Sex among HIV-Seropositive Injection Drug Users Independent of HAART Use*, 25 AIDS 2037-2041 (2011).

¹² Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 7 (2012).

determinants in the new MassHealth ACO model will positively impact individuals in the Commonwealth living with chronic illness. We believe that by clarifying flexible spending requirements, providing a uniform framework for the FSS program, and emphasizing FNS as a facet of whole-person treatment for SUDs, EOHHS can maximize this impact.

Again, we applaud EOHHS's efforts to provide whole-person accountable care to MassHealth members, and we would be happy to work with the Office to address any of the comments described above.

Sincerely,



Robert Greenwald
Faculty Director, CHLPI
Clinical Professor of Law, Harvard Law School



David Waters
CEO, Community Servings

Together with the following:

Action for Boston Community Development, Inc., Boston, MA

Children's HealthWatch, Boston, MA

Fresh Advantage® LLC, Cambridge, MA

Health Care for All, Boston, MA

Health Care Without Harm, Boston, MA

Massachusetts Law Reform Institute, Inc., Boston, MA

The Greater Boston Food Bank, Boston, MA

The Open Door, Gloucester, MA

Worcester County Food Bank, Shrewsbury, MA

Avik Chatterjee, MD, MPH, Physician, Boston Health Care for the Homeless Program and Instructor, Harvard Medical School

Forwarding for waiver public comments

Sent from my iPhone

Begin forwarded message:

From: Gloria Craven <gcraven@policystrategists.com>

Date: June 27, 2016 at 4:50:44 PM EDT

To: "Cassel Kraft, Amanda (EHS)" <Amanda.CasselKraft@MassMail.State.MA.US>

Cc: "Stacey Ober (Stacey Ober)" <sober@policystrategists.com>

Subject: Cost efficiency estimate

Hi Amanda:

It was great to see you on Friday. It's clear that you and your team have been very busy. Thanks for all you are doing.

Stacey and I were both pleased and intrigued that Governor Baker in the proposed MassHealth 1115 Demonstration waiver states, "Restructuring Massachusetts' health care delivery system requires a well-equipped health care workforce **that practices at the top of its licenses.**" and supports a student loan repayment program that highlights advanced practice registered nurses. See full waiver proposal p. 48, dated June 15, 2016.

Enclosed please have an estimate on cost and opportunity loss of the "physician supervision" requirement on NPs licenses that prevent us for "practicing to the top of our licenses" from only one community health center. This is what we are looking to remove in our bill *H. 1996/S. 1207 An Act to Remove Restrictions on the Licenses of NPs and CRNAs as Recommended by the Institute of Medicine and the Federal Trade Commission.*

My question is simple, does MassHealth have an estimate in relation to efficiencies that its looking for by this statement in the waiver? The example included here is for only one Community Health Center, which of course cares for a predominant number of MassHealth recipients.

Let us know your thoughts and best estimates of savings to the system.

Best,

Gloria

Craven & Ober Policy Strategists, LLC

Cell: 617-680-0330

www.policystrategists.com

13 NPs at NSCH; 6 MDs at NSCH

Based on each NP meeting for 1 hour quarterly with collaborating MD (4 hours/year). The combined cost to pay salary for both the NP and MD for that hour they are not seeing patients is approximately \$150/hour.

13 meetings x 4 hours x \$150 = **\$7800**/year spent on MD/NP salary dedicated to "supervision"

There is also opportunity costs. 13 NPs meet with his/her collaborating MD for 4 hours per year for "supervision" = 52 hours we have 2 providers that could be seeing patients.

52 hours x 2 providers x \$140 (reimbursement rate) x 3 patients per hour = **\$43,680**/year loss of revenue b/c NPs are meeting with MDs for "supervision"

Total cost of NP supervision to NSCH annually is \$7800 + \$43,680 = **\$51,480**

From: Cassel Kraft, Amanda (EHS)
Sent: Tuesday, June 28, 2016 1:48 PM
To: MassHealth.Innovations (EHS)
Subject: Fwd: Cost efficiency estimate

Forwarding for waiver public comments

Sent from my iPhone

Begin forwarded message:

From: Gloria Craven <gcraven@policystrategists.com>
Date: June 28, 2016 at 1:44:19 PM EDT
To: "Cassel Kraft, Amanda (EHS)" <Amanda.CasselKraft@MassMail.State.MA.US>
Cc: "Stacey Ober (Stacey Ober)" <sober@policystrategists.com>
Subject: RE: Cost efficiency estimate

Hi Amanda:

I don't know if this is helpful but our colleagues from the AARP Public Policy Institute quote the estimates below:

According to the Florida Office of Program Policy Analysis and Government Accountability,^[i] potential cost savings from expanding scope of practice in primary care could be significant. Annual Medicaid savings are estimated between \$7 million to \$44 million. Additional savings would result in APRNs could provide primary care to Florida state employees.

In Texas, noted economist Ray Perryman, calls for removing barriers to APRN care to improve patient care and reduce costs. The Perryman Group's impact analysis^[ii] estimates that legislative changes to remove barriers to APRN practice and care could increase the state's economic output by \$8 billion annually.

Craven & Ober Policy Strategists, LLC
Cell: 617-680-0330
www.policystrategists.com

From: Gloria Craven [<mailto:gcraven@policystrategists.com>]
Sent: Monday, June 27, 2016 4:51 PM
To: CasselKraft, Amanda (EHS) <amanda.casselkraft@state.ma.us>
Cc: Stacey Ober (Stacey Ober) <sober@policystrategists.com>
Subject: Cost efficiency estimate

Hi Amanda:

It was great to see you on Friday. It's clear that you and your team have been very busy. Thanks for all you are doing.

Stacey and I were both pleased and intrigued that Governor Baker in the proposed MassHealth 1115 Demonstration waiver states, "Restructuring Massachusetts' health care delivery system requires a well-

equipped health care workforce **that practices at the top of its licenses.**” and supports a student loan repayment program that highlights advanced practice registered nurses. See full waiver proposal p. 48, dated June 15, 2016.

Enclosed please have an estimate on cost and opportunity loss of the “physician supervision” requirement on NPs licenses that prevent us for “practicing to the top of our licenses” from only one community health center. This is what we are looking to remove in our bill *H. 1996/S. 1207 An Act to Remove Restrictions on the Licenses of NPs and CRNAs as Recommended by the Institute of Medicine and the Federal Trade Commission.*

My question is simple, does MassHealth have an estimate in relation to efficiencies that its looking for by this statement in the waiver? The example included here is for only one Community Health Center, which of course cares for a predominant number of MassHealth recipients.

Let us know your thoughts and best estimates of savings to the system.

Best,
Gloria

Craven & Ober Policy Strategists, LLC
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^[i] The Florida Legislature Office of Program Policy Analysis and Government Accountability, *Expanding Scope of Practice for Advanced Registered Nurse Practitioners, Physicians Assistants, Optometrists, and Dental Hygienists*. (Tallahassee, FL: The Florida Legislature, 2010). Accessed at <http://www.floridanurse.org/arnpcorner/ARNPDocs/OPPAGAScopeofPracticeMemo.pdf>.

^[ii] The Perryman Group, *The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas: An Analysis of Local and Statewide Effects on Business Activity*. (Waco, TX: 2012) Accessed at http://www.texasnurses.org/associations/8080/files/PerrymanAPRN_UtilizationEconomicImpactReport.pdf.

July 6, 2016

Daniel Tsai
Assistant Secretary for MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: Recognition for Critical Access Hospitals in Final Section 1115 Medicaid Demonstration Waiver

Dear Assistant Secretary Tsai,

As leaders of the three Critical Access Hospitals (CAHs) located in Massachusetts, we recognize and commend the Commonwealth in their efforts to restructure MassHealth to move towards a care delivery model that transitions from a volume based to a value based system of care, whereby, our community's health status is improved through integration and care coordination.

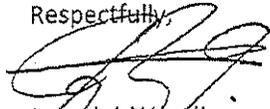
Our joint communication is submitted to highlight the import for recognizing the specific needs of our federally and state designated CAH hospitals. Specifically, as Massachusetts moves towards an accountable care organization (ACO) model in place of a fee for service model, we request that there are protections maintained to ensure that our CAHs continue to receive the dedicated funding required within both federal and state law.

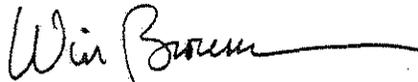
As you know, the intention of creating the CAH designation at the federal level was to reduce the financial vulnerability of rural hospitals and improve access to health care by providing essential services to the rural communities we serve. CMS is currently required, by federal statute, to reimburse CAHs at 101% of their allowable costs. In 2012, the Massachusetts legislature included section 253 of Chapter 224 of the Acts of 2012, which requires that MassHealth and the Health Safety Net program reimburse CAHs in Massachusetts at least 101% of allowable cost following the Medicare cost reimbursement methodology.

Therefore, in order for our three CAHs to continue to be protected as intended under the federal and state law, we encourage you to ensure that our hospitals will be exempt from any cost protocol reviews under any one of the proposed ACO or other payment design changes within the 1115 Demonstration Waiver, as our CAHs Medicaid payments are intended to reimburse our hospitals above cost.

In closing, our CAHs may be the smallest acute care hospitals, but our approach to quality, patient safety, patient satisfaction and cost effectiveness, mirrors that of every other hospital in the Commonwealth and our mission is critically important to the rural communities we care for.

Respectfully,


Joseph L. Woodin
President & CEO
Martha's Vineyard Hospital


Winfield S. Brown, FACHE
President & CEO
Athol Hospital


Anthony J. Rinaldi, Jr.
Executive VP
Fairview Hospital

Disability Advocates Advancing our Healthcare Rights

December 7, 2015

Daniel Tsai

EOHHS Assistant Secretary and Director of MassHealth

One Ashburton Place

Boston, MA 02108

Dear Assistant Secretary Tsai:

Disability Advocates Advancing Our Healthcare Rights (DAAHR) wishes to thank you for your commitment to building a healthcare delivery system that better meets the needs of the poorest residents of Massachusetts, including people with complex physical and behavioral health disabilities, intellectual and developmental disabilities, and a variety of other chronic health conditions. We support the state's intention to secure performance incentive payments within CMS's Delivery System Reform Incentive Payment (DSRIP) program under the broad authority of the 1115 Waiver to transform the health care delivery system.

The purpose of this letter is to ask you to consider DAARHR's recommendations for transforming the system in order to build a sustainable infrastructure, with an emphasis on quality-of-life goals, to best serve MassHealth members with disabilities. We also want to state our appreciation for the many recent steps your office has taken to support innovative healthcare, including continuation of the One Care demonstration and by delaying the inclusion of long-term services and supports (LTSS) and home and community-based services and supports (HCBS) into the ACO program currently under development.

Transformation of the service and care system for MassHealth members with disabilities requires careful design and implementation to prevent perpetuating the status quo, creating new but only marginally improved systems, or worse yet, causing harm to members. Throughout this effort, MassHealth faces a number of challenges, including ones pertaining to politics, policy priorities, and analytics. Addressing the social determinants of health by linking payments to meaningful metrics and outcomes will be essential to the reform effort. MassHealth must raise the bar for clinical care while tackling the issue of over medicalization to ensure that resources are directed to total health and wellness. Within this framework, enrollee choice will be vital.

Large systems may seek control over the flow of resources and extended control over the broader service delivery system, which can seriously dilute person-centered care and jeopardize existing community-based care and services.

Cost and value, of course, must support the vision for improved person-centered care built around total health and wellness. DAAHR asks that MassHealth use DSRIP funds to support a community-based delivery system with a strong infrastructure, investing in information technology (including provider compatibility) and workforce development, including community health workers, peer specialists and other care providers.

The administration's efforts to better compensate PCAs exhibits a commitment to community-based services and person-centered LTSS that should be replicated. CBOs must not be put in the position of balancing the books on the backs of their staff.

It is critical that this transformation effort include the points below.

DSRIP dollars should be used to support integration of service delivery systems that are central to reducing tertiary care and associated high costs. This includes ensuring that MassHealth:

1. Distribute DSRIP funds to both ACOs and community-based organizations; funds should not have to flow exclusively through ACOs.
2. Invest DSRIP funds into building provider capacity to comply with the ADA, including guaranteeing that facilities and medical equipment are accessible, with complementary policies and procedures. We can no longer embark on system transformation of healthcare for people with disabilities if the system itself is allowed to be inaccessible.
3. Invest DSRIP funds upfront into non-clinical services "beyond the clinic walls" to reduce negative social determinants of health, food instability, homelessness, housing instability, lack of access to transportation, and underemployment.
4. Invest DSRIP funds to provide adequate compensation to CBOs, especially their staff, to ensure capacity and competency in service delivery. Value-based purchasing arrangements should reflect this commitment.

ACO should have the flexibility and Infrastructure to support innovation while also being guided by a defined set of incentives and outcome requirements to protect MassHealth enrollees. It is requested that MassHealth:

5. Establish requirements that ACOs are led by a diversity of entities and that governance committees include consumers and community-based providers. ACO boards must be comprised of at least 50 percent non-hospital entities. The definition of “risk bearing” should be broad to allow for the most inclusive governance structures within ACOs.
6. Create a glide path to support the creation of alternatives to medically-driven ACO models; consider investing in behavioral health, disability and other community organizations that address social determinants of health, with a longer-term commitment to bring them to suitable scale and expertise.
7. Establish a risk-adjustment approach that accounts for social, cultural, and economic factors so that:
 - a. Resources are available to provide culturally and linguistically appropriate medical services for people who are poor, are homeless, have difficulties with English, are from ethnic and/or minority populations, and have physical, mental health, intellectual or sensory disabilities.
 - b. Resources are available to address social determinants of health, including need for food, fuel assistance, and housing assistance, with maximized opportunity to collaborate with community-based providers such as WIC, immigration organizations, and housing authorities to increase quality of care and support nutrition and housing security.

The 1115 waiver must support person-centered care and protect MassHealth beneficiaries from harm. This can be done by ensuring that MassHealth:

8. Maintain the independence of LTSS for a minimum of the first two years of the initiative, with integration occurring only after a transparent review of the suitability of integration. All ACOs must be required to create a plan for integrating community-based LTSS into their system, with participation from LTSS providers, users of LTSS, and advocates that must be approved by vote of an implementation council established for the initiative (see below).
9. Keep auto assignments to ACOs or health homes to low numbers, and any successive assignments should be informed by performance data. The salient lesson of One Care is that initiatives for people with complex service and healthcare needs should be allowed to grow to scale, not be forced to do so. Enrollment in an ACO or health home must be intentional on the part of members.

10. Protect consumer choice by including choice of plans, services, and coordination. Consumer choice is vital. This includes but is not limited to consumer access to:

- a. A delivery system that is equitable, population-based, and person-centered with services provided to consumers based on identified need, not payer.
- b. An “opt out” provision for enrollees of ACOs so they can, at the end of each month, be able to join another ACO or leave the ACO system and receive services through the fee-for-service system.
- c. An independent, conflict-free case manager or service coordinator for all enrollees in ACOs and health homes.**
- d. A care coordinator function carried out by the person of the consumer's choosing—and not necessarily a primary care doctor.
- e. All providers outside the ACO network through single-case agreements to support continuity of care and access to expertise that may not exist within a network, ensuring that the complexity of a person's needs and/or lack of choice of specialists within a geographic area is not a barrier to care or service.
- f. In-person comprehensive assessment of enrollee needs within 30 days of enrollment in an ACO at a place of the enrollee's choosing, with preference given to assessments being done in the enrollee's home.
- g. Measurable integration of recovery principles and independent living philosophy into the development and implementation of care plans.
- h. Control over medical records, including determination of who has access to a consumer's medical records and the right of the consumer to have access to her or his medical records, including medical notes.

There also must be strict monitoring and enforcement of the requirement that ACOs not discriminate against those who request to join the group.

- 11. Establish an implementation council or similar MassHealth consumer-majority body. Its role should include guiding the overall growth and implementation of the waiver, including the review of systemic trends in collaboration with MassHealth, CMS, the various plans and providers, and an ombudsman office. The council should have access to and control over its own budget.
- 12. Establish an independent ombudsman office similar to what exists for One Care to support innovation, protect members on an individual basis, and address systemic concerns as they arise. Other consumer protections, such as rights to appeal services, must be established.
- 13. Extend enhanced benefits available to One Care enrollees to ACO enrollees. This includes the integration of oral health through provision of full dental benefits for enrollees and zero co-pays for prescriptions and all other services.

Put in place systems that support innovation in value-based purchasing and creation of transparent quality metrics:

- 14. Develop outcome measures reflecting consumer values such as independence, self-direction, employment, and integration, documenting rebalancing of spending and use of a

variety of LTSS by consumers. To be effective a value-based purchasing system must include incentives that may not result in direct savings but will lead to overall enrollee wellness.

15. Create a public-facing dashboard that includes population-specific metrics and a star rating system. The dashboard should include current quality metrics and metrics to be piloted over the course of the five-year waiver. Community involvement in the determination of ACO performance criteria and transparency is fundamental. The dashboard should include objective metrics that assist consumers to make an informed choice when choosing an ACO.

We thank you very much for your consideration of our concerns and the exhaustive work that you and your team have undertaken to engage the disability community in health reform.

Sincerely,

Dennis Heaphy, DAAHR co-chair, DPC

Bill Henning, DAAHR co-chair, BCIL

Cc: Secretary Marylou Sudders

From: Demirsoy, Ipek (EHS)
Sent: Monday, June 13, 2016 2:22 PM
To: Sing, Gary (EHS); Powell, Michael (EHS); Buckler, Stephanie (EHS); Bertic-Cohen, Monique (EHS)
Subject: FW: Comments

From: Dennis Heaphy [<mailto:dheaphy@dpcma.org>]
Sent: Friday, June 10, 2016 10:33 AM
To: Tsai, Daniel (EHS)
Cc: Demirsoy, Ipek (EHS)
Subject: RE: Comments

Dan,

Yes, I know it was too heavy on detail. I think I needed to go to the process in order to convey to you what are probably the most serious pieces missing from the document, and I apologize for the negativity in advance, because I do believe in the potential of ACOs and managed care. Anyway, these are learnings from the One Care experience:

Commitment to building the infrastructure of MassHealth-MassHealth staff are pushed from project to project, innovation to innovation, with no staff able to do the job of overseeing program integrity. Yes, there is discussion about DSRIP dollars for MassHealth, but not a high-level overall strategy for how MassHealth will carry out oversight of the entire healthcare reform process. There are good people and MassHealth, people doing this job for years that are innovative and want to both improve healthcare access and outcomes for people of low income as well as be cost-effective, but they do not have the space to do their job, and it seems that the message from up top over the course of a number of administrations has been anti-transparency. Look at the profits being made by SCOs. The public would be outraged if they knew the level of profit being made AND how MassHealth in general ignores these profits even as it focuses on reducing PCA costs.

Transparency-. MassHealth committed to transparency in One Care, for number reasons, this transparency has not been present, and when present, has only been provided in response to ongoing pressure by stakeholders.. Without initial commitment to a steering committee that includes robust consumer involvement, and the establishment of a baseline dashboard with objective measures that are cross system and look at both ACO performance and provider performance, including a rough Gantt chart that outlines projected benchmarks for different components of establishment of the steering committee and development/implementation of benchmarks to be met by the steering committee, MassHealth and ACOs, it is tough, if not impossible to support the waiver is written..

Finally, in speaking with a high-level official from a health plan, several things were made clear to me that have direct bearing on the creation of the ACOs:

1. Equity in access to services between people on straight Medicaid and dual eligibles is not likely to take place in ACOs for a number reasons, too many to detail here.
2. gaming the system will be easy. Already in One Care, both CCA and Tufts receive no guidance from MassHealth on bucketing of services under Medicare or Medicaid. It might seem that under the capitated model this might not matter, but it does. A plan can cherry pick which services it will pay Medicare rates and which services it will pay Medicaid rates.. This can result in some providers being squeezed and paid a lower rate, and other providers an inflated rate. It can also lead to profiteering.

Without guidance on bucketing, it can also be easy for plans to also claim that the capitation rates are not adequate. I have not seen the numbers, but is also my understanding MassHealth pays a disproportionate percentage services in the state, that it's in the state's best interest to protect itself from a disproportionate percentage of dollars

3. Passive enrollment is going to take place at increased speed with no commitment from MassHealth to tying growth to a transparent public facing dashboard that gives potential enrollees information to make informed decisions about whether One Care is right for them in addition to leaving stakeholders in the dark about the actual performance and sustainability of One Care or profiteering by plans.

And, whether it is true or not,, there is a perception of a number of different stakeholders, representing different constituencies, that the pilot is a handout to Steward and a way of moving the status quo forward, as well as give a leg up to existing ACOs.

All this said, the best intentions of you and your leadership will not result in change unless EOHHS commits to a strong oversight and stakeholder involved guidance plan what is being built will result in, paraphrasing the word from an executive from one ACO at a workgroup meeting requested, MassHealth should allow existing ACOs to "do what we already know how to do best." That is scary.

Again I apologize for the tone of this email, but all I think about are the folks I know who are homeless, the teenage moms and their babies that I interact with and so many folks the disability community who have nothing. I know you care about these folks as well, so please don't take this as a judgment of you or others on your team. It just makes me cringe to think of models of care, and the perception of people in Medicaid as "takers," pervasive in states like Kansas, Florida, Kentucky etc. and ruled by corporate interests, grabbing a foothold in Massachusetts beyond what they already have.

Please excuse the errors in this email.

Thank you again for your dedication,

Dennis

From: Tsai, Daniel (EHS) [<mailto:Daniel.Tsai@MassMail.State.MA.US>]

Sent: Thursday, June 09, 2016 10:32 PM

To: Dennis Heaphy <dheaphy@dpcma.org>

Cc: Demirsoy, Ipek (EHS) <ipek.demirsoy@state.ma.us>

Subject: RE: Comments

Dennis - many thanks for your thoughtful comments and the time you took to prepare them.

We are reviewing thoroughly. Some of the detailed comments, as you suggest, are indeed more appropriate for contracting vs. a CMS waiver application, but in any case, we look forward to collaborating closely with you and others on the points you raise

Thanks again

Daniel Tsai
Assistant Secretary, MassHealth
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02108

617-573-1770

From: Dennis Heaphy [dheaphy@dpcma.org]
Sent: Thursday, June 09, 2016 12:57 PM
To: Tsai, Daniel (EHS)
Cc: Demirsoy, Ipek (EHS); dheaphy@dpcma.org
Subject: Comments

Dan,

Thank you for the opportunity to write comments. I apologize in advance for areas that might be more appropriate contracting rather than the waiver itself.

The waiver document contains a number of comments. The other document contains specific recommendations..... Be careful what you ask for, you might just get it. And yes I know as I write these words they may come back to me.

Let me know if you have any questions.

Thank you again

Dennis

No virus found in this message.

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Version: 2016.0.7639 / Virus Database: 4598/12391 - Release Date: 06/09/16

Disability Advocates Advancing our Healthcare Rights

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02111

Submitted via email to MassHealth.Innovations@state.ma.us

RE: Comments on MassHealth 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai:

Disability Advocates Advancing our Healthcare Rights (DAAHR), comprised of over twenty disability, elder, healthcare, and legal services organizations, supports MassHealth's submission of an 1115 Demonstration Project Amendment and Extension Request. We wish to acknowledge the significant effort that has gone into the waiver's submission, including the regular involvement of stakeholders. DAAHR believes that performance-based funding, supported by a person-centered cross-sector approach, has the potential to improve the quality of life for the 1.8 million MassHealth members through greater focus on both individual goals and public health, use of innovative services, and improved integration of care and services across the medical, behavioral health, and long term services and supports systems.

However, we remain concerned about changes in reimbursements and institutional relationships that this broad experiment in improving care and delivery will require. In that regard, we join with Health Care for All and other advocates in their expressed concerns about consumer access, control, communications, and support. There are considerable uncertainties associated with many of the proposed changes and we seek the highest level of oversight, transparency, evaluation, and due process to assure that no harm is done to MassHealth members, particularly those with disabilities, as we launch into this demonstration.

In that respect, we cite the following areas of most concern and welcome engaged and regular dialogue with MassHealth and CMS in clarifying opaque aspects of the 1115 waiver application, as well as active participation in the implementation process. MassHealth needs to set the stage for effective, efficient, responsive and humane ACO development. To attain that outcome, we encourage:

- **Maximum transparency and readily available information** regarding administrative and care-delivery cost, service utilization and quality outcome across all ACOs,

demonstrating the rebalancing of spending and the effectiveness of MassHealth investment more broadly;

- **Assurance of appropriate and needs-based consumer choice**, unencumbered by narrow networks, lock-ins, or lack of true conflict-free case management; and
- **Elimination of burdensome and discriminatory co-pays or service limitations.** The PCCP penalty, punitive co-pays and restrictive prior approval processes have repeatedly been shown to diminish access to needed services and provide little in the way of genuine incentives in service/plan choice for people who are poor, including those with disabilities.

The remainder of our comments provide more specificity on these matters and also includes areas of concern and recommendations that DAAHR believes would improve the initiative; elements that we believe are notably positive; and things for which we need clarification or more information.

Areas of Concern

There are provisions of the state's 1115 DSRIP application that require clarification and improvement in order to protect MassHealth members from harm, particularly people with complex conditions, to ensure success for the ACO initiative. Such provisions that are cause for concern include the following:

- **12-month member lock-in of members into ACOs** – The lock-in policy is contrary to evidence that supports alternative methods to reduce churn. Current research indicates that extending Medicaid enrollment is the most promising way to reduce the cycle of Medicaid members on and off the program.¹
- **Cost-sharing** – It is expensive to be poor.² The punitive copayment system is antithetical to good public health practice that places increased burden on an already strained population that is confronted by rising housing³ and food costs.⁴ Use of co-pays results in members delaying, foregoing, or rationing care – leading to more acute, costly problems down the line and worse outcomes.⁵ This trend is also true for the middle class.⁶

¹ <http://www.commonwealthfund.org/publications/in-the-literature/2015/jul/reducing-medicaid-churning>
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/>

² <http://www.economist.com/news/united-states/21663262-why-low-income-americans-often-have-pay-more-its-expensive-be-poor>

³ <http://www.governing.com/topics/urban/gov-urban-affordable-housing-families.html>

⁴ <http://www.ers.usda.gov/media/921672/aer759.pdf>

⁵ <http://www.wsj.com/articles/more-cost-of-health-care-shifts-to-members-1417640559>

⁶ <http://www.usatoday.com/story/news/nation/2015/01/01/middle-class-workers-struggle-to-pay-for-care-despite-insurance/19841235/>

- **Fee for Service (FFS) penalty** – Reduction in services to MassHealth beneficiaries under FFS will potentially harm many members, particularly people with disabilities; these are the same individuals who will “opt out” of joining an ACO for fear of losing a relationship with a Primary Care Provider (PCP). High percentages of members eligible to enroll in One Care opted out of the program, despite the promise of enhanced services, in order to maintain relationships with their PCPs and a fear of reduced LTSS (a fear legitimized by NCD findings).⁷ Members should not have to choose between seeing their preferred providers and securing coverage for eyeglasses, hearing aids, orthotics, and chiropractic care, as well as full coverage for prescription drugs.
- **Conflict-free case management not established** – ACOs that operate direct LTSS services should not be permitted to perform functional assessments in determination of LTSS. The magnitude of the task of protecting against conflict of interest within ACOs is daunting and has the potential to continue to silo populations into specific delivery systems by diagnosis or category (i.e. behavioral health or developmentally disabled). There needs to be definitive establishment of conflict-free case management.
- **Reductions in consumer choice and consumer control** – DAAHR opposes any policies that impinge on consumer choice or consumer control of LTSS. This includes the implementation of Electronic Visit Verification (EVV), ACO contract requirements to “maintain or increase the level of recoveries from LTSS providers,” or other policies that reduce the ability of care teams to create comprehensive care plans that meet the goals of ACO members.

General Recommendations for the MassHealth 1115 Waiver Application

Following are general recommendations for the waiver application.

- **Healthy People Massachusetts**
 - Use the DSRIP funding to improve the overall health of MassHealth members enrolled in ACOs. ACOs should be required to support the state in meeting the goals included in the Public Health Prevention and Wellness Trust Fund, part of Chapter 224⁸, augmented by population-specific goals for people with behavioral health needs and people with disabilities.
 - Work with the Office of Health Equity in the Massachusetts Department of Public Health to establish other potential quality metrics that are in keeping with DPH objectives and integrate oral health into primary care based on guidelines set out by oral health advocates. The lack of a glide path towards full integration of oral health into primary care will do nothing to improve the primary cause of increased health care costs and reduced quality of life.⁹ Please see the Oral Health Integration Project’s comments on the waiver for useful improvements.

⁷ <https://www.ncd.gov/publications/2016/medicaid-managed-care-community-forums-final-report>

⁸ <http://www.mass.gov/eohhs/docs/dph/com-health/prev-wellness-advisory-board/annual-report-2014.pdf>

⁹ <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2015/february-march/in-focus>

- Provide specific details on all the quality metrics to be included in the evaluation on the use of DSRIP dollars and ACO performance.
 - Establish a public-facing dashboard that contains sufficient information needed by MassHealth members to make informed choices about their healthcare options. More detailed content also can help to evaluate ACOs and the larger DSRIP program.
 - Establish a stakeholder process that outlines strategies for educating members.
- **Steering Committee to Provide Oversight of Implementation**
 - Establish a Steering Committee along with workgroups to support accountability as the DSRIP waiver is implemented, with an emphasis on transparency.¹⁰ It would be charged with guiding MassHealth in the establishment of mechanisms for providing transparency such as a public-facing dashboard while also monitoring consumer choice, participating in program evaluations, and reviewing ACO contracting processes. The committee should include political leaders and policymakers, ACO members and advocates,¹¹ clinicians, community-based organizations, social services agencies, and other parties as identified.
- **Establish Carrots to Change Member Behavior, Not Sticks**
 - Eliminate sticks such as the 12-month lock-in, reducing services within the FFS system, and instituting a punitive cost-sharing structure.
 - Increase likelihood of enrollment and stability of membership through broad provider networks and reasonable criteria for single-case agreements to maintain continuity of care or meet individual member needs, particularly those whose conditions are complex.
 - Establish carrots or rewards for members for enrolling. For instance, build on the success of One Care by providing enhanced services and build in \$0 co-pays. ACOs should provide coverage for innovative services and equipment designed to meet the independent living and recovery goals of the member.
- **Member Education & Assistance**
 - Increase the responsibilities and leverage of the ombudsman—as compared to One Care—in arbitrating concerns and grievances of ACO members. Also allow for reporting on systemic issues that the office identifies.
 - Educate members on care planning, care team functions and other aspects of the model, which may not be understood by members. This will be essential when the ACO program begins.
 - Establish a robust outreach and education program that engages MassHealth members and community-based organizations that serve members to better understand managed care, establishing trainings throughout the course of the implementation of the waiver period.
 - Require ACOs to partner with CBOs to develop training programs for newly enrolled members into an ACO to increase the understanding of how the model of care within the

¹⁰ <http://www.healthreform.ct.gov/ohri/site/default.asp>

¹¹ The ACO members and advocates should represent a majority of the Steering Committee and represent a full spectrum of members from the physical disability, mental health disability, intellectual/developmental disability and substance addiction communities.

ACO functions and support the ability of the member to access navigator or care coordinator services.

Positive Elements of the Application and Detailed Recommendations to Amend and Strengthen the 1115 Waiver Application

The following comments address key components of the waiver application, including important positive elements:

- **Recommendation 1. Strengthen the Role of the Community Partners.** The development of Community Partners (CPs) is a major part of the 1115 Waiver application. DAAHR is very supportive of providing DSRIP funding to support capacity building for CPs, especially so they can work with ACOs on the integration of behavioral health, long-term services and supports and health-related social services. DAAHR is concerned, however, about the lack of detail in this plan.
 - Concern: The 1115 Waiver Application does not set forth clear and concrete criteria for CPs to meet before becoming eligible for funding. Moreover, the application favors ACOs over CPs in terms of the potential to realize gains from risk sharing. ACOs will include significantly large health care systems and hospital systems that will be allowed to benefit from assuming financial risk for the total cost of care for their attributed members. CPs, on the other hand, will not enjoy any upside risk sharing that can be used to build a stronger program model.
 - Solution 1: DAAHR requests that MassHealth develop criteria for CPs in conjunction with disability advocates to create a framework for upside risk sharing for CPs, as well as an opportunity for CPs to participate in the governance of the ACO.
 - Solution 2: MassHealth should provide prescriptive guidelines to ACOs on the establishment of CPs to prevent ACOs from building CPs off of existing hospital community partnerships rather than establishing relationships with community-based organizations that have historically served the community. This includes ILCs, ASAPs and Recovery Learning Communities (RLCs).
- **Recommendation 2. Strengthen the Role of the LTSS Representative.** The 1115 Waiver application establishes an “LTSS Representative” position as part of the ACO structure. DAAHR appreciates the mention of this new position, but – lacking any detail – finds it difficult to understand how this may help consumers.
 - Concern: DAAHR is concerned that the ACO LTSS representative may have a more limited role than either the IL-LTSS Coordinator in the One Care program or the Geriatric Services Supports Coordinator (GSSC) in the Senior Care Options (SCO) program. This would undermine the trust of the disability community and the value of the role to the member’s care. IL-LTSS Coordinators and GSSCs are essential to shifting the balance away from the medical model to the independent living and recovery models.
 - Solution: DAAHR requests that the 1115 Waiver Application require that MassHealth establish an LTSS Coordinator position that has the same status that the GSSC has under the SCO program, engaging in discussion with disability advocates on specific aspects of the position.

- **Recommendation 3. Rebalance Spending.** DAAHR is pleased that the waiver language now includes reference to rebalancing spending. This must be at the top of the agenda for ACOs. The 1115 Waiver Application must include a strategy to rebalance spending across the system, including spending to address social determinants of health. There needs to be a clear commitment to rebalancing spending of LTSS away from institutional settings to the least-restrictive setting of a consumer’s choice. Ongoing in-home care is an essential piece of both *Olmstead* compliance and reducing costs and should be emphasized in the waiver. Rebalancing spending should also look to reducing homelessness and recidivism among members involved within the criminal justice system.
 - Concern: MassHealth has not put forward an effective strategy for reducing the number of members residing in SNFs or those who are chronically homeless or at risk of homelessness or involved with the correctional system. Housing First initiatives are a proven tool to reduce health care costs and yet the use of DSRIP funds for the purpose of housing supports seems to be overly limited. The application also lacks any mention of habilitative services, home care, delivered meals, and other cost-effective, independence-supporting services that are, for instance, available in One Care and various HCBS waivers. A lack of such services can negatively impact the health outcomes of ACO members.

Also, the waiver proposal does not explicitly describe how risk adjustment will include social determinants or provide guidance on how “flexible” dollars are to be used to support the mitigation of social determinants to reduce costs and improve quality of life. We would suggest that the use of flexible dollars be directed toward a broad range of services and equipment, including innovative services that may not meet the traditional criteria of being “evidence-based,” but that show promise based upon the individual member’s experience or that of the provider’s practice. Finally, concurrent with this application, MassHealth has proposed to significantly restrict the use of overtime of personal care attendants (PCAs) and establish third party assessments for LTSS, matters that in themselves could dramatically alter and destabilize LTSS, at least in the short term, as new systems of service and oversight are implemented. It appears that the proposed Third Party Administrator initiative, including the implementation of Electronic Visit Verifications and ACO contract requirements to “maintain or increase the level of recoveries from LTSS providers” may reduce the ability of care teams to create comprehensive care plans that meet the goals of ACO members.

- Solution 1: ACOs should be required to establish practices that favor community-based care over institutional care to promote rebalancing of spending. ACOs must also be required to implement services akin to those in the Money Follows the Person (MFP) demonstration. This is particularly important as MFP sunsets in Massachusetts and ACOs move into the LTSS arena, with control of LTSS dollars. ACOs should also be held accountable for providing continuity of care for transitions to behavioral health facilities or medical facilities and from behavioral health and medical facilities to the least restrictive setting possible, preferably the member’s home.

- Solution 2: MassHealth should set reporting requirements by ACOs for reductions in the percentage of members residing in institutional settings. These benchmarks should include metrics, including these:
 - The number of members transitioned out of Skilled Nursing Facilities into the community, including the type of setting where the member moves;
 - The number of members receiving transitional assistance from CBOs in hospital settings, which will support member choice and reduce the number of people transitioning from hospitals into institutional settings; and
 - Reductions in the number of members transitioning from hospital settings into institutional settings.
- Solution 3: Pursue as feasible a Housing First model. MassHealth should provide guidance to ACOs on low-threshold support services for members who are chronically homeless. This should include prescriptive language requiring ACOs to align provider incentives in a manner that supports these services. In addition to members who are homeless, ACOs should be required to provide data that demonstrates competency in provision of services to members with a history of involvement in the corrections system. MassHealth should also require ACOs to actively seek out opportunities for persons eligible for MassHealth coming out of the corrections system to enroll in their ACO. This is of particular importance to people with behavioral health needs and/or cognitive or physical disabilities.
- Solution 4: MassHealth should use appropriate risk adjustment strategies and incentive alignments to support the ability of ACOs to provide habilitative services in the home, home care services, delivered meals, and other cost-effective home care services. This will demonstrate that MassHealth is committed to population health beyond reduction in costs.
- Solution 5: MassHealth should use a use population-appropriate risk adjustment when developing global payments for ACOs to protect consumer access to LTSS and BH services by building in initial funding necessary for an ACO to deliver services in a fiscally sustainable manner. We learned from One Care that the fee-for-service system fails to address significant needs of people with complex needs; there was a dramatic reclassification of people from risk category C1 to C2 and C3 (as high as 25% of members) because of significant need for more services. Global payments should also include risk adjustment that enables ACOs to provide low-threshold support services for members who are chronically homeless to assist them to remain in long-term housing.
- Solution 6: MassHealth should establish a population-based risk adjustment approach that includes social, cultural, and economic factors, so that resources are available to:
 - Provide culturally and linguistically appropriate medical services for people who are poor; homeless; have difficulties with English; are from racial/ethnic minority or gender identity/sexual orientation minority populations; and have physical, mental health, intellectual or sensory disabilities; and

- Address social determinants of health, including the need for food, fuel assistance, and housing assistance, with maximized opportunity to collaborate with community-based providers such as WIC, immigration organizations, and housing authorities and search agencies to increase quality of care, nutrition, and housing security.
 - Solution 7: The implementation of changes to the PCA program and adoption of new methodologies for LTSS assessments (the TPA initiative), which could lead to reductions in services, should be delayed until the competency of ACOs to deliver PCA and other LTSS services is determined in consultation with consumers and advocates.
- **Recommendation 4. Obtain Americans with Disabilities Act (ADA) Compliance.** DAAHR commends the significant emphasis placed on ADA compliance for ACOs in the waiver proposal. This will be a vital step in addressing disparate care received by people with disabilities. We support continued dialogue with community experts to establish clear, enforceable expectations for ACOs on compliance.
 - **Recommendation 5. Establish an external ombudsman program.** DAAHR appreciates the recognition by MassHealth of the value of an external ombudsman program. But the waiver provides no clarity about the scope of responsibilities of the external ombudsman program or how it will be funded. We believe the office should take liberally from what has worked well with the One Care ombudsman program, while eliminating restrictions that impede the office from tracking and reporting systemic issues, reporting data in real time, and doing outreach and training of members about their rights and responsibilities.
 - **Recommendation 6. Develop quality metrics and address capacity concerns.** Based on its experience with One Care, DAAHR is extremely concerned about the apparent absence of a vision to address population health. The application does not establish expectations of Alternative Payment Methods (APMs) to align provider behavior with appropriate outcome metrics in the provision of LTSS, recovery services, and broader BH services. It also lacks any provision of a transparent public-facing dashboard for members to access in order to make informed choices. Quality metrics should include patient-reported outcome measurements that are developed in conjunction with members and their advocates.
 - Concern: MassHealth capacity to implement the 1115 waiver is not demonstrated in the application. Learning from the experience of One Care, lack of capacity has led to an intense, unsustainable workload for MassHealth staff as well as an inability to deliver basic data to stakeholders in a timely manner. One Care also still lacks any population-based benchmarks beyond reduction in ED visits and hospitalizations. APM incentives not aligned with population-based quality metrics may, particularly in the case of LTSS and BH services, lead to emphasis on medical rather than community-based services. Also problematic is that APMs may be

ineffective if they require the provider to take on risk and/or go against fiscal self-interest in order to appropriately serve members.

- Solution 1: MassHealth should demonstrate the amount of DSRIP funding that will be used to build capacity to effectively implement the 1115 waiver program in a competent manner. The funding should go to service providers who have traditionally been underfunded or not reimbursed, not to build capacity in large health care organizations that already should have been providing care coordination as part of their charge.
 - Solution 2: MassHealth should indicate deliverables for stakeholders to review prior to CMS approval of the 1115 waiver. Deliverables should include expected dates for the establishment of quality workgroups, deadlines for the quality workgroups to deliver information to stakeholders, dates for releasing information on the financial health of the 1115 waiver and financial status of ACOs, and establishment of a platform to build a public facing dashboard and benchmarks to be met to have the dashboard available to members.
 - Solution 3: MassHealth should set out, even if initially aspirational, benchmarks to be met by ACOs, including:
 - Meeting benchmarks set out in by the legislature in the Public Health Trust Fund;
 - The number of children, teens, and adults who have visited the dentist in the last year (this is of particular importance to people with disabilities, who have higher incidences of poor oral health than the general population);
 - Number of female members, ages 15-44, who are sexually active and receiving reproductive health services in the past 12 months (CDC standard);
 - Knowledge of serostatus by HIV-positive members;
 - The inclusion of LTSS quality outcome measures to determine the competency of ACOs to receive global payments in the delivery of LTSS;
 - Utilization of mental health recovery principles, in particular Certified Peer Specialists;
 - Number of school days missed by children.
- **Recommendation 7. Financial structure.** DAAHR is hopeful that the new payment structure for ACOs will support improved quality of care, reduction of inequities in health care access and outcomes by different populations, and overall higher quality of life for MassHealth beneficiaries.
 - Concern: The magnitude of the change taking place in the delivery of health care cannot be overstated. The 1115 waiver application includes provisions on cost-sharing but this is very vague. In essence the waiver calls for hospitals to go against their own best interests by reducing emergency department visits and hospitalizations. The same is also true of medical providers who, rather than being paid for the number of people they see, will be paid for outcomes. As a result, mergers and acquisitions may increase as the industry consolidates around the most profitable product lines.¹²

¹² <http://www.valuewalk.com/2015/10/alternate-payment-models-why-the-healthcare-industry-will-never-look-the-same/>

EOHHS must therefore ensure that the financing of this new ACO program demonstrates that there are clear and objective ACO and provider incentives in place that align with the health and quality of life goals for MassHealth members.

- **Solution 1:** Contracting requirements must protect consumers from the creation of an oligarchical system of medical and community-based services. MassHealth and CMS together must create disincentives to counter the strong incentives that currently exist for medical providers to preserve their medical infrastructures and offset losses resulting from reduced ED and hospitalizations through mergers with other medical entities and acquisition of community-based providers of behavioral health and LTSS services or bringing services in-house. Contractual requirements should include prescriptive language that prevents ACOs from reducing consumer choice by including in the 1115 waiver a requirement that ACO members must have a minimum of choice of two conflict-free community-based behavioral health and LTSS providers in their geographic area. MassHealth and CMS should further work with stakeholders to establish other protections that preserve consumer choice and access to culturally competent quality care.
- **Solution 2:** Financing must include positive incentives for members, including, but not limited to no copayments, and the opportunity to receive enhanced services, including services that impact social determinants of health. Negative incentives may harm Medicaid beneficiaries.¹³ Even states like Idaho have piloted positive incentives to promote behavior change. These incentives include giving Medicaid beneficiaries who consult with a doctor on losing weight or quitting smoking a \$100 voucher to be used in the gym or weight-management program. Idaho also offered beneficiaries \$10 a month for keeping well-child exams and immunizations up to date.¹⁴
- **Solution 3:** The 1115 waiver should outline how MassHealth will protect the integrity of MassHealth dollars and ensure reinvestment by ACOs into delivery of services to members. This outline should include definitions of how value-based purchasing and use of APMs are to be used by ACOs to reduce costs and increase quality. For example, ACO gains could be capped at 3% net, with income over 3% going back into service delivery to members.
- **Solution 4:** Changes taking place at the health plan level must be monitored over time. Monitoring should address the following:
 - The alignment of incentives (to ensure continued and improved access to care across all services).
 - Protection of LTSS and BH spending, reductions in medical care, and the rebalancing of dollars from SNF and other institutional settings to community services.
 - Adequacy of risk adjustment to accommodate true costs and risk.
 - The need for direct payments for social risk factors to address social determinants of health.
 - Levels of unmet member need that may exist.

¹³ http://www.chcs.org/media/Healthy-Behavior-Incentives_Opportunities-for-Medicaid_1.pdf

¹⁴ http://www.chcs.org/media/Healthy-Behavior-Incentives_Opportunities-for-Medicaid_1.pdf

- The distribution of DSRIP dollars by ACOs to community-based organizations and to innovative, traditionally non-medical services.
- Expenditures by plans on administration.
- Expectations around performance-based measures, including reduction targets for ED and inpatient admissions.
- Adoption of One Care privacy principles and best practices.
- Establishment of relationships with school systems, correctional institutions, and public housing entities.

Reporting requirements and definitions of services should be standardized so as to allow comparison of delivery/outcomes between ACOs, and promote best practices.

As members of the DAAHR Executive Committee, we thank you for consideration of these concerns.

Sincerely,

Dennis Heaphy, DAAHR co-chair, dheaphy@dpcma.org

Bill Henning, DAAHR co-chair, bhenning@bostoncil.org

Deborah Delman, The Transformation Center

Susan Fendell, Mental Health Legal Advisors Committee

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July 15, 2016

Daniel Tsai
Assistant Secretary and Medicaid Director
Executive Office of Health and Human Services
Office of Medicaid, Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Assistant Secretary Tsai:

On behalf of Dana-Farber Cancer Institute, I am pleased to submit the following comments for your consideration as the Executive Office of Health and Human Services develops its MassHealth Accountable Care Organization (ACO) program and the 1115 Medicaid Waiver proposal to implement the program.

Dana-Farber is committed to ensuring that patients from diverse backgrounds receive equitable cancer care and treatment – and to serving medically underserved populations in our community who may face barriers to obtaining care. Ensuring that MassHealth patients who may be low-income, disabled or otherwise at risk of experiencing health care barriers have access to specialized cancer care is a key part of our mission and work as a comprehensive cancer center. As the MassHealth ACO program seeks to better-coordinate healthcare delivery in a way that is cost-effective, value-based, and patient-centered, we want to ensure that patients enrolled in ACOs are not denied access to high-quality specialty and subspecialty services that are critical to achieving these important program goals.

Patient Access to Sub-Specialized Services:

The MassHealth ACO program should be structured to ensure that patients have access to medically necessary and clinically appropriate services, including the sub-specialized services of a comprehensive cancer center, and all necessary oncology-based services provided through the continuum of care.

Dana-Farber maintains a unique role in the continuum of care in the Commonwealth as the only free-standing NCI-designated comprehensive cancer center in Massachusetts and only one of eleven such centers in the country. This special status, and the importance of including comprehensive cancer center services within the ACO framework, was recognized in the provisions of Chapter 224 authorizing the Health Policy Commission (HPC) to certify ACOs. Among the additional elements to be considered by the HPC in certifying ACOs is ensuring “patient access to health care services across the care continuum, including, but not limited to, access to... the services of a comprehensive cancer center...” (M.G.L. c. 6D, s. 15(c)).

While it is not reasonable to expect that Dana-Farber be included in every ACO network in the Commonwealth, we believe it is critical, and consistent with the clearly articulated policy of the Commonwealth, to ensure that patients who could benefit from the expertise of our sub-specialized care

teams, our specialized services such as molecular pathology, and our more than 750 clinical trials should not be denied access. Also with reference to the HPC authority, M.G.L. c. 6D, s. 15(b) establishes among the standards for ACO certification whether the ACO will assure the provision of “medically necessary services across the care continuum,” and that “any medically necessary service that is not internally available shall be provided to a patient through services outside the ACO.” If Dana-Farber is not included in an ACO network, there may be a financial disincentive for a patient to be referred outside of the ACO for a second opinion consultation or treatment. We are concerned that this financial disincentive may result in some patients who require highly specialized cancer care being confined to the ACO network inappropriately, contrary to Commonwealth policy, and therefore compromising patient care and outcomes as a result.

For example, a key predictor of the quality of outcomes for highly specialized cancer care is the volume of services provided. There are only a few centers in the Commonwealth that perform bone marrow transplants (BMT) and fewer still that perform pediatric BMT. The sufficient volume of these procedures at select tertiary cancer centers has promoted the achievement of significantly better survival outcomes at those higher volume centers compared to both regional and national statistics.

To this end, patients requiring such specialized services such as pediatric oncology, care for sarcoma, and treatment for other hematologic malignancies, for example, should have access to the services of a comprehensive cancer center to ensure their needs are met and to optimize quality of life and survival outcomes. In addition, ensuring access also requires that the care provided to patients outside of the ACO is reimbursed adequately at rates consistent with those the principal commercial payers set as appropriate.

Pathways to Seek Care Outside of the ACO:

The design of the MassHealth ACO program plays an important role in ensuring that patients have access to such services by maintaining pathways for patients to seek care outside of the ACO where clinically appropriate and ensuring that reimbursement for such services is consistent with contracted rates. Because the ACO structure could create a financial disincentive for the ACO to refer a patient to a non-participating provider, ample safeguards should be developed within the ACO program to ensure that patients have appropriate access to care outside of the ACO. This is consistent with the policy embedded in the HPC authorization, and MassHealth should promote a similar public policy.

Specifically, we recommend the following:

Disclosure: MassHealth should require certified ACOs to inform patients that they are included in an ACO and explain what that means from a patient perspective. Patients should be informed of their rights, including their ability to seek approval to receive care outside of the ACO network. Specific information should be provided about how a patient could request a referral outside the ACO.

Tracking Access: MassHealth should require that certified ACOs report the volume and result of out-of-ACO requests and/or referrals for treatment and second opinion consultations for select services including oncology.

Reimbursement: Specialty care that is provided outside of the MassHealth ACO to optimize patient quality of life and survival should be reimbursed to out-of-ACO providers at rates consistent with those the principal commercial payers set as appropriate.

We recognize the difficulty in developing metrics to evaluate meaningful access to services outside of an ACO, but believe this is of critical importance to ensure that the needs of cancer patients in ACOs are being met. We would be glad to work with MassHealth in examining and developing other metrics or opportunities to evaluate access for cancer patients in ACOs.

We appreciate the opportunity to provide written comments on the proposed MassHealth ACO program design and would be pleased to work with you going forward to evaluate access to highly specialized cancer services within the ACO model. If you have any questions, please do not hesitate to contact me at 617-632-4433.

Sincerely,

A handwritten signature in cursive script that reads "Anne Levine".

Anne Levine

Vice President of External Affairs



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July 13, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: Comments on Demonstration Extension Request

Dear Assistant Secretary Tsai:

These comments on the 1115 Demonstration Extension Request are submitted on behalf of the Boston Center for Independent Living (BCIL), the Metrowest Center for Independent Living (MWCIL), the Stavros Center for Independent Living (Stavros), the Disability Law Center (DLC) and Greater Boston Legal Services (GBLS). For over a decade we have been working to improve physical access to health care for people with disabilities in Massachusetts. We strongly endorse the overall direction the Office of Medicaid is taking with the Extension Request, which will greatly enhance the ability of MassHealth members with disabilities to have equal access to high quality care. Our comments are focused on the aspects of the Demonstration Request that deal directly with improving access to care, which we think are key components of the broad effort to emphasize "value in care delivery" and "provide integrated and coordinated care, while moderating the cost trend."

We would like to highlight and commend the many specific references to accessibility in the Extension Request:

The Protection and Advocacy System for Massachusetts

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- MCOs will be required to demonstrate competencies in the independent living philosophy, Recovery Models, wellness principles, cultural competence, accessibility, and a community-first approach, consistent with the One Care model. Pg. 4
- MCOs will also be required to demonstrate compliance with the new Medicaid Managed Care regulations, and to demonstrate meaningful supports and processes for providers to improve accessibility for members with disabilities, including ensuring full compliance with the Americans with Disabilities Act (ADA). Pg. 4
- Through this transition to value-based care delivery and payment, MassHealth remains committed to preserving and improving the member experience. The member experience today ... including ... accommodations and competency to support individuals with disabilities -varies across the state. Pg. 4
- MassHealth will ensure that members have adequate access and choice in networks and will continue to require that MCOs and ACOs have provider networks that comply with all applicable managed care rules. Pg.5
- Delivery System Reform Incentive Program (DSRIP) Investments: To fund a set of investments to more efficiently scale up statewide infrastructure necessary for reform compared to provider-specific investments (e.g., ... access to medical and diagnostic equipment for persons with disabilities...). Pg. 7
- Massachusetts also recognizes that providers' experience and capacity to address the unique medical needs and diagnostic challenges presented by individuals with physical, developmental and intellectual disabilities varies widely across the state. Pg. 13
- Goal 2: Establishing explicit expectations for the coordination and delivery of care for... members with disabilities. Pg. 15
- 4.1.8 Member Rights and Protections. MassHealth will work closely with its MCOs, ACOs and PCC plan providers to ensure providers offer their patients with disabilities the medical and diagnostic equipment and accommodations necessary to receive medical care. P.29

In addition to these strong policy statements, the commitment to improving access for members with disabilities is built into the contracts with the Accountable Care Organizations and Managed Care Organization through the explicit references to federal managed care requirements. "Model A ACO/MCOs must be licensed carriers in accordance comply with state law and are subject to federal managed care regulations." Pg. 24 "Each Model A ACO/MCO will have a defined provider network that meets access and adequacy requirements." Pg. 25 "Members in MCOs (including those in Model C ACOs) will have access to the MCO's provider network (which must satisfy all applicable MCO rules and network adequacy requirements) subject to their MCO's network policies." Pg. 28 "MCO contracts will require MCOs to assure that their network providers are able to make specific accommodations for MassHealth members with disabilities, including the provision of accessible medical and diagnostic equipment. DSRIP funding may be available to support related enhancements." Pg. 35

The references to federal managed care requirements, access, network adequacy, accommodations and accessible medical and diagnostic are significant because they represent what is likely the first-in-the-nation adoption of the significant improvements for Medicaid recipients in the newly promulgated Medicaid Managed Care Regulation. 81 Fed. Reg. 27498 (May 6, 2016)

Several of the proposed uses of Delivery System Reform Incentive Program (DSRIP) funds will greatly enhance access for members with disabilities. Under the heading of Support Development of Statewide Infrastructure, the Extension Request envisions use of funds to "scale up statewide infrastructure and workforce capacity." Pg. 38. This includes support for the "use of comprehensive care assessments in care plans for members with disabilities. Pg. 41. DSRIP funds will also be available to support improved accommodations for people with disabilities:

MassHealth has hundreds of thousands of members with disabilities who need reasonable accommodations to receive the medical services they need. Massachusetts providers strive to meet such needs, but some providers lack the resources to further enhance accommodations. Examples include physical site access, medical equipment access, communication access as well as programmatic access to accommodate physical, cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities. As Massachusetts plans to encourage members to work with their ACOs and PCPs, it is looking to ensure that all members have equal access. To promote this goal, MassHealth requests authorization to use DSRIP funding to assist providers in purchasing necessary items or making adjustments to accommodate persons with disabilities. Pg. 51

Full implementation of the plan envisioned by the Extension Request will encourage and require related reforms. Screening procedures for identifying patients with disabilities and assessing their needs for accommodations will be incorporated into routine practice. Electronic Health Records (EHR) will be adapted to incorporate comprehensive health needs assessments, notify providers of the accommodation needs of patients with disabilities, track whether accommodations have been provided and provide a base of information for quality assessment. Requirements specifying the type and quantity of accessible medical needed for proper care in all health care settings will be developed. Training programs for providing patient-centered care for patients with disabilities will be expanded. In many instances installation of accessible medical equipment will trigger the removal of architectural barriers and changes in policies and procedures. Taken together the explicit references to meeting the needs of members with disabilities, the commitment to enhanced managed care networks, the use of comprehensive assessments and the allocation of DSRIP for tangible access improvements will provide a firm foundation for realizing the promise of equal access to high quality care for all MassHealth members.

As has often been noted by advocates, we are in the 26th year of the Americans with Disabilities Act. The time is now for healthcare to be provided in a manner that is fully accessible to people with disabilities, and the steps that are discussed in the waiver application represent major movement in this direction. We look forward to continued collaborative effort to achieve this fundamental goal.

Sincerely,

Christine M. Griffin, Esq.

Christine M. Griffin, Director
 Stanley J. Eichner, Litigation Director
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 Disability Law Center

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Daniel Tsai
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Executive Office of Health and Human Services One Ashburton Place, 11th floor
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July 17, 2016

We thank you for the opportunity to provide comments on the MassHealth Section 1115 Demonstration Project Amendment and Extension Request. As a state chapter representing over 1,500 doctors and providers in Massachusetts who serve MassHealth patients, we welcome the move towards value-based care that aligns with the Triple Aim.

As the physician organization that worked with EOHHS in 2010 to host a town hall meeting of over 200 providers on the topic of payment reform -- as our contribution to early stakeholder support of what became law with Chapter 224 in 2012 -- we are excited to have this opportunity to contribute to this stage of payment reform implementation. Doctors for America has been and remains a committed to system reform to ensure affordable, accessible, and high quality health care.

The vision of patient-centered, whole person care across the care continuum is both admirable and necessary. Successful implementation, however, will involve many challenges. Below are detailed comments on important considerations to promote successful reform. We anticipate many of these positions will align with other public-health minded advocates. In some instances, our positions outlined below are to express support for already articulated recommendations.

Enhancements/Support for Primary Care

We strongly support the described enhancements for primary care. Robust primary care and the medical home are the pivotal points for whole person care across the care continuum. For effective integration of BH and LTSS with medical care, primary care must be the centerpiece of the healthcare system.

We support the very thoughtful grants for community providers to participate in Accountable Care Organization (ACO) related activities to improve care at their clinic and for general workforce development. We appreciate the significant investments in primary care workforce development, through loan repayment and funding to offset the costs of trainees working in FQHCs. These are important mechanisms to increase the number of primary care providers.

There is also concern for increasing provider “burn out”, especially in primary care.¹ Half of primary care providers report symptoms of “burn out” that is attributed to administrative burden, regulatory demands, increasing demands on primary care without additional support.² This provider burn out leads to reduced quality of care to patients and contributes to loss of providers from the work force amid an existing primary care provider shortage.

We recommend ACOs be required to have internal monitoring and reporting to the state for provider turnover and vacancies. Instability of provider workforce within an ACO can disrupt care for patients, lower quality of care (e.g. worsened blood pressure control in primary care), and worsen patient experience of care.³ MassHealth may consider incentives to reward high rates of primary care provider retention or may consider contract or certification requirements that address provider instability within an ACO. Strong, longitudinal primary care provider and patient relationships are known to improve outcomes,⁴ and organizations that support their caregivers and keep them in the workforce should be rewarded.

Quality and Outcome Metrics

As ACOs use quality metrics to hold providers accountable for the quality of care, the final metrics chosen for ACO accountability are of paramount importance and have multiple implications. We agree with the described quality domains but are concerned by the lack of further detail on this critical aspect of ACOs. Specific measures used to determine quality and payment targets for ACOs must be vetted through a public engagement process that includes practicing clinicians to ensure the metrics used are relevant, feasible, valid, and actionable. One option for this public engagement process could be to utilize the existing multi-stakeholder group like the State Quality Advisory Committee (SQAC).

We encourage ACO quality metrics that align with the framework of the Core Measures Collaborative, as described by Patrick Conway’s Health Affairs Blog to “Reduce, Refine, Relate.” This initiative also has a mechanism to continually evaluate measures, through a multi-stakeholder process, to consider new measures to add and which measures should be retired.⁵ This process partners with physician groups and other stakeholders and invites feedback on experience with measures.

Risk Adjustment, Feasibility, and Technical Support

We ask for more clarity around whether all of the ACO models will be risk adjusted and for further information about how the risk adjustment will be performed. We believe that risk adjustment is crucial to the success of all institutions participating in the ACOs. In particular public hospitals and FQHCs who care

¹ <http://healthaffairs.org/blog/2016/04/21/make-the-clinician-burnout-epidemic-a-national-priority/>

² <http://www.annfamned.org/content/11/3/272.full>

³ <http://www.ncbi.nlm.nih.gov/pubmed/25985320>

⁴ <https://hbr.org/2015/10/strong-patient-provider-relationships-drive-healthier-outcomes>

⁵ <http://healthaffairs.org/blog/2015/06/23/the-core-quality-measures-collaborative-a-rationale-and-framework-for-public-private-quality-measure-alignment/>

for a high proportion of MassHealth members will be most vulnerable if risk adjustment is not adequate. We are also concerned of the potential for adverse selection if measures that determine payments do not adjust for drivers of cost that are not easily modifiable within the healthcare delivery system. We recommend the methodology described in the National Academies of Health report by the Committee on Accounting for Socioeconomic Status in Medicare Payment Programs.⁶ Risk factors to adjust for should include wealth, sexual orientation and gender identity, environmental measures of residential and community context, and access to social supports

Further there should be careful consideration of the feasibility of reporting from data sources, administrative burden of reporting any ACO metrics, and investment in infrastructure and technical assistance for measure reporting. Specifically, small independent clinics find it challenging and time consuming to collect and submit quality metrics and is an opportunity cost. Resources spent on quality reporting are then siphoned off from actual care delivery. Dedicated infrastructure support and technical assistance resources will be required for any new ACO measures.

Measurement Setting and Accountability

We seek clarification on how measurement and accountability will be determined in the new integrated model of care. We ask this given the knowledge that measure specifications indicate the setting for use and data collection. This is particularly relevant to the integration with LTSS services as the measures for these clinical services have typically been separate from acute or outpatient medical care. We seek to understand how the performance metrics that set incentives, determine payment will create and attribute accountability across various settings, including LTSS. We caution that established measures that are considered valid and reliable in one setting, if used in a novel way or in a new setting, may no longer be valid and reliable. Therefore, careful consideration of how accountability is measured and attributed across the integrated care model is essential. While we support the use of cross cutting measures, we also recommend measures that promote ownership of results and inform actionable plans for improvement.

Population Health Measures

We note, while the Triple Aim is oft-cited in healthcare improvement, many existing measure sets have an imbalance between measures mapped to each of the three aims of per capita cost of care, population health, and experience of care. Specifically, we often hear of re-admissions or annual total medical expenditure (TME), which represent short-term outcome measures to identify preventable cost to the system. Payer-driven measure sets, however, contain few outcome measures assessing population health. There is often little overlap between the population health metrics used by the Centers for Disease Control (CDC) or Department of Public Health (DPH) versus those of payers. We encourage greater use of existing datasets from such public agencies and greater collaboration between MassHealth and DPH to better track and improve population health. The metrics for population health are particularly important in pediatrics as

⁶ <http://www.nap.edu/catalog/23513/accounting-for-social-risk-factors-in-medicare-payment-criteria-factors>
<http://www.nap.edu/catalog/23513/accounting-for-social-risk-factors-in-medicare-payment-criteria-factors>

commonly used pediatric measures in payer sets do not measure the health and well-being of healthy children.

Consumer Experience and Patient Engagement Measures

For patient experience, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are used. The versions evaluating patient experience in hospital and outpatient settings (H-CAHPS and CG-CAHPS, respectively) are most common. Standard CAHPS surveys do not capture outcomes that patients experience in their daily lives, namely those of functional status, mental health, and self-efficacy. As new payment models expand the scope of care to incentivize home-based care and community partnerships, the measurement must follow. In re-aligning measurement, our tools must assess the quality of care across the full care continuum.

Further, while there are metrics for patient satisfaction, there is no current metric for patient engagement. A national study found higher patient satisfaction to be linked to higher healthcare expenditures, higher hospital admission rates, and higher mortality.⁷ A systematic review of the literature found that unrealistic patient expectations of the benefits and harms of interventions can influence decision-making and may be contributing to increasing intervention uptake and health care costs.⁸ Consumer-facing measures should assess consumer experience that aligns with the goals of the ACO rather than create perverse incentives. By contrast, higher patient engagement is associated with lower readmission rates, lower medication errors, and other reduction in patient harm.⁹ There is evidence, that more engaged patients also participate in better health behaviors and better partner with providers to improve health outcomes.

Transparency

While we fully support informed consumer decisions based on data sharing to assess quality of care, we seek further information about the extent to which the metrics will be reported publicly, especially those measures that may be newly developed or not yet tested in a MassHealth population. New measures (or modified measures used in new ways) may be less stable, lack benchmarks, or not be appropriately risk-adjusted. Preliminary data on new measures could serve to misinform rather than support informed consumer choice. Decisions on which data and metrics will be publicly reported should also be made in conjunction with quality experts and consumer representatives. Educational materials on quality measurement should be available to consumers that describe, in lay terms, what measures do or do not measure, limitations, and appropriate uses. Given the low “numeracy” among Americans (see Health Literacy section below), this support for consumer comprehension of quality metrics is critically important.

⁷ Fenton JJ, Jerant AF, Bertakis KD, Franks P. The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality. *Arch Intern Med.* 2012;172(5):405-411. doi:10.1001/archinternmed.2011.1662.

⁸ Hoffmann TC, Del Mar C. Patients’ Expectations of the Benefits and Harms of Treatments, Screening, and Tests: A Systematic Review. *JAMA Intern Med.* 2015;175(2):274-286. doi:10.1001/jamainternmed.2014.6016.

⁹ <http://www.beckershospitalreview.com/accountable-care-organizations/supporting-aco-success-with-meaningful-patient-engagement.html>

Attribution Methodology and Continuity of Coverage

A key aspect of accountability is attribution of a patient to a specific primary care provider, medical home, or ACO. This is challenging in a population that has frequent changes in eligibility which leads to “churn”, or several change in insurance status or type within a 12-month period. In the U.S., over 7% of children have discontinuous coverage in the year. Another study found that over 40% of adults have change in eligibility over a 12-month period¹⁰

Even a 1-2 month disruption in coverage has been shown to lead to delayed or missed care, cause pent up need, and change utilization patterns. In the Medicaid population specifically, such seemingly brief gaps result in missed medication doses, missed care, and increased emergency room visits.¹¹ A loss of MassHealth coverage for as little as 1 month could have significant impact on preventable utilization like ED visits, hospitalizations, or other performance targets measured by an ACO quality slate for which ACOs are at risk.

Therefore, attribution that does not account for such gaps in coverage and resulting changes in care or health could unduly penalize providers or ACOs. Specifically, when a care relationship is disrupted by insurance status or type change, the resulting outcomes would not be related to the attributed provider’s or ACO’s quality of care but to due to coverage disruption. Any attribution methodology must also include a measure of churn and health care coverage disruption and to adjust for this.

Further, administrative simplicity that reduces churn is required to prevent gaps in coverage. A policy that allows 12-month continuous coverage after proving eligibility would help mitigate causes of discontinuous coverage. Another barrier to continuous coverage is processing times for eligibility determinations and waiting periods between proving eligibility and accessing care. It is critical that MassHealth be committed to reducing barriers to continuous coverage as it is continuous health insurance coverage that is a prerequisite to access to needed care and appropriate care utilization. Data show that patients who experience gaps in health insurance often lack a usual source of care or primary care provider and then are more likely to rely on emergency departments for care.¹²

Access to Services and Care Delivery

We are enthusiastic about the importance that has been ascribed to addressing social determinants of health with services and programming, which previously was considered outside the purview of medical care. We look forward to having formal collaborations with CPs and LTSS. Details on these constructs in the waiver

¹⁰ <http://www.ncbi.nlm.nih.gov/pubmed/24622387>

¹¹ Banerjee, R., Ziegenfuss, J., Shah, J. “Impact of discontinuity in health insurance on resource utilization.” BMC Health Serv Res. 2010; 10:195. doi:10.1186/1472-6963-10-195.

¹² <http://www.nejm.org/doi/full/10.1056/NEJMSa043878#t=article>

proposal are limited, however, and their success or failure will be dictated by how they are defined, measured, compensated, and the value they bring to the care of the patient.

We seek more information about this part of the waiver proposal, including:

- How will risk and shared savings be distributed between different provider types?
- How will quality and performance metrics, that determine payment, be measured across these new linkages? Will there be quality metrics for each setting of care? Will cross continuum care be measured by comprehensive metrics?
- How will payment to each provider type be determined?
- What will these communications/linkages between CPs and LTSS actually look like?
- How are the collaborations facilitated?
- Will provider groups have control over which groups they partner with?
- What type of communications will be permitted (keeping in mind that they must be HIPAA compliant, realistic, and feasible)?
- What are the mandates for data-sharing and communications?
- How will reimbursement and compensation for LTSS and CPs be determined?
- How will performance for LTSS and CPs be determined?

Network Adequacy

Ensuring adequate access to care and preserving care relationships are of paramount importance. Especially given provider shortages and disparities in provider density by geography, narrow networks can lead to barriers to care, missed care, and can worsen disparities. Further, effective care occurs within care relationships of trust. Care should be taken to avoid disruption of patient-provider relationships. Narrow networks are more likely to lead to loss of a trusted provider in order to stay in network.

Network adequacy is especially important for service types and vulnerable populations most at risk for disparities. Examples are behavioral health providers and pediatric providers. Specific metrics for network adequacy for each ACO and each provider type within ACOs (e.g. pediatric providers, behavioral health providers) are critical.

Further network stability is critical. Member choice of a network happens at the time of selecting coverage. However, many plans renew contracts or change provider networks after a member has enrolled in coverage. This can disrupt existing care relationships despite continuous insurance coverage. It is essential that up-to-date provider directories are maintained.

Specific network adequacy metrics should include:

- Wait times to appointment
- How are the collaborations facilitated?
- Distance to provider
- Travel time to provider
- Minimum provider/enrollee ratios
- Percentage enrollees who changed primary care providers in a year
- Percentage of change to provider network per year

These network adequacy metrics, to be collected and reported by ACOs or MCOs, must be made transparent, kept up to date, and be readily available to the public. While we recognize that many of these metrics may already be reported as per MCO contracts, this information is not often easily available to members at the time of choosing a plan. At the time of enrollment in a plan type, a consumer must be empowered with accurate and easy to access information on the provider network of that plan. Also to promote consumer choice and ability to compare plans, these network requirements and metrics should be standard across MCOs and the PCC plan.

Member Experience and Network

We have concerns about restrictions on members and providers as described in section 4.1.5.2. It describes members would need to access providers based on the network of their attributed Primary Care Providers (PCP). For many patients with complex health needs, their most important care relationship and their functional “medical home” may be with a specialist. This applies, for instance, to those undergoing cancer treatments with oncologists, those with multi-system diseases cared for by rheumatologists, or children with complex medical conditions like genetic syndromes. Especially given the complexity and variation of the ACO models, we have concerns as to whether the implications of ACO choice or PCP choice will be clear to members. A detailed plan for educating members on this and ensuring members are making informed choices is required, especially in light of the lock in period proposed.

Going out of network could also have serious financial implications for patients. Current data tell us that nearly 7 in 10 of individuals with unaffordable out-of-network medical bills did not know the health care provider was not in their plan’s network at the time they received care.¹³ Further the requirement for PCPs to participate in one ACO may limit their patients’ access to other providers, hospitals, or facilities. This becomes especially critical in non-urban areas or in emergency situations. There are many reports of “balance billing” by hospitals when patients unknowingly receive care from out-of-network providers in emergency situations, from surgeries, or during hospitalizations.¹⁴

Health Literacy and Member Education and Assistance

We appreciate that MassHealth will require ACOs and MCOs to make information about their coverage and care options readily accessible and that MassHealth will enhance its own customer service, website, publications, and community collaborations. The proposed ACO initiative will make the system more complicated for members, as acknowledged by MassHealth in the waiver proposal. With the changes, the simple act of choosing one’s primary care setting will bring with it a host of important consequences. Particularly if the MCO enrollment restrictions are put into place, members will need extensive guidance to determine what plan best meets their needs.

¹³ <http://kff.org/private-insurance/issue-brief/surprise-medical-bills/>

¹⁴ <http://www.npr.org/sections/health-shots/2015/12/24/460829936/er-docs-say-rule-change-could-raise-patients-out-of-network-bills>

This added complexity is in the context of already low health literacy. Data show that over 30% of Americans have low health literacy or the inability to understand prescription instructions. Over half of Americans have low health “numeracy” or the inability to use numbers in daily life.

U.S. Health and Human Services describes the following on health literacy, “The primary responsibility for improving health literacy lies with public health professionals and the healthcare and public health systems. We must work together to ensure that health information and services can be understood and used by all Americans.”.¹⁵ HHS further describes:

Health literacy is dependent on individual and systemic factors:

- Communication skills of lay persons and professionals
- Lay and professional knowledge of health topics
- Culture
- Demands of the healthcare and public health systems
- Demands of the situation/context

Health literacy affects people's ability to:

- Navigate the healthcare system, including filling out complex forms and locating providers and services
- Share personal information, such as health history, with providers
- Engage in self-care and chronic-disease management
- Understand mathematical concepts such as probability and risk

Populations most likely to experience low health literacy are older adults, racial and ethnic minorities, people with less than a high school degree or GED certificate, people with low income levels, non-native speakers of English, and people with compromised health status.⁷ Education, language, culture, access to resources, and age are all factors that affect a person's health literacy skills. These high risk groups are overrepresented in MassHealth.

We urge MassHealth to:

- Commit to a specific budget and resources for member education and navigation assistance, including implementation of an enhanced community-based public education campaign for members, as well as a major expansion of in-person enrollment assistance. Some best practices for this may be found in the lessons learned from the OneCare program’s implementation.
- Create an Office of Consumer and Community Engagement that extends navigation assistance beyond insurance enrollment to include ongoing support for effective utilization of services. This may include utilizing the customizable “Coverage to Care” resource by CMS.¹⁶ An additional tool is “My Health

¹⁵ <http://health.gov/communication/literacy/quickguide/factsbasic.htm>

¹⁶ <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Coverage2Care.html>

Finder” by HHS that enables consumers to search for personalized preventive health recommendations.¹⁷ Tools for appropriate healthcare utilization should be incorporated into the MassHealth website and/or written materials, as appropriate. This would promote seamless transition from health insurance enrollment to access to healthcare services.

- Provide tailored, personalized, linguistically and culturally competent assistance both pre- and post-enrollment. Members should have access to individual assistance with choosing a plan and understanding the coverage and care options available.
- Utilize all forms of media to do outreach, including text messaging, as has been shown to be successful for Medicaid and SCHIP enrollment and outreach.¹⁸ This may include expanding the member outreach model represented by Text4Baby initiative that already exists in MassHealth.
- Work with community resources like schools, libraries, faith-based groups, advocacy groups, and other community leaders to disseminate information broadly. There are best practices from enrollment efforts following the 2006 reform (Chapter 58) on successful public outreach in Massachusetts.
- Have a year-round health literacy campaign and dedicated funding to improve the baseline health literacy of the MassHealth population. We recommend using best practices outlined in the National Action Plan to Improve Health Literacy.¹⁹ Especially given increasing complexity and implications of choices in the ACO model, dedicated support for better comprehension is required. MassHealth members must be supported to be fully informed and engaged consumers of healthcare to choose and utilize the right ACO option for their own care.
- Ensure the ombudsman, or another entity such as the Office of Patient Protection, has a role in arbitrating ACO members’ appeals and grievances for coverage as well as ACO-specific treatment or referral decisions, while identifying and addressing systemic issues.

Member Protections

While we support the shared responsibility, we express caution on the issue of cost-sharing in a program that serves low income families. We oppose new cost-sharing that is not evidence-based to add value and instead contributes to delayed or missed care. Data on effectiveness of cost to change consumer behavior are mixed. Data from Oregon and Connecticut Medicaid programs show that higher cost-sharing contributes to Medicaid disenrollment and going uninsured.²⁰ In Oregon, those who left Medicaid programs due to higher cost sharing had lower primary care utilization and higher emergency room visits.²¹ A Kaiser Family Foundation report describes how higher cost sharing results in delayed care and poorer health outcomes.²² All these consequences then put greater strain on safety net resources and shift costs towards within the system rather than resulting in cost savings or better health outcomes. Given the stated goal of

¹⁷ <https://healthfinder.gov/myhealthfinder/>

¹⁸ <http://kff.org/medicaid/issue-brief/profiles-of-medicaid-outreach-and-enrollment-strategies-using-text-messaging-to-reach-and-enroll-uninsured-individuals-into-medicaid-and-chip/>

¹⁹ http://health.gov/communication/hlactionplan/pdf/Health_Literacy_Action_Plan.pdf

²⁰ <https://www.cthealth.org/wp-content/uploads/2011/04/Policy-Brief-2-Proposed-Medicaid-Cost-Sharing-Evaluating-The-Impact.pdf>

²¹ <http://content.healthaffairs.org/content/24/4/1106.full>

²² <https://kaiserhealthnews.files.wordpress.com/2014/07/8417.pdf>

continuing near-universal healthcare coverage in Massachusetts while reducing costs and improving outcomes, careful monitoring of unintended consequences of cost-sharing is needed.

Further, the introduction of copays also puts the onus on providers to collect new fees. This creates new administrative burden for providers and can promote adversarial, non-cooperative interactions between patients and providers at the time of care delivery.

Therefore, consideration should be given to non-monetary ways to redirect consumer behavior. Given the role of poor health literacy as a barrier to appropriate care seeking behaviors, there must be appropriate educational materials to support patients in their care seeking decisions. A better and more proven mechanism to improve value-based health care decisions by consumers/patients is to support better health literacy and patient engagement.

We support the redesign of the MassHealth website to ensure greater usability. We encourage testing of new design elements of the website through focus groups or ways to ensure the website design remains consumer-friendly and has high usability. In addition to written content, use of videos may promote better understanding. An example would be an “MassHealth ambassador” showing how to navigate various aspects of the system. Generally, the information that matters most to consumers should be easily available in a way that is intuitive and easy to access.

Appeals and Grievance

We support MassHealth’s proposal that members in all ACO models will have access to an ACO- specific grievance process, as well as existing appeals and grievance procedures for eligibility and coverage determinations. We also support the inclusion of an external ombudsman resource to help resolve members’ problems or concerns. We request, however, more details on the ACO-specific grievance process and the scope of responsibilities of the external ombudsman. We encourage MassHealth to consider the One Care ombudsman, with certain improvements and expanded capacity, as a model.

Further, to minimize the occurrence of appeals and grievances, robust member education and outreach materials and strategy are needed. The nature of the multiple ACO models and the variation in structure that will result are likely to be confusing to patients and providers alike. Too often, clinicians and providers are asked to take time from clinical care to help patients navigate the healthcare system, explain benefits, or process paperwork to advocate on behalf of patients.

We do have concerns over the potential for non-collaborative patient-provider relationships given the understandable concern that patients may have about ACO incentive to reduce low value care and utilization. Unless patients/consumers share in the goals of value-based care and understand the standards used, they may perceive providers as rationing needed care as opposed to advising choices based on data, evidence, and standards. Proactive education on value-based care used by ACOs is required. Further measures of and supports for patient engagement would help incentivize the right patient-provider interactions to improve collaboration and positive interfaces with providers and the overall system.

Pediatric Health

MassHealth is the payer for healthcare for 40% of children in the Commonwealth. Despite being the largest demographic in the program, healthy children account for the lowest cost. In an era of value-based care, that matches resources to level of need, there is a potential threat to pediatric health care funding and resources. Specifically if there is only focus on immediate cost drivers and high cost populations, at the expense of long term population health, then pediatric health needs may be disregarded or underfunded. Given the stated goal to bend the cost curve in the short term while in producing better outcomes, there is potential of redistribution of resources from pediatric care towards other, more costly populations. As we move towards better care coordination and care management for high cost populations, care must be taken to preserve and improve care for children as well.

The indicators of poor health in children may not be captured by usual indicators such as total cost of care or condition-specific re-admissions. Rather, metrics like missed school days or high school completion rates are important proxies for health-related functional status and outcomes. These data may be available from sister agencies such as the Department of Education, Department of Public Health, etc. MassHealth should invest in the infrastructure needed to promote interagency collaboration and data sharing to measure and track whole-child care.

Commonly used pediatric metrics include immunization rates and well child visits. Massachusetts has historically scored high on this. While these are important public health indicators that could be an important "balance" measures (to ensure there is not a drop in the rates), the already high rates do not allow much room for improvement. This may result in there being less incentive for ACOs to invest in pediatric health. The already suggested metrics on network adequacy should also reported specific to network adequacy for pediatric providers as network adequacy is of particular concern for the pediatric population.

Some potential cuts to pediatric health services may be in more subtle ways such as reduction of specific child-centered and patient-centered resources. Examples are cuts to staff like child life specialists or loss of discretionary funds that were previously used by hospital social workers for meal vouchers or cab vouchers for families with young children.

For children with special health care needs, we recommend utilizing existing expertise within the state for this specialized population whose risks, care needs, and costs are not often captured by measure sets. Specifically, the CMMI-funded "4 C" program at Baystate Medical Center and Boston Medical Center serves as a state-specific model of value-based care for children with special needs that improves outcomes through improved care coordination.²³

²³ <https://www.baystatehealth.org/services/pediatrics/family-support-services/4c-program>

Further, as children are dependent on their parents or guardians, then models of care and coverage should take into account the whole family. ACO models that cause parents and children to be on different plans or seen by different provider systems would put a strain on the family. Care should be taken to ensure ACO models do not create greater fragmentation of care within a single family unit.

Oral Health

We are encouraged by MassHealth's plans to promote the integration of oral health and primary health care through a range of methods (e.g., inclusion of an oral health metrics in the ACO quality measure slate, contractual expectations for ACOs). We urge MassHealth to strengthen oral health integration in its ACO models by more clearly outlining a plan which includes phased-in dental services and targeted investments to help facilitate integration. We also urge MassHealth to shift dental service payment methodologies to incentivize high-value, evidence-based, preventative care. Further attention should be given to addressing number of dental providers participating in the MassHealth program to ensure adequate access.

Health Homes

We support the use of the Health Home funding opportunity to be applied to behavioral health integration and coordination. We seek greater clarity on the eligibility health home services, specifically which diagnosis codes would qualify for these enhanced services.

Behavioral Health

We applaud MassHealth's goal of integrating physical health and behavioral health given the high burden of behavioral health disorders among Medicaid members. For many consumers with a behavioral health diagnosis, their behavioral health clinician is their primary point of contact with the health care system. As such, we are encouraged that the waiver plan establishes a strong role for Behavioral Health CPs to manage care coordination, with a goal of fostering communication between an individual's primary care provider and the treatment community, while respecting members' privacy and preferences.

Specifically, we support the prioritization of Integrated Care Delivery for patients with serious mental health problems with a special focus on interdisciplinary care teams. Several systematic reviews have shown that the integrated or collaborative care model is effective in depression management.^{24 25} A critical component of collaborative care is a multi-professional approach to care including a primary care provider and at least one other health professional such as a psychiatrist, nurse, or psychologist.²⁶ A second key

²⁴ Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev.* 2012;10:CD006525.

²⁵ Thota AB, Sipe TA, Byard GJ, Zometa CS, Hahn RA, McKnight-Eily LR, et al. Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis. *Am J Prev Med.* 2012;42(5):525-38.

²⁶ Gunn J, Diggins J, Hegarty K, Blashki G. A systematic review of complex system interventions designed to increase recovery from depression in primary care. *BMC Health Serv Res.* 2006;6:88.

component of collaborative care is structured and evidence based management plans for depression treatment. Ensuring that care teams are properly resourced to provide additional staff as well as evidence based guideline treatments will be important.

We seek more information on section 4.2.3.1 on the methodology used to identify members who may benefit from CP services. We recommend this risk assessment strategy be based on expert advice and evidence-based best practices. Especially in a high need BH population, often, claims data-based algorithms to identify risk may not be accurate.

We ask for clarification in Sections 4.2.3 and 4.2.3.3 regarding BH CPs. Requiring that “BH CPs must either be a Community Service Agency for the Children’s Behavioral Health Initiative or have agreements with local CSAs for serving children.” We support an approach that ensures adequate access to pediatric BH services. However, given the already limited access to BH services, especially in certain geographic areas, we caution an approach that may exclude critical programs that focus on adult care only. We recommend that, in developing the contracting requirements for BH CPs, behavioral health experts are consulted to ensure adequate breadth, scope, and availability of services in all regions of the state.

We are encouraged by MassHealth’s strong proposal to provide enhanced substance use disorders (SUD) services, including expansion of residential care and recovery supports. We also support MassHealth’s exploration of preventive models such as Screening, Brief Intervention and Referral to Treatment (SBIRT), and encourage MassHealth to implement these models as part of its strategy to address SUD. Productive collaboration between DPH and MassHealth will bring in more federal resources to address an overwhelming need for SUD treatment services, particularly for residents struggling with opioid addiction. We also support MassHealth’s undertaking to address Emergency Department boarding and enhance diversionary levels of care to meet the needs of members within the least restrictive, most appropriate settings.

Long-Term Services and Supports

We support MassHealth’s plan to phase in integration of LTSS into ACOs, and the utilization of LTSS CPs to offer care coordination and LTSS services. MassHealth should ensure that ACOs rely on community-based providers’ expertise in serving people with disabilities and not “over-medicalize” the LTSS needs of members, while relying on evidence-based best practices. It is important to ensure that changes made to LTSS services, payment, and coordination are based on an evaluation of the current gaps in the system to address those unmet needs and are designed to ensure optimal functioning for patients. Given this is a novel level of integration, active, continued, and meaningful engagement with stakeholders is essential for design, implementation, and evaluation of LTSS services as described in the waiver proposal.

Population Health and Prevention

Social Determinants of Health

We strongly support that the proposed restructuring framework incorporates linkages to social services in an effort to address social determinants of health, including designating a portion of DSRIP funds for “flexible services.” As part of ensuring meaningful ACO collaboration with social services providers, we seek to better understand how DSRIP funds will reach these providers. While DSRIP funds will clearly be directed to BH and LTSS CPs for infrastructure and care coordination, it appears that social service providers do not receive direct DSRIP funding as they are not “certified” community partners.

In determining the criteria that must be met to pay for such flexible services, we urge MassHealth to innovate around how to use DSRIP funds to address social determinants of health. We support the suggestion by Health Care For All of a social services “hub.” Such a hub can offer a single point of coordinated access to a wide range of social services which have a documented impact on health outcomes and on reducing the cost of care. A hub model could work with multiple ACOs to bridge medical and social service systems, providing culturally and linguistically competent services, engaging multiple social services agencies, and providing access to medically beneficial, evidence-based programs in each geographic region. With any model, MassHealth should work to promote access to all available services, such as the Supplemental Nutrition Assistance Program (SNAP) and housing supports.

Community Health Workers

We also strongly support strengthening the role of community health workers (CHWs) in connecting people to care resources and promoting overall health. Including CHWs as part of health care teams has been shown to contain costs by reducing high risk. CHWs also improve access to primary care, improve quality of care, and improve health outcomes by improving use of preventive services and offering chronic disease self-management support. They offer family-centered care through maternal-child home visiting and perinatal support. In particular, Massachusetts has been recognized in a leader in utilizing CHWs for health insurance enrollment and community outreach.²⁷ CHWs have a particular role to play in improving LTSS services in the home and community and for senior care.

While ACOs will have flexibility in how to structure care teams, including CHWs, we recommend that the role of CHWs be more formally incorporated into the ACO models. We recommend MassHealth utilize the experience of DPH for effective deployment of community health workers within ACOs. In particular the community-based programs funded by the Prevention and Wellness Trust Fund that utilize CHWs should be tapped for best practices for effectiveness. All CHW in ACO models should be required to be certified by DPH to ensure quality and standard practice. Additional best practices may be found from Medicaid models in Minnesota and CMMI-funded initiatives. An additional local resource is NEHI or Network for

²⁷ <http://content.healthaffairs.org/content/29/7/1338.full>

Excellence in Healthcare Innovation that published an issue brief describing successful implementation of CWH.²⁸

Transparency, Oversight, and Member Engagement

We are pleased that the proposal calls for ACOs to include members in their governance boards and requires ACOs to establish Patient and Family Advisory Councils (PFACs). In order to ensure meaningful engagement, members should be formally integrated as advisors in the design and governance of ACO policies and procedures. In addition, the ACO-level PFACs must coordinate closely with the already established hospital-level PFACs.

Administrative Burden

As the Commonwealth moves towards “value-based payment”, the goal is to reduce waste and improve health outcomes for both the sickest patients as well as maintain wellness in the general population. One aspect of value-based payment is that rather than paying per service – where then the gate-keeping of cost and quality on the payer side -- the responsibility for appropriate and cost-effective care is shifted to the provider side where “outcomes” based on quality metrics are used to determine payment. Current status of administrative burden is contributing to waste of resources, barriers to care access, and ineffective use of provider time that contributes to provider burn out.

Cost to the system of administrative burden

- Administrative costs in the United States consumed an estimated \$156 billion in 2007, with projections to reach \$315 billion by 2018²⁹
- A study in 2013 showed that administrative burden accounts for 25.3% of U.S. hospitals expenditure³⁰
- The United States spends 30-70% more on administrative costs compared to similar developed countries. This included publicly administered insurance programs.³¹

Cost to Providers of administrative burden

- In the United States, administrative tasks consumed 13.5 percent of physicians' time, valued at \$15.5 billion.
- A 2014 survey of over 4000 physicians found the average doctor spent 8.7 hours per week (16.6% of working hours) on administration. Psychiatrists spent the highest proportion of their time on administration

²⁸ http://www.nehi.net/writable/publication_files/file/jhf-nehi_chw_issue_brief_web_ready_.pdf

²⁹ Collins SR, Nuzum R, Rustgi SD, Mika S, Schoen C, Davis K. How health care reform can lower the costs of insurance administration. Issue Brief (Commonw Fund) 2009;61:1–19.

³⁰ A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far. David U. Himmelstein, Miraya Jun, Reinhard Busse, Karine Chevreul, Alexander Geissler, Patrick Jeurissen, Sarah Thomson, Marie-Amelie Vinet, and Steffie Woolhandler Health Aff September 2014 33:91586-1594

³¹ Wikler, Elizabeth, Peter Bausch, and David M. Cutler. 2012. "Paper Cuts: Reducing Health Care Administrative Costs." Washington, DC: Center for American Progress.

(20.3%), followed by internists (17.3%) and family/general practitioners (17.3%). Those in large practices, those in practices owned by a hospital, and those with financial incentives to reduce services spent more time on administration.³²

Barrier to care access due to administrative burden

- Medicaid administrative burden is described as a barrier to access for Medicaid patients. A number of primary care doctors and specialists do not take public insurance due to the “hassle” factor of paperwork.³³

Given the above data, we recommend careful consideration of new tasks added to the workload of primary care providers and to physicians. Addressing this issue of administrative burden may also improve provider participation rates in Medicaid, especially in fields like behavioral health where there is a concerning provider shortage.

With more emphasis on practicing to top of license many administrative tasks can be done by other types of providers or employees of an ACO. Some utilization management activities may be addressed by the value-based nature of reform which changes the incentive from volume to value. As administrative burden may be reduced, the goal should be to return that time to providers to apply to patient care.

Addressing Barriers to Care Coordination and Data Sharing

Integrated and coordinated care is the gold standard for whole person care. However, the healthcare system, Electronic Health Records (EHRs), legal parameters, and other factors often pose barriers to successful coordination, sharing of data, and true whole person care. Past attempts at integrating care have led to mandates on providers to share health information while legal or privacy obligations prevent sharing of that same protected health information. While there are some genuine legal barriers, more often, there are misconceptions and overly conservative interpretations of HIPAA by hospital administrators and legal advisors.³⁴ Dedicated discussion with health care administrators is necessary to clarify the allowance within HIPAA to share information for the sake of patient care. For the scope of reform envisioned by MassHealth, it is essential to ensure misinterpretation of HIPAA does not result in unnecessary barriers to care coordination.

The barriers to information sharing is of particular concern in the area of behavioral health as privacy laws often prevent sharing of the very BH and substance abuse data that would assess risk, help identify patient needs, or allow care coordination. For those ACOs that utilize a contracted behavioral health carve out, the operational and legal requirements to allow sharing of behavioral health information between medical and behavioral health providers would need to be clearly defined. Further EHR penetration among BH providers is low, limiting the ability to integrate BH providers with medical providers whose clinical

³² http://org.salsalabs.com/o/307/images/Physician%20admin%20time_IJHS.pdf

³³ P. J. Cunningham and A. S. O’Malley, “Do Reimbursement Delays Discourage Medicaid Participation by Physicians?” *Health Affairs*, Jan./Feb. 2009 28(1): w17–w28.

³⁴ <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/HIPAA-Privacy-Rule-and-Provider-to-Provider-Communication.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR:+No+local+token>

operations rely on EHRs. Especially in the case of reporting BH quality metrics at an ACO level, lack of EHR integration may be challenging. In order for BH integration to be successful, it is necessary to ensure primary care providers receive the BH information they need to support and participate in true BH integration. Many of the EHR incentives, such as “meaningful use” did not include BH providers and for EHR uptake similar incentives or support will likely be required.

Another area of concern for data sharing is the coordination with schools for pediatric patients. Good coordination with school is essential for whole child care. It is critical to ensure that adequate health information exchange occurs between the school, families, and providers on a child’s health care needs. However, currently, the ability to share information between schools and medical professionals can be limited by the need to respect HIPAA. For instance, sending information via non-secure fax to a school may lead to a potential violation of privacy. Current interpretation of HIPAA allows a fax to be sent from a provider to a school when “Both the disclosing and receiving entity have in place “reasonable and appropriate administrative, technical, and physical safeguards”³⁵ to protect the privacy of the PHI that is disclosed.” However, the ability to assess the existence of such safeguards may be difficult for the sending provider. Addressing these current barriers to needed care coordination for pediatric care may require partnership with the Department of Education.

Patient Safety

As we move forward to much needed reform for better integration and care coordination, it is essential that initiatives that currently support patient safety do not get abandoned or sidelined. A recent study from Johns Hopkins published in the British Medical Journal that hospital errors count as a 3rd leading cause of death in the U.S.³⁶ Continued emphasis on preventable harm is essential to ensuring a safe, high quality system that promotes good outcomes.

Any innovation introduces new risks. One illustrative example is that of Health Information Technology (HIT). This innovation that address certain safety issues has been shown to create new patient safety concerns and patient harm.³⁷ For that reason, the National Quality Forum (NQF) launched an initiative to measure and address HIT safety³⁸ and HHS published the Health Information Technology Patient Safety and Surveillance Plan.³⁹ Any infrastructure supports or incentives for EHRs should utilize the most current guidance and best practices from HIT patient safety experts and federal agencies. HIT vendors should also be required to ensure their products meet such safety standards. All stakeholders who are reimbursed for services and products in healthcare delivery should be held accountable for quality and safety according to evidence-based standards.

³⁵<http://www.mass.gov/eohhs/gov/laws-regs/privacy-security/school-health/hipaa-and-school-health-frequently-asked-questions.html#coveredEntity>

³⁶ <http://hub.jhu.edu/2016/05/03/medical-errors-third-leading-cause-of-death/>

³⁷ http://www.jointcommission.org/assets/1/18/SEA_54.pdf

³⁸ <http://www.qualityforum.org/ProjectDescription.aspx?projectID=77689>

³⁹ https://www.healthit.gov/sites/default/files/safety_plan_master.pdf

Applying Lessons Learned from Past MassHealth Initiatives

In taking the lead with system transformation, Massachusetts has been a “test case” for many types of reform initiatives on medical home transformation, behavioral health integration, community-based supports, and other types of reform. There is a wealth of experience that clinic directors, front line providers, community-based organizations, patients have that may offer an important different perspective and understanding of operational issues than system-level administrators. A mechanism should be established to leverage this existing experience and knowledge to identify and mitigate barriers to transformation and promote greater efficiency. This may allow better understanding of barriers to transformation that may require infrastructure investments, technical assistance, member education, or changes in funding structure.

Identifying and Disseminating Best Practices

Successful transformation requires rapid cycle change and creativity that can be difficult in large systems or when there are multiple barriers. This has also been faced by the Veterans Affairs system for their improvement efforts. In response to this, the VA launched a “Diffusion of Excellence” initiative and created the “Innovators Network” to empower employees to contribute to improvement.⁴⁰ Another component is the governance model that brings together decision makers from different parts of the VA system to reduce silos. Further, the VA has created a “shark tank” type of competition to have improvement ideas tested and vetted for support and dissemination.⁴¹ Such a model could be considered by MassHealth to promote healthy competition between ACOs with shared learning. In particular, this kind of “diffusion of excellence” model from the VA system may work for sharing best practices for flexible funding for social determinants of health.

Ongoing Stakeholder Engagement: Oversight Steering Committee

During detailed program development and implementation stages there should be stakeholder engagement to ensure the new system is fair and functions well for all stakeholders. Specifically there should be engagement with the end users such as front line clinicians and patients.

As evidenced by the experience of both Primary Care Payment Reform (PCPR) and OneCare, at the time of rollout and implementation, there were unexpected challenges for both providers and members. Often, solutions or workarounds can require alterations in significant aspects of outreach, care delivery, payment, or types supports. One solution to ensure transparency and inclusion for end-to-end implementation is to establish and oversight Steering Committee modeled after the Implementation Council for the One Care program.

⁴⁰ <http://www.innovation.va.gov/innovatorsnetwork/>

⁴¹ <http://www.blogs.va.gov/VAntage/28017/san-francisco-vamc-shark-tank/>

The Steering Committee should have significant authority and be required to approve any significant changes from the approved 1115 waiver. The oversight Steering Committee should have both clinical and non-clinical members, key state legislators, sister agencies (e.g. DPH, Education, Transportation), and other policymakers. The Committee should serve as a public forum to provide accountability to make sure the demonstration is meeting its goals, identify areas for improvement, help to troubleshoot unexpected challenges. The minutes of these meetings should be available on the public record. In addition, experience of reform can be monitored through ongoing key informant interviews, focus groups, and informal feedback mechanisms from the front lines of care.

Thank you again for this opportunity to comment on the proposed 1115 waiver submission to redesign MassHealth. Please contact Dr. Audrey Provenzano or Dr. Amy Baughman at massachusetts@drsforamerica.org with questions or comments. We look forward to continuing to inform and assist your efforts as you move forward with implementation.

Sincerely,

Audrey Provenzano, MD MPH

Sonali Saluja, MD MPH

Amy Baughman, MD MPH

Massachusetts Chapter Health Reform Leadership Team



East Boston Neighborhood Health Center

July 15, 2016

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place
11th Floor
Boston, MA 02108

To Whom It May Concern:

The East Boston Neighborhood Health Center (as used further in this letter, "EBNHC" or "the Health Center") is pleased to submit comments to the Executive Office of Health and Human Services on the Office's proposal to renew the Commonwealth's existing Medicaid waiver under section 1115 of the Social Security Act. We appreciate that the Office has solicited comments from the public on this important initiative and thank you for giving us an opportunity to comment.

Our comments relate generally to section 6 of the Proposed Waiver: "Safety Net Care Pool Restructuring." As we understand the proposal, the Commonwealth proposes to create five streams of funding to re-design the Safety Net Care Pool (as used further in this letter, "the Pool"). These streams of funding are:

- o Delivery System Reform Incentive Program (DSRIP);
- o Public Hospital Transformation and Incentive Initiative;
- o Disproportionate Share Hospital allotment pool;
- o Uncompensated Care Pool; and
- o Connector Care Affordability Wrap.

As part of the proposed restructuring, the Commonwealth has proposed to discontinue the Delivery System Transformation Initiatives (DSTI) program that was approved in December, 2011 to provide incentive payments to seven hospitals to undertake delivery system reform activities. As the Commonwealth notes, these payments were necessary to provide "ongoing operational support because of their high public payer and low commercial payer mix." Demonstration Project Amendment and Extension Request (hereafter, "Extension Request") at 54. Under the proposed pool redesign, DSTI payments would be re-purposed into uses related to delivery system reform (which would be made through the new DSRIP program) and uses related to support for ongoing operations.



This new set of safety net payments targeted toward support for ongoing operations will be "available to a broader set of providers that serve a high proportion of MassHealth and uninsured patients." Extension Request at 57. EBNHC agrees with this statement entirely and applauds the Commonwealth for recognizing that the current DSTI payments were focused on a narrower universe than was necessary to support the delivery system re-design that is fundamental to the waiver renewal. However, we are concerned that the Commonwealth's proposal remains "hospital-centric" in the sense that, while payments are made to a broader class of providers, each of those providers are hospitals.

In our view, hospital-based and affiliated community health centers will play a crucial role in the system re-design that the Commonwealth is envisioning. This is so for several reasons:

- o The mission of health centers is to focus on primary care. Health centers help to ensure a healthier population that will not require more complex medical care.
- o Health centers can operate more cost effectively, because they rely on the provision of care through mid-level practitioners.
- o The Commonwealth notes that one of the goals of the waiver extension is to "improve integration among physical health, behavioral health, long-term services and supports, and health-related social services." Extension Request at 2. Community health centers are already familiar with the importance of this integration. Indeed, EBNHC is already affiliated with North Suffolk Mental Health Association and that collaboration will grow deeper in the year ahead as the two organizations negotiate a possible merger.
- o Health centers serve a much higher proportion of MassHealth and uninsured patients than many hospitals. In the case of EBNHC, for example, fully 85% of our revenue is derived from Medicaid, dual-eligible Medicare/Medicaid programs, and the safety net care pool. We therefore are clearly described by the recipients of the prior DSTI program: "high public payer and low commercial payer mix."

Accordingly, we would request that the Commonwealth revise its proposal to target a portion of these new safety net payments directly to EBNHC.¹ We recognize that this would be a deviation from the DSTI program that the new payments will replace. However, such a modification to the proposal would be fully consonant with the Commonwealth's goals. EBNHC fully supports the concept of accountable care organizations and believes that it can play an integral role in

¹ We recognize that these safety net payments are likely treated as disproportionate share hospital (DSH) payments under § 1923 of the Social Security Act which are targeted at hospitals and are subject to the statewide cap set forth in § 1923(!)(2). Because EBNIIC sites are provider-based under 42 C.F.R. § 413.65, we believe that these payments could flow through Boston Medical Center and appropriately be treated as DSH payments.



Medicaid ACO development. It can help to achieve greater collaboration of patients' physical and mental health needs.

We are requesting an allocation of \$12 million per year under our request, less than 2% of the \$675 million average annual amount that the Commonwealth has allocated for this revenue stream. By way of comparison, and including funds made available under the prior DSTI program, Carney Hospital (which is roughly 60% the size of EBNHC in terms of annual revenue) received \$7.7 million in special supplemental payments. Applying that ratio to EBNHC revenue equals roughly \$12 million, which is the basis for our request.

In conclusion, EBNHC is anxious to work with the Commonwealth and to be a part of the revised waiver initiative. We believe, however, that a dedicated revenue stream to EBNHC will help to ensure the success of the Commonwealth's initiative for the reasons set forth in our comment. We would sincerely appreciate your support for our request as you finalize your submission to CMS and would be pleased to answer any questions about our proposal.

Sincerely,

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Emani J. DeAraujo, Esq.
Vice President & General Counsel



July 8, 2016

Comments on MassHealth Section 1115 Demonstration Project and Extension Request

Prepared by Ethos

Ethos is an independent, community-based not-for-profit organization based in southwest Boston. In operation for 43 years, its mission is to promote the independence and well-being of the elderly and disabled through the delivery of high quality and affordable long term support services. It is a state-designated Aging Services Access Point and a city-designated Elder Nutrition Project. It currently assists over 3,000 elderly and younger disabled consumers who seek to stay at home and in their communities for as long as possible.

Ethos wishes to go on record as formally endorsing the comments submitted by Mass Home Care. In particular, Ethos wishes to stress two recommendations made by Mass Home Care on June 24, 2016:

1. Conflict-free care coordination for LTSS should be strengthened. It should not be limited to LTSS assessments but should extend to on-going care coordination. This is the role that Aging Service Access Points have played in the state Home Care program for 40 years. Entities that provide direct LTSS should be limited in the number of self-referrals they are able to make when assessing enrollee LTSS needs. This is an important protection against self-dealing.
2. Enrollment counseling should be performed by SHINE counselors. The network that currently counsels consumers on Medicare and One Care enrollments should be utilized to counsel enrollees on Medicaid ACOs. The proposed replication of this function within MassHealth's existing customer service system would be duplicative and wasteful. Consumers would be better served by experienced and trained SHINE counselors, many of whom are volunteers.



July 17, 2016

Secretary MaryLou Sudders
Executive Office of Health and Human Services
Assistant Secretary Tsai, Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: 1115 Waiver Proposal

Dear Secretary Sudders and Assistant Secretary Tsai:

Thank you for the opportunity to comment on the MassHealth draft 1115 waiver to the Centers for Medicare and Medicaid Services (“CMS”). Headquartered in Waltham, Massachusetts, Fresenius Medical Care North America (Fresenius) is the largest provider in the U.S. of products and services for patients undergoing renal dialysis due to end stage renal disease (“ESRD”). Operating approximately 2,200 outpatient dialysis clinics, Fresenius provides dialysis services to an estimated 180,000 individuals with kidney failure in North America, including 2,700 patients at 33 clinics in Massachusetts, and treating approximately 45% of the Commonwealth’s residents with ESRD requiring renal dialysis,

Over the past three years Fresenius has met on several occasions with MassHealth and members of the Health Policy Commission (“HPC”) to discuss the development of a renal-specific ACO in Massachusetts that could provide all currently covered medical benefits to the ESRD population under an integrated, capitated model. Although the MassHealth draft 1115 Waiver refers generally to ACO model development in Massachusetts, it does not include a specific request for the authority to include **both** Medicare and Medicaid beneficiaries in a capitated alternative payment for a disease specific chronic condition, such as ESRD. The payer mix for ESRD is approximately 80% Medicare, 40% duals and 7 % Medicaid primary. The inclusion of Medicare beneficiaries in an alternative payment model for ESRD beneficiaries is essential, as these small patient number / high cost patients makes a Renal ACO different from other population-based ACOs.

Due to the high reliance on government payers, in order for a Renal ACO to be feasible in terms of patient numbers **Medicare beneficiaries must be permitted to enroll in a state-run model under Chapter 224**. The Centers for Medicare and Medicaid Innovation (“CMMI”) has developed an ESRD ACO model that is currently under Demonstration, however, the design and limitations of this model results in few dialysis provider participants, and none in Massachusetts. Additionally, the CMMI ACO model for ESRD permits enrollment of Medicare beneficiaries only, **excluding Medicaid beneficiaries**.

Renal failure is a costly condition. The HPC's Cost Trend Report found that five percent of patients account for nearly half of all spending among the Medicare and commercial populations in Massachusetts, and that significant savings can be captured by focusing on a subset of the population with identifiable and predictable characteristics. Renal failure is identified in this report as a high cost and persistently high cost medical condition. The Commonwealth's Center for Health Information and Analysis ("CHIA") has documented that the Chronic Kidney Disease ("CKD") and ESRD populations as persistently costly. The total average annual cost of care for Medicare beneficiaries with ESRD on dialysis is approximately \$75,000, approximately 10 times the cost of a Medicare beneficiary without ESRD. Nationwide, although ESRD beneficiaries comprise approximately 1 percent of the Medicare population, they account for nearly 8 percent of Medicare spending. The majority of individuals diagnosed with ESRD have common comorbid conditions such as diabetes and hypertension, and many also suffer from congestive heart failure, cardiovascular disease, hereditary hemolytic or sickle cell anemia and other common conditions

Due to the high cost of care for dialysis patients and their highly specialized needs, ESRD beneficiaries are likely to be considered the high-cost outliers by general, broad population-based ACO programs. Although general ACOs have an obligation to furnish renal dialysis services under the ACO requirements of Chapter 224, such ACOs do not have the specialized resources or experience to coordinate the bulk of renal-related medical care to this group of patients in the way that a Renal ACO would be designed to deliver. Given the complex and costly nature of this patient population, some ACOs may, in fact, wish to exclude ESRD beneficiaries from their risk-bearing models.

In addition to the multiple responsibilities with which the HPC is charged, Section 7(f) of SECTION 15 of The Act requires the commission to coordinate multiple public expenditures, any funding available through the Medicare program and any funding expended under the MassHealth section 1115 demonstration waiver.

"(f) To the maximum extent feasible, the commission shall seek to coordinate expenditures from the Healthcare Payment Reform Fund with other public expenditures from the Prevention and Wellness Trust Fund, the E-Health Institute Fund, the Massachusetts Health Information Exchange Fund, the Distressed Hospital Trust Fund, the Health Care Workforce Transformation Trust Fund, the executive office of health and human services, any funding available through the Medicare program and the CMS Innovation Center, established under the federal Patient Protection and Affordable Care Act and any funding expended under the Delivery System Transformation Initiative Master Plan and hospital-specific plans approved in the MassHealth section 1115 demonstration waiver."

Additionally, the Legislature recognized that the ability to drive transformational health care delivery system change is dependent upon organizing alternative payment models across multiple payer sources. Therefore, the Legislature set out in SECTION 28o, subsection (b):

“The executive office of health and human services shall seek a federal waiver of statutory provisions necessary to permit Medicare to participate in such alternative payment methodologies. Upon obtaining federal approval for Medicare participation, such participation shall be commenced and continued and the executive office shall seek extensions or additional approvals, as necessary.”

Implementing improved care delivery models for ESRD patients now will lay the critical groundwork for decreasing costs and improving outcomes for this costly, medically complex and rapidly growing patient population. As an increasing number of people are diagnosed with diabetes mellitus, hypertension and CKD, there will be a corresponding increase in the incidence of individuals diagnosed with ESRD. As a result, the need to address outcomes and costs for this unique population will only become more acute over time. Failure to include in alternative payment models 80% of Massachusetts residents with ESRD who have Medicare as their primary payer may result in little meaningful change in the ways that care is delivered to this small, complex costly patient population in Massachusetts. We urge you to revise the 1115 Waiver to ensure that CMS will permit Medicare beneficiaries with ESRD to participate in alternative payment models developed in accordance with the requirements under Chapter 224.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, reading "Cathleen O'Keefe". The signature is written in a cursive style and is positioned above a horizontal line.

Cathleen O'Keefe, RN, JD
Vice President, Government Affairs
Fresenius Medical Care North America

cc: Commissioner David Cutler, Chairman Cost Trends and Market Performance
Committee, Health Policy Commission

David Seltz, Executive Director, Health Policy Commission



HEALTH CARE FOR ALL

One Federal Street
Boston, MA 02110
617.350.7279 **Office**
617.350.0974 **TTY**
800.272.4232 **HelpLine**

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Comments on MassHealth 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai,

On behalf of Health Care For All (HCFA), thank you for the opportunity to comment on the MassHealth Section 1115 Demonstration Project Amendment and Extension Request (“Waiver Request”). Through this Waiver Request, MassHealth has an opportunity to promote approaches to payment reform that fundamentally transform the way care is delivered through accountable care organizations (ACOs). ACOs should deliver high quality, high value care that treats the individual as a whole person and ensures coordination of care, improved communication, member support and empowerment, and ready access to health care providers, services and community-based resources and supports. In our view, success of this effort will be measured by the extent to which member experience, quality of care and health outcomes are improved. We offer the following comments and recommendations in response to the Waiver Request released for public comment on June 15, 2016.

While the Waiver Request outlines a framework for changes to MassHealth’s payment system and its delivery of care, implementation will be the true test for the success of the proposed redesign. The Waiver Request is just the start of a much longer implementation process, which will require close monitoring and input by members, stakeholders, and affected communities. We urge MassHealth to continue the open, collaborative process as implementation proceeds.

Member Protections

ACOs must be built upon a strong foundation of robust consumer protections that ensure MassHealth member rights are safeguarded and access to care is not impeded. As new models of care and payment are developed and providers take on increased risk, reward, and responsibility, it is important that MassHealth ensures that the evolution and application of consumer protections keep pace. MassHealth should prioritize the inclusion of a broad array of consumer protections as outlined in this section, as well as areas discussed in other sections such as heightened quality reporting requirements, consumer-friendly notice and transparency requirements, emphasis on member outreach and education, payment design features, and adequate protections concerning enrollment, attribution, and data sharing.

Appeals and grievances

Increased levels of risk for financial losses coupled with greater influence over utilization management shifts the balance of incentives for providers, increasing the potential for ACOs to stint on care. Because an individual’s treating provider may have a direct financial relationship with the ACO, grievance and appeals processes should be robust, easily accessible, and designed to address this unique context.

We support the Waiver Request’s specification that MassHealth members will continue to have access to all existing grievance and appeals processes currently available, and that fixed enrollment period determinations, if implemented, will be appealable upon implementation (4-5, 29). With the development of new complicated

ACO models and proposed enrollment lock-ins, it will be particularly critical for members to have timely access to appeals and grievance procedures to ensure that members get the care they need and that ongoing care is not interrupted.

We also strongly support that the Waiver Request states that members in ACO models will have access to ACO-specific grievance processes (4-5). However, we seek additional information, as the reference to ACO-specific grievance processes only appears in the Executive Summary and is not included in section 4.1.8 on “Member Rights and Protections.”

Under M.G.L. c. 176O, § 24, the Office of Patient Protection (OPP) must promulgate regulations necessary for risk bearing provider organizations (RBPOs) to implement internal appeals and grievance processes. In addition, OPP must establish an external review process for patients of RBPOs. These provisions were included under Chapter 224 of the Acts of 2012 to directly protect against the potential for providers to stint on necessary care as they are taking on more financial risk, and to allow consumers to formally voice concerns that may arise in the ACO context, such as denials or restrictions on referrals to providers not affiliated with the ACO; denials or restrictions on the type or intensity of treatments or services; patient choices and preferences not reflected in the treatment plan; or insufficient, inadequate or omitted testing or assessments. Providers who stand to share in ACO savings should be required to provide members with a description of all possible treatment options and the provider’s basis for deciding on the recommended treatment. Members who are concerned about a provider’s decision should have access to a process to seek a second opinion, outside of the ACO network, that does not incur additional cost sharing.

The Waiver Request states that all MassHealth ACOs, with the exception of those in the pilot, must meet the Massachusetts Health Policy Commission’s (HPC) ACO certification requirements. These requirements include as a prerequisite to certification that an ACO “is in compliance with the HPC’s Office of Patient Protection guidance regarding an appeals process to review and address patient complaints and provide notice to patients.”¹ The OPP approved Interim Guidance on establishing appeals processes for patients of RBPOs on May 6, 2016, including a sample notice.^{2,3} We strongly urge MassHealth to specify in the Waiver Request that all ACO models comply with this Interim Guidance and subsequent final regulations for internal and external appeals once promulgated. Alternatively, at a minimum, MassHealth should establish an equivalent, parallel process for all ACO models and provide details of how that process will function to ensure the same level of consumer protections as the procedures established through OPP. In addition, ACOs should be required to report the number and types of internal and external grievances and appeals to the external ombudsperson and to MassHealth in order to identify systemic issues, including patterns of underservice or underutilization.

Monitoring underutilization

Another way to safeguard against potential incentives to deny or limit care, especially for members with high risk factors or multiple health conditions, is to track and monitor under-service and underutilization through both concurrent and retrospective methodologies. Under-service refers to the systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value-based payment arrangements.⁴ Safeguards against underservice should be incorporated at a number of different levels, including payment design features that impact an ACO’s or a provider’s

¹ <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/certification-programs/aco-certification-final-criteria-and-requirements.pdf>.

² <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/regulations/20160506-bulletin-rbpo-appeals-final.pdf>.

³ <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/regulations/20160506-sample-notice-rbpo-appeals-final.pdf>.

⁴Id. at 2.

behavior and additional safeguards layered on top of a program's internal incentive structure to further minimize the risks of under-service and member selection.

ACOs should be required to establish internal monitoring mechanisms as part of agreements with participating provider groups and individual providers, and/or via ACO contracts with MassHealth. Specifically, ACOs should establish performance standards, monitor for inappropriate practices including under-service and member selection, hold providers accountable, and report publicly on the information gathered through internal monitoring.

A second layer of safeguards should include MassHealth's retrospective monitoring and analysis of claims data on an annual basis. As the payer, MassHealth can play a central role in monitoring for under-service and member selection as it would monitor for over-service, fraud and abuse. Changes in utilization could serve to identify stinting on care and variations in the risk profile of an ACO over time could suggest avoidance of high-risk members. At a minimum, MassHealth should monitor under-service by assessing utilization, total cost of care, cost of care by service type, and health outcomes over time to identify patterns of variation. In addition, MassHealth should identify populations that may be at particular risk (i.e. characterized by specific clinical conditions and/or socioeconomic factors), and conduct population-specific analyses. When potential under-service is flagged via monitoring claims data, additional follow-up should be performed to assess the root cause of the variation, to evaluate whether repeated or systematic under-service and/or member selection is likely to have occurred.

Additional methods of identifying problems related to underutilization include soliciting member feedback through survey-generated measures, including patient reported outcome measures, and capturing member feedback through member advocacy services such as the ombudsperson resource, both of which are discussed in greater detail in other sections of these comments. MassHealth should also survey members who disenroll from ACOs to uncover any systemic issues with an ACO or its care.

Member Engagement

Ensuring that delivery of care meets the needs of members and their families requires meaningful engagement of members and families at both the individual and governance levels.⁵ This entails formally integrating members as advisors in the design and governance of policies and procedures, as well as ensuring that members (and/or their family member(s) or caregivers) understand their own role in the care process and are confident in taking on that role.

Memberrepresentation in ACO g overnance bodies and PFACs

Individual patients and consumers are the heart of the health care system, and must be valued members of ACO design and governance teams. Patient and family-centered care means bringing the perspectives of members and families directly into the planning, delivery, and evaluation of health care, and thereby improving its quality and safety. When consumers and families, providers, and health care administrators work in partnership, the quality and safety of health care rises, costs decrease, and provider and consumer satisfaction increase.⁶

⁵ For a thorough definition of meaningful engagement and what it entails, please refer to the framework described in Carman, K.L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., Sweeney, J. (2013). Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs* 32(2): 223-231.; See also Millenson, M.L. (2015) Building Patient-Centeredness in the Real World: The Engaged Patient and the Accountable Care Organization. Health Quality Advisors, available at: <http://www.nationalpartnership.org/research-library/health-care/building-patient-centeredness-in-the-real-world.pdf>;

HCFA can also provide the following: HCFA's Principles to Achieve Meaningful Patient and Family Engagement in Care and Multidimensional Framework for Patient and Family Engagement in Health and Health Care: A Model for Massachusetts(2015).

⁶ Institute for Patient- and Family-Centered Care. (2014). *Advancing the Practice of Patient- And Family-Centered Care: How To Get Started*. Bethesda, MD.

We applaud MassHealth for including in the Waiver Request a requirement that all ACOs include patient/consumer representation in their governance structure and establish a Patient and Family Advisory Committee (PFAC) as part of the HPC's certification requirements (23). We urge MassHealth to ensure meaningful involvement of members and consumer advocates in governing bodies and PFACs in the following ways:

- Sufficient and appropriate representation on the ACO's Governance Board. We recommend building on the HPC's requirement to have at least one patient or consumer advocate in the governance structure to requiring at least two members, family caregivers, and/or consumer advocate representatives on an ACO's governance board, who do not have financial interest in the ACO. Having multiple consumer advocates and member representatives on a governance board will ensure more sufficient representation of the ACO's member population and avoid isolating the representative. ACO governing boards should also include representatives from community-based organizations, including those concerned with public health. In addition, ACOs should ensure consumer advocate and member representation on the governance board reflects the diverse member population it serves.
- Representatives are meaningfully engaged in decision-making. All representatives on the governance entity (including consumer advocate and member representatives) must have an equal seat and say at the table and an opportunity to share their perspectives and influence decisions as they are being made.
- Patient and Family Advisory Councils establish formal procedures and address substantive issues. PFACs should address issues related to the ACO's quality, member experience, and affordability goals from the member perspective, including continuous quality improvement. Councils should:
 - Have membership that currently receives care at the ACO. Membership should reflect the populations/community served by ACO (including age, race, ethnicity and language preference).
 - Hold meetings at least quarterly, with agendas developed in collaboration with the group, and distributed in advance of the meeting.
 - Regularly share member satisfaction/complaints and other relevant data.
 - Have a documented "feedback loop" in which recommendations are carried up to the leadership of the ACO. Appropriate follow-up should be then demonstrated to the governance entity to ensure accountability.
 - Develop and implement written policies and procedures that include, at a minimum, purpose and goals, membership eligibility, officers, orientation and continuing education, and roles and responsibilities of members.
 - Have a named staff member responsible for managing the work of the PFAC and integrating the work of the PFAC in other ACO committees.
 - Write an annual report that includes financial performance information and summarizes the work of the PFAC which is provided to MassHealth and made publicly available.
 - Develop and implement a plan to regularly communicate with members, including a process to receive direct input and recommendations from members and communicate back with members regarding any responses or actions taken.
 - Coordinate closely with the already established hospital-level PFACs.
- All representatives receive orientation and onboarding support to facilitate their successful participation, as well as ongoing opportunities to connect with peers in other ACOs. Successful partnerships with consumer advocate and member representatives on ACO governing boards and PFACs require a greater level of support from the ACO, including providing orientation and onboarding support. ACOs should describe in their governance board and PFAC applications an orientation and onboarding process for consumer advocate and member representatives. We

encourage MassHealth to offer guidance and assistance to ACOs with respect to developing onboarding and orientation processes. MassHealth should also facilitate an ongoing process to allow all consumer representatives on these boards to learn from each other, share best practices, and interact with experts on issues related to ACOs.

Finally, it is important for ACOs to monitor and continuously assess the degree to which consumer advocate and member representatives are meaningfully engaged in governance structures and whether changes the ACO makes are actually improving member care experiences and outcomes. This information must be part of MassHealth's evaluation of ACOs. We encourage MassHealth to work with ACOs and consumers to determine the most appropriate ways to track and share this information.

Member engagement in monitoring and oversight

Continuous member engagement will be critically important throughout the design, implementation and evaluation processes of the ACO program. We support MassHealth's determination to continue to seek input from technical advisory groups on key topics, such as certification criteria for Community Partners, quality and member experience measures, and other ACO model details (20). We also support MassHealth's plans to establish an advocate and member advisory group to ensure that members have an appropriate forum to provide input to support design, implementation planning and roll-out (20). We recommend that MassHealth establish this advisory group as a formal Steering Committee modeled after the One Care Implementation Council. The Steering Committee should have significant authority, and include MassHealth members, community-based organizations, and social services agencies, as well as key state legislators and other policymakers. In addition to the functions outlined by MassHealth, the Committee should serve as a public forum to provide accountability to make sure the ACO program is meeting its goals, and to identify areas for improvement.

MassHealth and the ACO Steering Committee should continuously monitor and evaluate the program's implementation through development and dissemination of a public dashboard. This will also require publicly setting system-wide, measurable goals for what we hope to accomplish by moving care to ACOs, such as reduced hospitalizations, reduced institutionalization, improved quality of life, improved health outcomes, and reduction of health disparities.

Member engagement in care

Numerous studies show that individuals who are more actively involved in their health care experience better health outcomes at lower costs.⁷ Many health care organizations are employing strategies to better engage individuals, such as educating them about their conditions and involving them more fully in their care.⁸ Such engagement allows individuals and providers to be full partners in care, improving outcomes and lowering costs.⁹

MassHealth should encourage the following approaches to achieve member engagement in direct care:

- *Use shared decision making.* In this approach, members and providers together consider the member's condition, treatment options, the medical evidence behind the treatment options, the benefits and

⁷ Hibbard, J. H., Greene, J., Sacks, R., et al. (2013). When Seeing the Same Physician, Highly Activated Patients Have Better Care Experiences Than Less Activated Patients. *Health Affairs*, 32(7): 1295–1305; Hibbard, J.H., Greene, J. (2013). What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs* 32(2): 207-14; Hibbard, J. H., Greene, J., & Overton, V. (2013). Patients with lower activation associated with higher costs. *Health Affairs*, 32(2): 216–222.

⁸ Health Policy Brief: Patient Engagement," *Health Affairs*, February 14, 2013; Shortell, SM, et al., (2015). An Early Assessment of Accountable Care Organizations' Efforts to Engage Patients and Their Families. *Medical Care Research and Review*, 72(5) 580-604.

⁹ Carman, K. L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., and Sweeney, J. (2013). Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs* 32(2): 223-31.

risks of treatment, and the member's preferences, and then arrive at and execute a treatment plan. Shared decision making often includes the use of decision aids.

- *Use trained health coaches, certified peer specialists and community health workers.* Health coaches provide members with knowledge and awareness of their treatment options, help them to sort out their treatment preferences, and encourage them to communicate those preferences to their health care providers.¹⁰ Certified Peer Specialists and community health workers are additionally helpful, as discussed in greater detail in other sections.¹¹
- *Help members become "activated."* Members who have the skills, ability, and willingness to manage their own health and health care experience have better health outcomes at lower costs compared to less activated members. The "Patient Activation Measure" is a validated survey that scores the degree to which someone sees himself or herself as a manager of his or her health and care. Interventions that tailor support to the individual's level of activation and that build skills and confidence are effective in increasing patient activation.¹²
- *Provide patients with access to all their medical records, including behavioral health records.* Patient portals, which provide members with access to their medical information as well as a means to communicate with their providers, have been shown to increase patient engagement. In addition, opening up behavioral health records to members decreases provider stigma by requiring providers to describe behaviors in non-judgmental terms.¹³
- *Increase patient confidence.* Health confidence measures the individual's level of knowledge, skills, and self-efficacy about taking an active role in their health care and managing their health conditions. Assessing health confidence can result in immediate provider action and lead directly to improved patient engagement. If an individual's health confidence is low, motivational interviewing can be used to help the individual reflect on personal strengths, identify behavioral goals and develop a support plan.¹⁴

ACOs should be required to measure and publically report on these activities and engagement/activation measures in a way that members can understand. Meaningfully engaging members as partners in care and delivering member-centered care that meets the needs of members and families and improves overall health is the best way to encourage members to stay within the ACO when seeking care.

Population Health and Prevention

Social determinants of health and community-clinical linkages

We strongly support MassHealth's proposal to integrate community-based partners and linkages to social services in an effort to address social determinants of health. Given that many MassHealth members may face significant social, economic, and environmental barriers that substantially impact their health, it is critical that ACOs support their members with accessing community resources in their area, and integrate community services into the physical, behavioral, and oral health care provided.

¹⁰ Veroff, D., Marr, A., and Wennberg, D.E., (2013). Enhanced Support for Shared Decision Making Reduced Costs of Care for Patients with Preference-Sensitive Conditions. *Health Affairs* 32(2): 285-93.

¹¹ See, e.g., Keif, et al., (2014). Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence. *Psychiatric Services*. 65(7): 853 (lower relapse rates); Gidugu, et al. (2015). Individual Peer Support: A Qualitative Study of Mechanisms of Its Effectiveness. *Community Mental Health Journal*. 51(4): 445-52. (as an adjunct to traditional mental health services); see also National Coalition for Mental Health Recovery (2014). *Peer Support: Why It Works*. Retrieved from <http://www.ncmhr.org/downloads/References-on-why-peer-support-works-4.16.2014.pdf>.

¹² Hibbard, J. H., Greene, J. (2013). What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs* 32(2): 207-14.

¹³ Kahn, et al., (2014). Let's Show Patients Their Mental Health Records. *Journal of the American Medical Association*. 311(13):1291.

¹⁴ Wasson, J., and Coleman, E. (2014). Health Confidence: A Simple, Essential Measure for Patient Engagement and Better Practice. *Family Practice Management*. 21(5): 8-12.

Specifically, we support MassHealth’s clear expectations for ACOs and community partners to address social determinants of health, including an assessment of members’ social service needs, inclusion of social services in members’ care plans, making referrals to social service organizations, and providing navigational assistance for accessing social services (31). We further support that a portion of DSRIP funding to ACOs will be explicitly designated for “flexible services” to fund members’ social service needs (31-32, 41, 42-43). In determining whether the criteria has been met to pay for such flexible services, we urge MassHealth to take a broad and flexible approach to encourage ACOs to innovate around how to use DSRIP funds to address social determinants of health.

As MassHealth does not plan to designate social services providers as “certified” Community Partners, as is proposed for behavioral health (BH) and long-term services and supports (LTSS) providers, we seek clarification on how ACOs will be held accountable for ensuring that collaboration with social services providers is both meaningful and robust.¹⁵ We recommend that MassHealth require ACOs to detail their plans for these collaborations and use of flexible funding in their RFP responses and in ACO/MCO and ACO/MassHealth contracts.

While the Health Policy Commission’s initial proposed ACO certification criteria contained a requirement that ACOs collaborate with social services and community-based organizations, this requirement was removed in the final approved ACO criteria. As one key reason for removing the criteria, the HPC staff indicated that MassHealth ACOs would have “robust requirements” for collaborating with social services providers. It is critically important for the MassHealth ACO program to live up to this promise, which will have a direct impact across the Commonwealth.

We also seek clarification as to how DSRIP funds will reach social services providers. While DSRIP funds will clearly be directed to BH and LTSS Community Partners for infrastructure and care coordination, social service providers do not receive direct DSRIP funding as they are not “certified” CPs, and instead may receive DSRIP funding indirectly through the ACO flexible services funds. It is critical that adequate DSRIP funding reach social services providers to ensure meaningful, strong and ongoing collaboration between ACOs and community-based social services agencies. For example, social service providers will need upfront investments in order to participate in two-way referral systems with ACOs, building on DPH’s community e-Referral system being established under the state’s State Innovation Model (SIM) grant and the Prevention and Wellness Trust Fund (PWTF).¹⁶

We recommend that MassHealth consult with DPH and incorporate lessons learned from PWTF, especially in regards to community partnerships. Through PWTF, we have learned that effective linkages between

¹⁵ In the New York DSRIP program, Performing Provider Systems (PPSs) are encouraged to engage with Community Based Organizations (CBOs) such that the state stipulates the proportion of funding that the PPS can re-direct to the CBOs themselves. This relationship, however, is only encouraged but not mandated. Although this framework between PPS and CBO is considered to be new and innovative, further improvements are needed to create strong relationships between the PPSs and CBOs, including specific guidance by the state to effectively direct PPSs on how to effectively partner with CBOs. According to a recent Commonwealth Fund report (*Implementing New York’s DSRIP Program: Implications for Medicaid Payment and Delivery System Reform*, April 2016), PPSs are not making sufficient investments in interventions addressing the social determinants of health. Looking at New York as an example, our concern is that without specific requirements and sufficient funding, most ACOs will continue to contract with organizations with whom they are already comfortable, rather than doing the more important, yet difficult work of creating alliances with CBOs that address the social and economic determinants of health.

¹⁶ For additional examples of why social services organizations need upfront funding for effective and ongoing collaborations to address social determinants of health, see Bachrach, D., Bernstein, W. et al., *Implementing New York’s DSRIP Program: Implications for Medicaid Payment and Delivery System Reform*, Commonwealth Fund (April 2016); Guyer, J., Shaine, N. et al., *Key Themes From Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States*, Kaiser Family Foundation (April 2015).

clinical providers and community organizations take significant time and effort to build and maintain. In PWTF, infrastructure was supported to establish these connections and ensure their ongoing functionality, including the role of the coordinating partner to manage relationships, communications, responsibilities, and workflow across multiple organizations, as well as the time and effort needed to establish new working relationships between organizations with different organizational cultures, methods of operating, and referral technology.

Another promising model to ensure members have the broadest access to social services agencies is through a social services “hub.” Such a hub can offer a single point of coordinated access to a wide range of social services which have a documented impact on health outcomes and health care cost reduction. This would be particularly helpful for small, specialized agencies (such as a group that focuses on a single immigrant community) that may not have the capacity to contract with multiple ACOs, but could work with hubs to allow them to assist members in many ACOs. A hub model could work with multiple ACOs to bridge medical and social service systems, providing culturally and linguistically competent services, engaging multiple social services agencies, and providing access to medically beneficial, evidence-based programs in each geographic region. The Hub manager will hold contracts with ACOs, and will subcontract with local nonprofit service providers, as well as share in the risk and benefits with the ACO, thereby building trust and sustainability.

Community health workers

ACOs have the opportunity to promote public and community health through strengthening the role of community health workers (CHWs) in connecting people to care resources and promoting overall health. Research has shown the efficacy of including CHWs as part of health care teams. CHWs help contain costs by reducing high risk patients’ use of urgent and emergency room care and preventing unnecessary hospitalizations.¹⁷ CHWs also improve quality of care and health outcomes by improving patients’ access to and use of preventive services, chronic disease self-management support, maternal-child home visiting and perinatal support.

Aside from the brief acknowledgment that ACOs can utilize CHWs as one of several potential strategies to enhance member communication and follow-up (41), the Waiver Request barely mentions the CHW workforce. We urge MassHealth, in consultation with DPH, to endorse the use of CHWs as vital members of patient-centered health care teams. We also recommend that the role of CHWs be more formally incorporated into the ACO models. For example, MassHealth could require – as a condition of contract – that ACOs demonstrate how they will integrate CHWs into interdisciplinary teams for high-risk/high need patients.

Workforce development and training

We support MassHealth’s proposal to use a portion of DSRIP for statewide investments, such as a workforce development grant program that includes training and support materials to promote best practices for equitable, culturally competent care for LGBTQ members, for individuals with physical, intellectual, and development disabilities, as well as for members with behavioral health needs (50).

Further, MassHealth must require ACOs to train their providers on cultural competence and make efforts to reduce implicit bias among caregivers. At a minimum, ACOs should be required to comply with the Culturally and Linguistically Appropriate Services (CLAS) standards issued by the HHS Office of Minority Health. The purpose of the CLAS standards is to ensure that all people entering the health care system receive equitable and effective care in a culturally and linguistically appropriate manner. The standards are

¹⁷Massachusetts Department of Public Health, “Achieving the Triple Aim: Success with Community Health Workers,” May 2015. Available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness/comm-health-wkrs/>.

meant to be inclusive of all populations, but are specifically designed to meet the needs of racially, ethnically, and linguistically diverse populations that experience unequal access to health care services.

Addressing community needs

Prevention and public health are critical to lowering health costs and improving quality. In addition to promoting community-clinical linkages, ACOs should look beyond their members to address the public health needs of the service area or community where the practice is located. By focusing on the underlying social determinants of health at the community-wide or geographic level, ACOs have an opportunity to work towards improving health outcomes and advancing health equity. As part of this model, ACOs should collaborate with external partners and community members to address community-based drivers of poor health. If the ACO has established a PFAC that truly represents the patients being served, the PFAC can be an invaluable partner in evaluating and echoing the needs of the community within the ACO leadership structure.

We support that under the HPC's ACO certification criteria, ACOs will be required to report on how the ACO uses the socio-demographic information gathered on its patient population to develop and support community-based policies and programs aimed at addressing social determinants of health to reduce health disparities within the ACO population (Criterion 3, Required Supplemental Information Questions). We urge MassHealth to take this one step further and require ACOs to perform an assessment of community assets and challenges (e.g., high levels of violence, poor access to healthy food) to better understand community needs and target partnerships and interventions. This will ensure that medical practices and public health agencies work together towards improving health at the individual, delivery system, and community levels.

Care Delivery Models

Oral health integration

Oral health is a critical component of overall health. While there is increasing evidence suggesting that the provision of oral health care actually lowers overall health care costs,¹⁸ oral diseases are among the most common chronic diseases for both children and adults in the U.S., and are linked to millions of hours of missed school and work days annually.¹⁹ Low-income adults in Massachusetts report difficulty biting and chewing as their top oral health problem, and 36% report avoiding smiling, while 20% report reducing participation in social activities due to the condition of their mouth and teeth.²⁰ MassHealth bears a significant burden of poor oral health in the Commonwealth, paying for approximately half of all ED visits for preventable dental conditions.²¹

MassHealth cannot achieve its stated goals of both promoting fully integrated, coordinated care that holds providers accountable and addressing the opioid use disorder crisis without addressing oral health integration in a comprehensive manner. We are encouraged by MassHealth's plans to promote oral health integration into primary health care and are pleased to see the inclusion of an oral health quality metric in the ACO quality measure slate, alongside contractual expectations for ACOs. We urge MassHealth to strengthen oral health integration in its ACO models and more clearly outline a plan to help facilitate integration.

¹⁸Jeffcoat, M.K., Jeffcoat, R.L., Gladkowski, P.A., Bramson, J.B., Blum, J.J. (2014). Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions, *American Journal of Preventive Medicine*, 47: 174-182.

¹⁹National Center for Chronic Disease Prevention and Health Promotion, (2002). *Fact Sheet: "Preventing Dental Cavities."* Centers for Disease Control and Prevention.

²⁰Health Policy Institute. (2016). *Massachusetts' Oral Health and Well-Being*. Retrieved from

<http://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/Massachusetts-facts>. ²¹

Massachusetts Health Policy Commission. (2016). *ED Utilization for Preventable Oral Health Conditions in MA* [Powerpoint slides]. Boston, MA. Retrieved from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/committee-meetings/20160401-public-presentation-dental-findings.pdf>.

The existing dental care delivery system fails to adequately meet the needs of the MassHealth population, and does not focus on outcomes. ACOs must have accountability for dental services, which will improve integration of oral health into the rest of health care and help the overall system save money. Similar to the plan proposed for LTSS integration, we urge MassHealth to phase in oral health and dental services into the ACO total cost of care, and first pilot dental services integration.

There should also be sufficient upfront investments for oral health delivery system transformation; DSRIP funds can be used to ameliorate the separation between dental and medical services. Investing in health information technology and workforce development and training will help encourage providers to enter into ACOs while developing a critical foundation for effective care coordination. There is also an urgent need to improve the alignment of dental service payment policies with established clinical guidelines. The existing fee-for-service payment system in dentistry has not kept up with the science and illogically incentivizes procedure-based care instead of prevention. MassHealth must help transition dental services delivery to focus on high-value, evidence-based, preventive care.

We respectfully direct you to the Oral Health Integration Project's comments for detailed recommendations on how to achieve more robust and meaningful oral health delivery and payment system transformation.

Pediatric-specific capabilities and linkages

Children and youth – especially those with special health care needs – require care that is not adequately addressed in a system built for adults. Forty percent of the Commonwealth's children are enrolled in MassHealth and children comprise 34% of the MassHealth population,²² yet the Waiver Request does not specify how ACOs will address the unique needs of children and youth.

ACOs should emphasize prevention and early interventions with children and their families. Unlike most adult care models, the family plays a far more critical role in managing a child's care. Family experiences can provide a wealth of useful data and information in shaping some of the core elements of an ACO. All ACOs that serve children should have the ability to support the family and make linkages with other state agencies and with key community resources, such as schools, Head Start programs, social services agencies, and others.

Further, for some pediatric patients, there is a role for home visiting, which is not a traditional service provided by institutional providers; strong partnerships with community-based organizations that provide these services are essential. Home-based services are currently offered to children and families through such programs as Early Intervention (EI), the Children's Behavioral Health Initiative, as well as pilots such as Boston Children's Hospital's Community Asthma Initiative.²³ These services not only target medical and behavioral health issues, but also bring to light other factors, such as the home environment, which are important to the health of children. In fact, many children with special health care needs or heightened social determinants of health risk factors are more likely to engage in home-based services offered through the EI program.

²² Massachusetts Medicaid Policy Institute, "MassHealth: The Basics, June 2016." Available at: http://www.bluecrossfoundation.org/sites/default/files/download/publication/MassHealthBasics_Chartpack_FY2015_FINAL_1.pdf.

²³ MA Department of Public Health. (2015). *Massachusetts Home Visiting Initiative*. Executive Office of Health and Human Services. Retrieved from <http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/home-visiting/the-massachusetts-home-visiting-initiative.html>; MA Department of Public Health. (2015). *Children's Behavioral Health Initiative*. Executive Office of Health and Human Services. Retrieved from <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/>; Boston Children's Hospital. (2015). *Community Asthma Initiative*. Boston Children's Hospital. Retrieved from <http://www.childrenshospital.org/centers-and-services/community-asthma-initiative-program>.

ACOs must have sufficient pediatric primary and specialty care providers for the number of children managed by the ACO. MassHealth should also allow pediatric-focused ACOs, in addition to ACOs that provide care for both children and adults. Mechanisms should be in place to ensure that practices serving adults and children can partner with pediatric-focused ACOs and resources. We have particular concerns about network adequacy for pediatric specialty providers. Due to provider-MCO contracting issues, we already see children losing access to preferred specialists. This is particularly concerning for children with behavioral health needs, as there is often a shortage of pediatric providers in this field. Moreover, integrating oral and mental health care into the ACO's delivery and payment structure is essential, as among the most common major chronic care conditions children and adolescents experience are oral and mental health problems.

ACOs should establish access and quality standards specific to pediatric primary care, behavioral health, oral health, and specialty providers. We applaud MassHealth for including and prioritizing sub-populations, such as pediatrics, adolescents, oral health and maternity in the prevention and wellness quality measurement domain. Given the significant number of children enrolled, MassHealth and providers should develop pediatric-specific approaches including relevant payment frameworks, quality standards, and delivery systems in their ACO design.²⁴ An ACO established to serve adults will not necessarily have relevant pediatric expertise and capabilities, especially for children and youth with complex conditions.

Further, the primary goal in developing ACOs should not be cost reduction, particularly for children and youth with special health care needs. Nationally, medically complex children and youth make up 6% of children enrolled in Medicaid, yet account for 40% of Medicaid spending for children.²⁵ Effective care management techniques should aim to reduce children's unmet health needs, improve their health and functional status, improve their families' ability to cope, and reduce the burden of caregiving experienced by families. Available evidence shows that when ACOs address care coordination needs of this population of fragile children, costs go up, not down—this is due to uncovering undiagnosed health and human service needs.²⁶

Community partners

One of the unique features of MassHealth's proposal is the strong emphasis on ACOs' collaboration with community-based providers. Most of these organizations already serve a high volume of MassHealth members and play a significant role in care coordination and connecting members with non-medical services. We support MassHealth's proposal to connect ACOs with community-based behavioral health and LTSS providers, who can be certified as Community Partners (CPs), including providing direct DSRIP funding to support the capacity-building of CPs. CPs can use these resources to build out the required capacity to work with ACOs in supporting the integration of behavioral health, LTSS and health-related social services. We request more information about the certification criteria which CPs must meet, including cost and quality goals and checks and balances to guard against excessive self-referral.

Long-term services and supports

People with disabilities, seniors and individuals with chronic conditions should have choice, control and access to a full array of quality services, including LTSS, that assure optimal outcomes, such as independence, health and quality of life. This portion of our health care delivery system is among the most fragmented and poised for improvement. Massachusetts has made great strides in shifting utilization and spending of LTSS

²⁴The Agency for Healthcare Research and Quality (AHRQ) CHIPRA Quality Measures Program can serve as a foundation for appropriate pediatric quality measures: <http://www.ahrq.gov/policymakers/chipra/pqmpback.html>.

²⁵ https://www.childrenshospitals.org/~media/Files/CHA/Main/Research_and_Data/Research_Initiatives_and_Findings/CWMC/summary_of_medically_complex_children_and_total_children_in_medicaid_07012013.pdf.

²⁶ Lucile Packard Foundation for Children's Health, "What Children with Medical Complexity, Their Families, and Healthcare Providers Deserve from an Ideal Healthcare System," December 2015. Available at: <http://www.lpfch.org/publication/what-children-medical-complexity-their-families-and-healthcare-providers-deserve-ideal>.

from institutional settings to the community. Preliminary 2015 numbers show that the percent of MassHealth spending on community-based LTSS has risen to 65%, as compared to institutional settings.²⁷ Even so, many members still need to patch together services to get what they need, and the pieces of their care quilt rarely focus on shared care planning, continuity of services or sustained outcomes.

We support MassHealth's vision of adopting a person-centered approach to care, investing in community-based LTSS to prevent admissions to and transition members from institutional settings, and promoting independent living principles (35). MassHealth MCOs and ACOs must look beyond the medical model of LTSS to address everyday needs that keep people in the community, as well as overarching social determinants of health. For example, a 2013 survey conducted by the DPH and University of Massachusetts Medical School found that 85% of respondents with disabilities reported finding affordable housing as a significant health-related need.²⁸ Community-based LTSS providers can help members connect to social services for help with non-medical needs that contribute to their overall health, wellbeing and security.

We seek additional information on the role of the LTSS representative, who would be included in the interdisciplinary care team for members with LTSS needs. MassHealth must ensure that this representative truly has an independent voice in the care team and offers a level of coordination similar to that provided by the LTSS Coordinator in One Care or the Senior Care Options' Geriatric Support Services Coordinator. In addition, family caregivers are often an important part of an individual's care team, and, with permission and direction from the member, should be consulted and supported in LTSS planning and delivery.

HCFA supports MassHealth's requirement that MCOs demonstrate compliance with federal Medicaid Managed Care regulations and the Americans with Disabilities Act (ADA), as well as competencies in the independent living philosophy, Recovery Models, wellness principles, cultural competence, accessibility and a community-first approach, consistent with the One Care model (36). We request additional information as to how MCOs and ACOs become credentialed to manage LTSS and how MassHealth will measure MCO and ACO performance in this regard. MassHealth should work closely with members with LTSS needs, disability advocates and others to ensure that the transition of LTSS from fee-for-service to managed care includes robust member protections and choice.

Behavioral health integration

We share MassHealth's goal of integrating physical health and behavioral health. For many consumers with a behavioral health diagnosis, their behavioral health clinician is their primary point of contact with the health care system. As such, we are encouraged that the Waiver Request establishes a strong role for BH CPs to manage care coordination through the Health Homes opportunity, fostering communication between an individual's primary care provider and the behavioral health treatment community.

We view integrated health care as a coordinated system that combines medical, behavioral, LTSS and oral health services to address the whole person, not just one aspect of his or her condition(s). In this model, with the consent of the member, medical and behavioral health providers partner to coordinate the prevention, diagnosis, treatment, and follow-up of both behavioral and physical conditions; and consumers, behavioral health professionals, peers and family partners are key members of the team. However, physical health care providers may not provide the same quality of care to persons with psychiatric diagnoses as to those without

²⁷ Manatt Health Solutions. (Dec. 2015). *MassHealth Matters II Long-Term Services and Supports (LTSS): Opportunities for MassHealth*. Blue Cross Foundation. Retrieved from

http://bluecrossfoundation.org/sites/default/files/download/publication/Manatt_MMPI_ChartPack_FINAL_v05.pdf

²⁸ Massachusetts Department of Public Health. (2013). *Health Needs Assessment of People with Disabilities in Massachusetts, 2013*. UMass Center for Health Policy and Research. Retrieved from

http://commed.umassmed.edu/sites/default/files/8504_Health%20Needs%20Assessment%20PWD%20EHS%20Appr%2001-16-2014_0.pdf

mental health histories.²⁹ Therefore, it should be up to the individual enrollee whether and to what extent psychiatric information is shared among his or her physical health care providers. Members will be able to share such information with providers who inspire trust, a necessary element of any health care relationship.

We also applaud MassHealth's efforts to address psychiatric emergency department boarding, including seeking investment to support enhanced diversionary levels of care that will meet the needs of patients within the least restrictive, most clinically appropriate settings.

Behavioral Health Services for Children and Youth

Children with behavioral health needs require providers to consult with more "collateral contacts," such as parents, teachers, and other service providers. MassHealth should leverage the expertise of CBHI's community-based, child-serving provider organizations to coordinate care, enhance care quality, deliver care in lower cost community settings whenever appropriate, and improve the patient experience for children and youth MassHealth members and their families.

The Waiver Request requires Behavioral Health Community Partners to either be a Community Service Agency (CSA) or have contracts with CSAs to provide behavioral health services to children (34). We appreciate that MassHealth acknowledges the importance of CBHI services for children and youth delivered through CSAs, and we urge you to ensure that families maintain the ability to choose behavioral health providers outside the CSAs who can provide the full range of services needed.

A significant portion of necessary services provided to children with behavioral health needs may not currently be reimbursed by MassHealth, an experience echoed for some adults with serious mental illness, substance use disorders and other disabilities. MassHealth and ACOs themselves should develop partnerships and closely coordinate with the Departments of Children and Families (DCF), Mental Health (DMH), Developmental Services (DDS), Elementary and Secondary Education (DESE), Public Health (DPH), and other non-billing behavioral health providers. Ultimately, the question to tackle is how MassHealth can encourage ACO collaboration and develop systems to hold these agencies accountable for helping to care for children and youth with complex needs who are attributed to an ACO.

Recovery Model and Peer Supports

We are encouraged by MassHealth's recognition of the importance of recovery supports. ACOs should partner with organizations to deliver recovery coaching and peer supports and services provided by peer support workers, certified peer specialists, recovery learning communities, and licensed alcohol and drug counselors. Peer supports provide a unique and important role in the delivery of behavioral health care and can enhance the care and long-term success provided in integrated settings. Peer support services are delivered by individuals who have common life experiences with the people they are serving. Studies have shown that the use of peers may reduce costs and improve health outcomes, including decreased hospitalizations, improved quality of life, and reduction of the number of major life problems.³⁰

Peers also play an important role in increasing access as they have the potential to reach individuals who may not otherwise receive care, especially behavioral health care, and are viewed as more credible by some individuals. The use of peers may also reduce the overall need for behavioral health services over time. Twenty-two states provide reimbursement for peer support through their Medicaid programs. Today, MassHealth reimburses for Family Support and Training as part of the Children's Behavioral Health Initiative (CBHI), which provides linkages to community resources and a one-to-one relationship between a Family

²⁹ Fendell, S. (2014). The Unintended Results of Payment Reform and Electronic Medical Records, *Journal of Health & Biomedical Law*. 10:173-200.

³⁰ National Coalition for Mental Health Recovery (2014). *Peer Support: Why It Works*. Retrieved from <http://www.ncmhr.org/downloads/References-on-why-peer-support-works-4.16.2014.pdf>.

Partner and a parent or caregiver to help improve the capacity of the parent/caregiver and support youth in the community.³¹

Substance use disorders services

We are encouraged by MassHealth's strong proposal to provide enhanced substance use disorders (SUD) services, including expansion of residential care and recovery supports. Productive collaboration between DPH and MassHealth will attract additional federal resources to address an overwhelming need for SUD treatment services, particularly for residents struggling with an opioid use disorder.

In particular, we support MassHealth's proposal to provide additional services and promote best practices in the field, including:

- *Residential step down services.* The Waiver Request would add Residential Rehabilitation Services for individuals with substance use disorders to provide step down services after acute care. In most states, consumers are released from detox or intensive treatment and provided no follow up support during this vulnerable period when they are at high risk of relapse. The proposed residential rehabilitation is a crucial component of the full continuum of behavioral health care.
- *Person-centered care.* Providers in the medical and mental health systems would be trained in motivational interviewing. This person-centered technique for interacting with consumers is an excellent tool that allows providers to "meet people where they're at" and approach care-planning in a collaborative way that gives the consumer agency over his or her care. In addition, the proposed individualized care plans provide an opportunity for providers and consumers to work together to establish the best plan to fit consumers' needs.
- *Substance use recovery.* The SUD services proposed in the waiver include robust recovery supports, including care coordination by recovery coaches and recovery support navigators. These peer services provide essential support to consumers following treatment. The proposed recovery-focused community of care model acknowledges relapse is not a failure, but a part of the recovery process for many people.
- *Workforce development.* The waiver proposes investments in the substance use disorders workforce through training and education loan repayment for numerous provider-types (e.g., recovery coaches, care managers, mental health clinicians) and offering financial incentives to promote integration with primary care providers. This capacity building will strengthen the substance use treatment available through MassHealth and grow the network of providers across the state.

We urge MassHealth to further strengthen the SUD Waiver Request in the following areas:

- *Integration within behavioral health.* While the Waiver Request sufficiently addresses the integration of behavioral health with primary care, these efforts could be strengthened by including strategies for integrating substance use with mental health. These two systems remained siloed and consumers would benefit from better integration, especially given the incidence of co-occurring mental health and substance use disorders among the population.
- *Prevention.* We feel the Waiver Request falls short on primary substance use prevention efforts. As stated in the application, the DPH, DMH and EOHHS currently support important prevention initiatives across the state, and this Waiver Request would establish assessments for consumers seeking substance use treatment. While this is a good start, these efforts could be bolstered by MassHealth requiring ACOs to provide screening, brief intervention, and referral to treatment (SBIRT) to all consumers – not just individuals who present with a substance use problem – in primary care settings. Requiring this simple and quick verbal or written screening by ACOs would be

³¹ Executive Office of Health and Human Services. (2012). *Family Support and Training Performance Specifications*. Boston, MA: Executive Office of Health and Human Services. Retrieved from <http://www.mass.gov/cohhs/docs/masshealth/cbhi/ps-family-support-and-training-ps.pdf>.

the first step towards establishing statewide universal screening for all consumers covered by private or public health plans.

Care teams and care coordination

We applaud MassHealth for prioritizing seamless and easily navigable care coordination (15). As recognized in the Waiver Request, care coordination is vital to managing an individual's care, reducing fragmentation and improving outcomes and should be a core component of all ACOs. True member-centered care will require ACOs to implement payment methodologies that pay for coordination, wellness and prevention services that are not traditionally reimbursed, such as the Health Homes opportunity for BH CPs. We support the Waiver Request's emphasis on interdisciplinary care teams and care coordination, including engaging members in their care (32). ACOs should be required to document how they are pursuing a team-based approach to care and their progress towards this goal. Complex and high-risk members need and will benefit from care management the most, and attention to these populations will result in the best potential for cost savings and improved health outcomes.³²

MassHealth should further require ACOs to demonstrate, through robust program requirements and quality measures, the following:

- that they have mechanisms in place to conduct member outreach and education on the benefits of care coordination, including group visits and chronic disease self-management programs;
- an ability to effectively involve members in care transitions to improve the continuity and quality of care across settings, with case manager follow up;
- capabilities to engage and activate members at home to improve self-management, through methods such as home visits or telemedicine; and
- use of shared decision-making tools and processes.

As individualized care plans and team-based care are core elements of effective care coordination, we urge MassHealth to also emphasize care planning in ACO requirements. Where appropriate, ACOs should be encouraged to use shared care plans, which are jointly maintained and updated by members, family caregivers (with member consent), and members of the care team.³³ Care management should include the provision of services to create and implement thorough and appropriate treatment plans, including wellness, recovery, and transportation to recommended medical, social, and physical activities; peer assistance; exercise support; food delivery; and medical equipment.

Member access and choice

Benefits and cost-sharing

In order to make the ACO option appealing, members need an understandable, unbiased explanation of the advantages and risks of the available models, and should have the opportunity to make their own choices about what is best for them and their health.

As such, we strongly support the proposals intended to increase access to services for low-income residents, including:

- Eliminating copays for MassHealth members with income at or below 50% FPL;
- Assuring the sustainability of the CommonHealth program for working disabled adults age 65 and older;

³²Chawla, R., Colombo, C. et al. (2014). Medical homes and cost and utilization among high-risk patients, *The American Journal of Managed Care*, 20(3), e61-71; Gawande, A. (2011, January 24). The hot spotters: Can we lower medical costs by giving the neediest patients better care? *The New Yorker*, pp. 41-51.

³³See Consumer Partnership for eHealth. (2013). *Care Plans 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment*. Washington, D.C.: National Partnership for Women & Families. Retrieved from <http://www.nationalpartnership.org/research-library/health-care/HIT/consumer-principles-for-1.pdf>.

- Ensuring the sustainability and affordability of the ConnectorCare program; and
- Expanding MassHealth substance use disorders (SUD) treatment services.

However, we strongly oppose the following proposed changes that would restrict access to care:

- Eliminating coverage of chiropractic services, eyeglasses, hearing aids, orthotics or other state plan services in the Primary Care Clinician (PCC) plan;
- Increasing copays for members enrolled in the PCC plan;
- Instituting a 12-month MCO lock-in;
- Expanding the list of services to which copays apply; and
- Potentially increasing premiums for enrollees with incomes at or above 150% FPL.

PCC Plan Changes

We understand that MassHealth is proposing changes to the PCC Plan in order to incentive members to enroll in a MCO and/or one of the new ACO models. However, we believe the proposed policies are punitive in nature and will impose barriers to care for members remaining in the PCC Plan. MassHealth should not penalize members who do not choose to participate in an MCO or ACO. This change will harm low-income individuals who cannot afford the additional cost burden, and rely on providers only available through the PCC Plan. We urge you to rescind the proposal to reduce benefits and increase copays for PCC Plan members.

MassHealth MCOs provide good quality care and are the right choice for many beneficiaries, but an MCO is not the right choice for everyone. Most MassHealth MCOs' provider networks exclude some providers who are still available in the PCC Plan. The PCC Plan has been a lifeline for medically complex patients, including people with disabilities. In fact, PCC Plan membership consists of a higher percentage of people with disabilities (17%) than MCO membership (8%).³⁴ For medically complex members, narrow provider networks and other restrictions inherent in the MassHealth MCOs may not meet their medical needs, will disrupt their ability to see the providers they know and trust, and may impact their health. For example, under the proposed change, a disabled child may have to forego eyeglasses in order to maintain a relationship with the medical specialists the child needs given the limited access to certain specialty hospitals in the MCOs compared to the PCC Plan.

In addition, the PCC Plan has initiated many innovative programs for people with complex medical needs including:

- A program for housing support services for chronically ill and homeless individuals that has now been extended to the MCOs (CSPECH);
- Recovery peer navigators for repeated users of detox services through a CMS Health Innovations Award; and
- An Integrated Care Management program for members with complex medical, mental health and/or substance use disorders.

Further, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a mandatory Medicaid service for children and youth under age 21.³⁵ EPSDT includes all medically necessary Medicaid services regardless of what is in the state plan, and provides comprehensive coverage for dental, vision, hearing, and medical screenings and treatment. Children enrolled in all types of managed care, including PCC Plans, "are entitled to

³⁴ Massachusetts Medicaid Policy Institute, "MassHealth: The Basics (June 2016)." Available at: <http://www.bluecrossfoundation.org/publication/updated-masshealth-basics-june-2016>.

³⁵ See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

the same EPSDT benefits they would have in a fee for service Medicaid delivery system.”³⁶ We believe the proposed PCC Plan benefit cuts violate the Federal EPSDT requirement, and again urge MassHealth to reconsider these changes.

Cost-sharing

We oppose MassHealth’s proposal to increase cost-sharing for PCC Plan members as well as expand the list of services to which copays apply. Data from Oregon and Connecticut Medicaid programs show that higher cost-sharing contributes to Medicaid disenrollment.³⁷ In Oregon, those who left Medicaid programs due to higher cost-sharing had lower primary care utilization and higher emergency room visits.³⁸ A Kaiser Family Foundation report describes how higher cost-sharing results in delayed care and poorer health outcomes.³⁹ Increased cost-sharing for Medicaid enrollees leads to access barriers and puts greater strain on safety net resources, shifting costs rather than saving costs or improving health outcomes.

MCO lock-in

HCFA opposes the proposed 12-month MCO lock-in. At the same time, we acknowledge that implementation of this policy is currently set to occur in October 2016 regardless of the status of the Waiver Request. As such, we appreciate that MassHealth has reached out to advocates and providers for suggestions on the lock-in exceptions policy. If implementation goes forward, MassHealth should ensure broad exceptions to enable members to change MCOs, maintain continuity of care, and access the care they need.

In 2014, of the 36% of MassHealth members who experienced plan changes during the year, 30% were caused by involuntary plan changes related to eligibility and only 6% by voluntary plan changes.⁴⁰ Involuntary plan change (“churn”) is a serious problem. Coordination and continuity of care depend on continuity of coverage. For members, churn means disruptions in coverage, delayed care, worse health outcomes and medical debt.⁴¹ For MassHealth, it means the added administrative costs of terminating and reinstating eligibility.⁴²

One study estimated that within a six-month period, 35% of adults with incomes below 200% of poverty would have income changes that would shift their eligibility from Medicaid to Marketplace coverage or the reverse. Within a year, an estimated 50% would have income changes requiring a program change.⁴³ As most MassHealth enrollment volatility occurs due to eligibility changes, rather than voluntary plan changes, we believe that policies to reduce churn should address the primary cause. MassHealth should consider policy options such as 12-month continuous eligibility, rather than an MCO lock-in policy, to reduce churn.

³⁶ Centers for Medicare and Medicaid Services, EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, June 2014. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

³⁷ <https://www.cthealth.org/wp-content/uploads/2011/04/Policy-Brief-2-Proposed-Medicaid-Cost-Sharing-Evaluating-The-Impact.pdf>.

³⁸ <http://content.healthaffairs.org/content/24/4/1106.full>.

³⁹ <https://kaiserhealthnews.files.wordpress.com/2014/07/8417.pdf>.

⁴⁰ Report of the Working Group on Medicaid Managed Care Organizations, MA House of Representatives, October 2015.

⁴¹ R. Seifert, et al., Enrollment and Disenrollment in MassHealth and Commonwealth Care, Massachusetts Medicaid Policy Institute, 2010; L. Ku, New Research Shows Simplifying Medicaid Can Reduce Children’s Hospitalizations, Center on Budget and Policy Priorities, June 2007; L. Olson, et al., Children in the United States with Discontinuous Health Insurance Coverage,” NEJM, 353:382-391 (2005).

⁴² Supra

⁴³ Sommers, B., and S. Rosenbaum. Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. Health Affairs 30, (2011) no. 2: 228–236.

Research shows that when beneficiaries are enrolled in Medicaid for longer periods, the average monthly cost for their care declines.⁴⁴ The Federal Medicaid statute includes a state option to enroll children for 12-months of continuous eligibility, which to date 23 states have adopted in both their Medicaid and Children’s Health Insurance Programs (CHIP), and an additional 10 states in their CHIP programs alone.⁴⁵ While the Medicaid state plan option is limited to children, other authorities are available to extend the policy to adults.

CMS endorsed 12-month continuous eligibility for parents and other adults as a strategy available to states through 1115 demonstration authority.⁴⁶ New York and Montana have 1115 Waiver authority to extend continuous eligibility to parents and other adults.⁴⁷ After analyzing studies of the adverse effects and administrative expense of churning, the Medicaid and CHIP Payment and Access Commission recommended that Congress give states an option to provide 12-month continuous eligibility for adults.⁴⁸ There is also more limited authority to guarantee eligibility for 6 months at a time for managed care or PCC Plan enrollees.⁴⁹ We understand that MassHealth is currently focused on stabilizing its caseload, and when it reaches that point, strongly encourage you to consider policies to address the underlying issue of churn due to eligibility changes.

SHIP Premium Assistance

Under state regulations, students can waive their Student Health Insurance Plan (SHIP) if they are enrolled in comparable coverage, including MassHealth and ConnectorCare.⁵⁰ This policy is a significant improvement for low-income college students, particularly those who could not afford other expenses, such as books and housing, and had to choose to remain part-time students due to unaffordable SHIP coverage.

While we support MassHealth’s expansion of the Premium Assistance option to students who enroll in their SHIP, and implementation of continuous MassHealth enrollment through the duration of the SHIP, we do not believe this policy should be mandatory, as it may not fit every low-income student’s needs. As with Premium Assistance generally, students will only benefit from the cost-sharing and benefit wrap for providers who accept both MassHealth and their SHIP.

Many behavioral health issues begin to manifest during adolescence and early adulthood – high school and college age. As students enrolled through Premium Assistance are not eligible to enroll in an MCO or the PCC plan, they do not have access to the broader behavioral health networks available in these plans. Should a student’s behavioral health provider accept their SHIP, but not MassHealth (which is more likely than the reverse), the student could incur significant costs. For example, the Blue Cross Blue Shield plan available to UMass Boston students requires enrollees to meet a \$250 deductible then pay \$30 for each office visit.⁵¹ This could add up quickly for a low-income student, who may be forced to again reconsider tradeoffs he or she made before the ACA enabled students to maintain or enroll in MassHealth coverage

Network adequacy and continuity of care

We understand that MassHealth members enrolled in an MCO will have access to the full range of providers in the MCO’s network, and appreciate MassHealth’s expressed commitment to ensuring that members have

⁴⁴ L. Ku and E. Steinmetz, Bridging the Gap: Continuity and Quality of Coverage in Medicaid, George Washington University, (Association for Community Health Plans, Sept. 10, 2013).

⁴⁵ Data displayed on Medicaid.gov at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/continuous.html>.

⁴⁶ Letter from Cindy Mann, Director, CMS, to State Health Officials, Re: Facilitating Medicaid and CHIP Enrollment and Renewal in 2014, May 17, 2013.

⁴⁷ See: <http://kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-medicaid-and-chip-enrollment-and-renewal-processes/>.

⁴⁸ Medicaid and CHIP Payment and Access Commission, Report to the Congress on Medicaid and CHIP, Washington, DC: MACPAC; Chap. 2, p. 21–32. Mar. 2013.

⁴⁹ 42 U.S.C. § 1396a(e)(2).

⁵⁰ 956 CMR 8.00.

⁵¹ See: https://www.universityhealthplans.com/pdf/UMB_BenefitsSummary-1617.pdf.

timely access to high quality primary care, specialists, long-term services and supports and behavioral health providers regardless of the delivery model they choose. MassHealth should establish, with input from consumers, advocates and other stakeholders, and make publicly available its network, adequacy standards for MCOs, the PCC Plan and all ACO models. Under Federal Medicaid Managed Care regulations, states are required to develop time and distance standards for all capitated plans.⁵² All ACO models should be required to meet Federal Medicaid Managed Care regulations.

At a minimum, network adequacy requirements should consider:

- *Availability of all covered services:* ACOs should be sufficient in number and types of providers needed to serve the member population, including linguistically and culturally competent services, and compliance with the ADA, Mental Health Parity and Addiction Equity Act and other Federal and State nondiscrimination laws.
- *Accessibility:* Ensure timely access to needed care and reasonable travel distance for consumers, taking into account access to public transportation.
- *Quality:* Ensure that payment structures improve health outcomes, reduce hospital readmissions, improve patient safety and reduce medical errors, encourage implementations of wellness and health promotion activities, and reduce health and health care disparities.
- *Transparency:* MassHealth, ACOs and MCOs should post on their websites up-to-date, accurate, and complete provider directories, including information on which providers are accepting new patients, in a manner that is easily accessible to members and prospective members.

Individuals, particularly those with disabilities or chronic needs, benefit from continuity of care from both primary and specialty care providers who know them and their medical needs. As part of network adequacy requirements, all ACOs should have continuity of care provisions and parameters for contracting with providers outside of the ACO. For example, single-case out-of-network agreements should be permitted where an individual is in a course of treatment with a provider; where network providers do not have the same level of expertise, specialization, or cultural and/or linguistic appropriateness as the requested out-of-network provider; or if a network provider is not readily available or is otherwise geographically or temporally inaccessible. For members in ACOs, getting care from a provider outside the ACO could work similarly to getting care out-of-network from a Preferred Provider Organization (PPO) plan. The provider would still be subject to the ACO's payment and coordination requirements, ensuring that members maintain continuity of care and do not face additional barriers in accessing appropriate care.

In addition, MassHealth should ensure that ACOs have protections to ensure continuity of care when a provider leaves an ACO network. This includes notification to the member in advance of the change and the option to continue seeking treatment from the provider via an out-of-network arrangement. Continuity of care, particularly for specialty and behavioral health services, is key to ensuring positive health outcomes and long-term recovery.⁵³ It has been said that the “best fence is a good pasture.” Good ACOs will succeed in keeping members within their system because of the benefits of coordinated care.

⁵² 42 C.F.R. § 438.68.

⁵³ Rutenberg, M. (2014). Choices and Continuity of Care as Significant Issues for Equality in Mental Health Care. *J. Health & Biomedical L*, 10(201); Kluft, R. et al. (2000). *Treating the Traumatized Patient and Victim of Violence*. *Psychiatric Aspects of Violence: Issues in Prevention and Treatment* (“Continuity of care is an important aspect of long-term treatment, and the object constancy and reliability of the therapist may be one of the most important factors in treatment success.”); see also The National Council on Disability. (2013). *Medicaid Managed Care for People with Disabilities*. Retrieved from <http://www.ncd.gov/publications/2013/20130315/20130315Ch3> (emphasizes the need to protect continuity of care when designing health care systems).

Attribution and choice of providers

We support the requirement that all eligible members will have the right and opportunity to select their health plan and primary care provider (24). MassHealth should ensure that attribution methods adhere to the goals of care continuity and access and involve member choice to the maximum extent feasible.

Members should also be able to designate a non-primary care provider as their PCP for the purposes of attribution. This is especially important for members who have a primary behavioral health diagnosis, or who seek long-term treatment from a specialist. Members who do not actively choose a primary care provider should be assigned based on their recent care-seeking behavior. In determining retrospective attribution, the methodology should not only look at PCP claims but also claims from other providers, as well as non-claims-based factors such as geographical proximity, language and cultural competency, in order to determine the most appropriate assignment. However, allowing for direct member choice is always preferable to retrospective attribution.

Members should receive adequate notice about the right to choose or change providers and ACOs. Members who have been attributed to a provider should receive notice of the attribution and their right to change providers at any time. When individuals select a provider they should know if they are choosing a provider who is participating in an ACO. It should be made clear to the member if the provider has a financial incentive to refer in-network, and members should be notified of their right to go out of network and of any potential benefits to staying in the ACO network. All notices should be provided in a manner that is culturally and linguistically competent, accessible and understandable.

Member education and assistance

Enrollment assistance

We appreciate that MassHealth will require ACOs and MCOs to make information about their coverage and care options readily accessible and that MassHealth will enhance its own customer service, website, publications, and community collaborations. The proposed ACO initiative will make the system more complicated for members, as acknowledged by MassHealth in the Waiver Request. With the changes, the simple act of choosing one's primary care setting will bring with it a host of important and novel consequences. Particularly if the MCO enrollment restrictions are put into place, members will need extensive guidance to determine what plan best meets their needs.

We urge MassHealth to invest in member education and navigation assistance, including implementation of an enhanced community-based public education campaign for members, as well as a major expansion of in-person enrollment assistance. The need is for tailored, personalized, and linguistically and culturally competent assistance both pre- and post-enrollment. Members should have access to individual navigation and assistance with choosing a plan and understanding the coverage and care options available.

For many consumers, the health insurance eligibility and enrollment process is difficult to navigate. After MassHealth enrollees receive their program determination, they have the option to enroll into one of several MCOs or the PCC Plan. Based on recent data provided by MassHealth, approximately 65% of MassHealth members have been auto-assigned to their current plan, while only 35% actively chose their plan. With auto-assignment, a MassHealth member may not even realize in which plan she is enrolled and which restrictions apply, until she calls her provider for an appointment and finds out her doctor is not in the member's plan network. The MCO lock-in policy may further exacerbate this issue. Likely, a certain percentage of MassHealth members will continue to be auto-assigned into a plan under the new ACO initiative.

With frequently changing provider networks, many MassHealth members already find it difficult to discern which providers are in an MCO's network. Based on HelpLine client experiences and feedback from other enrollment assisters, the most important thing most members want to know about MassHealth plans is: can I

continue to see my current providers? This includes both primary care and specialist providers, particularly for behavioral health services.

Consumers should have a seamless enrollment experience, allowing for intentional choice of managed care plan and PCP at time of enrollment in MassHealth, taking into account non-PCPs who are important to the consumer. With that in mind, we request additional details on MassHealth's current thinking as to how the new ACO framework will interact with or change the current MassHealth enrollment process:

- How will MassHealth, providers and MCOs communicate new choices to members? How will members know which ACO model to choose?
- How will the enrollment process change? Currently, MassHealth members choose an MCO or the PCC Plan after they receive their program determination. Will ACO enrollment also be part of the initial enrollment process?
- Members choose an ACO based on their PCP selection within the MCO network (24). What happens if a member does not choose a PCP? If a member is auto-assigned to a PCP, is the member locked into this PCP for a certain amount of time, or can they switch? How will the selection process account for non-PCPs who are equally important to the member's care?
- Does MassHealth envision an ACO open enrollment period, along with the MCO open enrollment period, particularly for Model A and B ACOs? How will this work for PCC Plan members?
- How does MassHealth plan to train and support its Customer Service Team (CST) and MassHealth Enrollment Centers (MECs), as well as enrollment assisters in the community, to help people make these decisions?
- Can provider-based certified application counselors and Navigators assist enrollees with selecting options if they are employees of an ACO? Would this be considered a conflict of interest?

Member outreach and education

We recommend adding requirements to ensure that all individuals receiving care, or eligible to receive care, through an ACO be fully informed about what this means for them and what patient protections are available if necessary. ACOs should educate their members on what an ACO is, the benefits and expectations of care within the ACO, and the rights and responsibilities that accompany receiving care from an ACO, including the right to receive care from a provider outside of the ACO, the right to file a grievance or complaint with the ACO, and a user friendly guide about taking these actions. Additional information should include a description of financial incentives for ACO providers and the ACO as a whole, including incentives to manage the total cost of care and improve quality, definitions of under-service and member selection, and how the ACO is monitoring for under-service.

In the context of value-based care delivery, individuals should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's provider, how to evaluate if one is receiving appropriate care, how to access a second opinion, and what to do if one is concerned about the extent or type of care provided.

Information on ACOs should be provided in ways that are accessible and understandable to all members. While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different ACO models), the core elements should be consistent in order to promote a shared understanding across populations, promote continuity of information as individuals' insurance or health status changes, and give providers standard guidance about engaging members that aligns with what members are being told. Information should be made available both in advance of receiving care (e.g. at the time of enrollment) and at the point of care (e.g. in writing in the provider's office). To help ensure that this information is effectively shared and communicated, written materials should include taglines in at least 18 languages and large print that inform members of written translation services in all prevalent (500 or 5

percent of potentially attributed individuals) languages, as well as oral assistance for all members with limited English proficiency and assistance for people who are deaf and need American Sign Language.

MassHealth should also encourage ACOs to work collaboratively with community-based organizations (CBOs), including those that represent communities of color and/or non-English speaking beneficiaries, around education and outreach. Members are more likely to trust CBOs and local community groups, which will in turn create more buy-in from the member perspective to join or stay in the ACO.

Finally, we recommend that MassHealth convene a work group to advise them on the content to be contained in the core messages described above, and also on the appropriate media and means through which messages should be disseminated. Just as the creation of MassHealth ACOs offers an opportunity to reinvent patient care delivery models, so too do they offer an opportunity to improve communication with and education for members. This work group should recommend specific language to be incorporated in member communications. The work group should be composed predominately of members, consumer advocates, and providers. It should also include representatives of payers and state government agencies, and individuals with experience and expertise in communications, including communications with populations believed to be at particular risk of under-service or otherwise difficult to engage.

HCFA appreciates the long-standing collaboration between MassHealth and consumer advocates to improve the MassHealth eligibility and enrollment process. We believe this collaboration will be even more important as MassHealth implements its ACO program, and look forward to using monthly Medicaid Advocates meetings and other appropriate forums to elicit feedback throughout development and implementation of a streamlined member enrollment process.

Ombudsperson services

We applaud MassHealth for creating a new external ombudsman role that will be available to help ACO enrollees resolve problems or concerns. We request more information on how this new role will function and the criteria by which its success will be measured. At a minimum, the ombudsperson should be a one-stop source of accurate and up to date information for members, play a key role in helping members navigate the ACO enrollment process, and troubleshoot issues with enrollment and provision of care. The ombudsman should also have a role in arbitrating and expediting ACO members' appeals and grievances for coverage, as well as collaborate with the Office of Patient Protection on ACO-specific appeals and grievances for treatment or referral decisions. We also request more details as to how the new external ombudsperson will coordinate with other entities and individuals in the community and within provider organizations, including enrollment assisters, who already provide enrollment and provider navigation assistance to members.

We recommend that MassHealth build upon the One Care ombudsperson role, while eliminating restrictions that impede the office from tracking and reporting systemic issues, reporting data in real time, and conducting outreach and training of members about their rights and responsibilities. Reporting should include race, ethnicity and other population data necessary to track system-wide trends that identify and measure gaps in service. The ombudsperson office should track and document an enrollee's case from start to final outcome, and report aggregated data to ACO advisory bodies and MassHealth. This data should also be presented in the form of a public-facing dashboard that provides objective comparisons of enrollee grievances, resolutions and outcomes across ACOs.

Quality, Transparency and Monitoring

Quality metrics

In order to assess the progress of the DSRIP program and ACO models, it is essential to establish specific quality metrics and outcome goals. We support MassHealth's priority domains for quality measurement, which include prevention and wellness (including sub-populations such as pediatrics, adolescents, oral, maternity); reduction of avoidable utilization; behavioral health/substance use disorders; LTSS; and member

experience (28-29).

We seek additional information on these metrics and clarification of MassHealth's goals related to these quality metrics. In order to understand and measure the reduction in health disparities, we recommend stratifying quality metrics data based on factors, such as disability status, age, race, ethnicity, primary language, geography/zip code, gender, gender identity, sexual orientation. Additionally, MassHealth should require ACOs to use the new consensus metrics, developed by the National Quality Forum (NQF), to assess cultural competency and language services.⁵⁴ Implementing these measures is critical to addressing provider biases, poor patient-provider communication, and poor health literacy. We further recommend that MassHealth define avoidable utilization and include tracking underutilization as described above. LTSS measures should be developed and aligned with those used in the One Care program.

Member experience metrics will surely evolve over time to capture improved integration of physical health, behavioral health, LTSS, oral health, and social services (29). As part of that process, we urge MassHealth to obtain more in-depth consumer input on the member experience metrics and survey. This includes convening a technical expert panel to define a survey, and then cognitive testing and pilot testing of the survey instrument with members to ensure that it appropriately captures consumer input. Questions about survey length and completion rates can also be empirically answered through such testing.

We recommend that MassHealth use and simplify the Consumer Assessment of Healthcare Providers and Systems (CAHPS) baseline and supplemental measures as placeholders until new metrics can be developed, as there are certain gaps and weaknesses with the CAHPS instrument. Holding ACOs accountable for improved member health and experience of care will require quality measures that are focused on outcomes and member-reported data. We therefore recommend that several pilot metrics be added to begin the validating process, such as patient reported outcomes measures,⁵⁵ patient activation measures and questions related to oral health. These types of high impact quality measures, which are meaningful to both consumers and providers, will help ACOs drive quality improvement and increase value, and accelerate delivery transformation.

We also think it is important to consider how the member experience data will be used, including reducing health disparities as mentioned above. The survey results should be shared publicly, including any narrative comments to the survey questions. It is additionally important to consider other techniques for collecting information about consumer experiences, including focus groups, reporting of grievances and complaints, and ensuring strong feedback loops for consumer representation on the governance structure and through PFACs.

We also request additional details on how MassHealth will ensure that:

- Providers and CPs deliver care in a culturally competent manner (29, 34);
- Providers offer their patients with disabilities the medical and diagnostic equipment and accommodations necessary to receive appropriate medical care (29); and

⁵⁴National Quality Forum. (Aug. 2012). Healthcare Disparities and Cultural Competency Consensus Standards. Retrieved from http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx.

⁵⁵Blue Cross Blue Shield of MA has incorporated PROMS for mental health, orthopedics, oncology and cardiology as a complementary measure set for both its Alternative Quality Contract (AQC) and PPO payment reform models. Beginning with contracts in 2016, these measures will be used alongside the core quality measure set. Unlike the core quality measure set, where payment is based on performance, however, payment for the PROMs and other measures in the complementary measure set will be based on adoption and use to improve patient care. Since the BCBSMA introduction of PROMs in 2014 as a voluntary component of the AQC program, the reception from providers has been very positive. While introduction of PROMs into routine practice requires significant adaptation of both work flow and culture, providers have conveyed the significant clinical value in having the PROMs data and the usefulness of being able to monitor patients' progress over time using these measures.

- MCOs and all ACO models respect member dignity and privacy and provide their members with the opportunity to participate in treatment decisions (29).

While the ombudsperson or an agency such as OPP can offer some insight into whether ACOs and MCOs are meeting these competencies, MassHealth should also establish strong reporting requirements and implement monitoring mechanisms to ensure members' needs are met.

Public reporting and transparency

Public reporting can improve both health care performance and value. We support MassHealth's plan to release an annual report on ACO performance as a way of providing public transparency throughout the implementation of the program (20), and we seek more specifics about what information will be included in this report. We strongly recommend that ACOs be required to publicly report quality and cost information at the provider level, as well as at the ACO level. Providing publically available information on cost and quality performance at the individual provider level as well as the ACO level will help members to make informed decisions with respect to choice of provider and care setting. Providing transparent cost and quality information may also help members to understand the potential benefits that an ACO can provide, including how care will be better coordinated.

In addition, MassHealth should work with ACOs to publically report on an annual basis the following information:

- the names of HPC certified ACOs;
- the number of lives attributed to each ACO;
- the financial structure of ACOs and participating providers, including surplus or deficit margins;
- ACO leadership structures; and
- provider incentives in ACOs.

MassHealth should further work in conjunction with the Office of Patient Protection to publically report on an annual basis the number and types of internal and external grievances and complaints filed with the ACO and if and how they have been resolved.

As stated earlier in our comments, we recommend that MassHealth and the ACO Steering Committee monitor and evaluate DSRIP implementation through development and dissemination of a public dashboard. This will also require publicly setting consistent, system-wide, measurable goals for what we hope to accomplish by moving care to ACOs, including reduced hospitalizations, reduced institutionalization, improved quality of life and improved health outcomes.

Data Collection and Risk Stratification

Comprehensive data collection

Collecting data on key sociodemographic factors is a critical first step for effectively managing the health of an ACO's patient population, addressing risk factors that lead to poor health outcomes, and appropriately targeting intervention points and strategies. We support that under the HPC's ACO certification criteria, each ACO will be asked to report on how it assesses the needs and preferences of its patient population with regard to race, ethnicity, language, culture, literacy, gender identity, sexual orientation, income, housing status, food insecurity history, and other characteristics, and how it uses this information to inform its operations and care delivery to patients (Criterion 2, Required Supplemental Information Questions). We urge MassHealth to ensure that each ACO meets this requirement so that ACOs understand key barriers to health and how those barriers are distributed across its member population. ACOs should work jointly with BH and LTSS CPs to collect this information.

Having a comprehensive set of sociodemographic data for the ACO's patient population is also necessary to effectively conduct risk stratification, implement targeted population health programs, engage in ongoing collaborations and referrals with community-based organizations and providers, and partner with and invest in community health programs.

Risk stratification

To achieve more equitable health outcomes, it is crucial that ACOs incorporate disparity reduction goals into overall quality improvement goals and adopt tools that support disparities measurement and interventions. As indicated in our comments on quality metrics, outcomes and other quality indicators should be stratified by social determinants of health factors in order to appropriately target population health interventions, uncover and address health disparities, and improve how ACOs deliver care.

We recommend that ACOs also include social determinants of health in approaches for risk stratification of its member population, which could include factors such as homelessness or unstable housing, age, primary language, race and ethnicity, disability and functional status, activities of daily living, geography, gender identity and sexual orientation, and health literacy. Once collected, this information should be made publically available. Reporting this data will allow MassHealth and the public to assess how well ACOs are serving the entire spectrum of ACO members. Ultimately, as risk stratification tools are developed and tested over time, ACOs should use a standardized methodology for risk stratification in order to make meaningful comparisons across the Commonwealth's ACOs.

Each ACO should use this data to develop and implement programs targeted at addressing social determinants of health and improving health outcomes for its patient population, as called for in the HPC's ACO certification criteria (Assessment Criteria #5), which MassHealth ACOs will also be required to meet. ACOs should describe how programs address the specific identified social needs for their population.

Risk Adjustment

Costs of care vary substantially among individuals with similar medical conditions but varying social and economic profiles. If these factors are not taken into account, ACOs will face increased risk and instability from caring for more vulnerable or disadvantaged members. Payment adjustments must guard against disincentives for ACO providers to care for high-risk members or incentives for limiting care. We can learn from the One Care program, which has faced challenges in financing because payments were not adequately adjusted to account for the needs of the population being served. We therefore recommend that the ACO payment models incorporate some of the social determinants of health when risk adjusting for total cost of care.

Further, risk adjustment methodologies should be calibrated to not only reflect health status and social factors, but also age. Risk adjustment models for a standard population do not provide accurate modifications when applied to a pediatric-only population, and could result in inequitable reimbursement for providers specializing in pediatric care.⁵⁶

In addition to adjusting payments based on socioeconomic status and other sociodemographic factors, MassHealth should also consider making similar appropriate adjustments to some ACO quality metrics used in payment as well. The decision made by the National Quality Forum (NQF) to endorse adjusting outcomes measures⁵⁷ based on these factors reflects the concern that a provider should not be penalized as a poor

⁵⁶ Milliman. Risk adjustment for pediatric populations, November 2013. Retrieved from <http://www.milliman.com/uploadedFiles/insight/2013/risk-adjustment-for-pediatric-populations-healthcare-reform-bulletin.pdf>

⁵⁷ National Quality Forum. (2014). Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors. Washington, D.C.: National Quality Forum. Retrieved from http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociode

performer because it serves more vulnerable patients. For example, a recent study found that Medicare readmission rates varied significantly based on the patient population.⁵⁸ The researchers concluded that “Hospitals serving healthier, more socially advantaged patients may not have to devote any resources to achieving a penalty-free readmission rate, whereas hospitals serving sicker, more socially disadvantaged patients may have to devote considerable resources to avoid a penalty.”⁵⁹

However, these adjustments should only be made to measures that implicate patient characteristics, and should not apply to issues solely under the provider’s control (for example, surgical checklists or hand washing). In addition, unadjusted stratified data should be made available for measuring disparities and targeting quality improvement efforts.

We appreciate the opportunity to submit comments in response to MassHealth’s 1115 Waiver Request. We look forward to continuing to work with you to ensure that these reforms result in enhanced care and improved outcomes for MassHealth members. Should you have any questions or wish to discuss these comments further, please contact Alyssa Vangeli at (617) 275-2922 or avangeli@hcfama.org or Suzanne Curry at (617) 275-2977 or scurry@hcfama.org. Thank you for your consideration.

Sincerely,



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[sociodemographic_Factors.aspx](#); see also studies collected at <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>.

⁵⁸ M. Barnett, J. Hsu, J. M. McWilliams (2015). Patient Characteristics and Differences in Hospital Readmission Rates. *JAMA Intern Med.* 2015;175(11):1803-1812.

⁵⁹ Id.

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**RE: HLA Comments on the Commonwealth's Section 1115
Demonstration Project Amendment and Extension Request**

Dear Assistant Secretary Tsai:

We appreciate the opportunity to comment on the Commonwealth's proposed amendment to the MassHealth 1115 waiver (Waiver Request). Health Law Advocates (HLA) writes to you on behalf of our low-income clients who are members of MassHealth and the Health Safety Net (HSN). We strongly advocate that any "value-based restructuring" of the MassHealth program must preserve *member access to quality care and medically necessary services as the most important element of a new system* that also seeks to moderate health care costs.

Delivery system reform is a very worthy goal. An integrated system of care and coverage that incentivizes high quality outcomes offers great promise for MassHealth members. However, clarification and preservation of consumers' rights within the restructured system are critical to ensure access to care. HLA has reviewed the comments submitted by Health Care For All and the ACT!! Coalition and we strongly endorse their recommendations. We submit these comments to elaborate on the following issues:

- Behavioral health issues, including emergency department (ED) boarding, treatment for substance use disorders, community partners, and mental health parity.
- Language access and cultural competency;
- Ensuring a robust health care safety net;
- Appeals and grievance processes;
- ACOs and the One Care model;
- PCC Benefit Reductions and the MCO Lock-In;
- Accommodations for people with disabilities;
- Network adequacy and continuity of care.

Behavioral Health

HLA is pleased that MassHealth is working towards greater integration of behavioral health care and physical health care, combined with improved long term services and supports (LTSS) and stronger linkages to social services. We also applaud the proposal to improve MassHealth members' access to treatment for mental health conditions and substance use disorders. We are particularly encouraged by: 1) The plan to reduce emergency room psychiatric boarding; 2) the proposed expanded scope of services to treat substance use disorders; and 3) the required establishment by Accountable Care Organizations (ACOs) of behavioral health Community Partnerships. HLA also urges the Commonwealth to ensure compliance with state and federal mental health parity laws, which is among HLA's highest priorities.

1) Emergency Department psychiatric boarding

HLA is pleased to see a targeted effort to combat Emergency Department (ED) psychiatric boarding. We support MassHealth seeking DSRIP funding to support diversionary levels of care that emphasize treatment in the least restrictive, clinically appropriate setting. The levels of care identified are all important and no doubt need to be enhanced and/or expanded. However, we believe that investment should also be made in emergency department and inpatient hospital care as some patients who board require hospital-level care. We recommend that MassHealth seek DSRIP funding to expand inpatient services for members with both mental illness and developmental disabilities and/or complex medical needs.

We caution that making funding of services dependent on achieving a pre-determined target to reduce ED boarders is too simplistic an approach. As EOHHS aims to reduce ED boarding it must study whether increased funding of the identified levels of care has provided members with the care they need and contributed to their sustained, community-based recovery.

2) Expanded access to treatment for substance use disorders

HLA strongly supports the goal of expanded access to treatment for substance use disorders. We agree that an improved SUD treatment system should be built on principles from the American Society of Addiction Medicine (ASAM) and focused on individual treatment within a recovery-centered continuum of care. MassHealth is a vital insurer for Massachusetts residents who are seeking substance use disorder treatment. We are heartened by the plan to add ASAM Level 3.1 and 3.3 treatment services to the list of MassHealth covered services. These residential treatment settings are essential to recovery for many individuals struggling with SUDs. We support the requirement that Managed Care Entities cover medically necessary care for ASAM Level 3.1 and 3.3 services with no pre-set unit-of-service limit. HLA encourages MassHealth to fund *all* medically necessary Transitional Support Services and Residential Rehab services provided to MassHealth members enrolled in Managed Care Organizations (MCOs), the Primary Care Clinician (PCC) plan and Fee-For-Service MassHealth.

HLA regularly assists low-income clients with difficulty accessing SUD residential services. We are encouraged by recognition of the important role played in recovery by this type of care. Obtaining Federal Financial Participation (FFP) for this critical care setting makes absolute sense and will open up a great number of needed beds.

MassHealth proposes to use the weighted average length of stay for several ASAM levels of care to develop a reimbursement rate for MCOs. While this proposal sounds reasonable, we believe

safeguards are necessary so that medically necessary care for SUD treatment will not be limited by an MCO or ACO based on fears of low reimbursement.

Similarly, we urge EOHHS to review its proposed capitation approach. It is proposed that the total cost of care for MassHealth ACO models will include physical health, behavioral health, and pharmacy from Year 1. We suggest that MassHealth phase-in behavioral health as a factor in setting the capitation rate while Community Partner relationships are established and strengthened over the first several years.

HLA also supports MassHealth's proposal to cover family SUD treatment services in 24-hour community-based settings. We appreciate EOHHS's proposal that ACO providers conduct Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care settings. We also support EOHHS' plan to invest in ongoing recovery services by funding enhanced care management and recovery navigation. In this regard, we encourage EOHHS to be expansive in its approach to investing in long term services and supports for SUD recovery, considering such essential services as, for example, sober homes. Further, we applaud EOHHS's effort to examine outcome measures outside of health, such as reduced court-involvement, school attendance and graduation and employment rates.

While we recognize that FFP for Medicaid coverage of undocumented immigrants is restricted, we nonetheless encourage MassHealth to consider requesting federal assistance to expand at least some of the new SUD treatment options to those enrolled in MassHealth Limited. By excluding this group of MassHealth members from access to SUD services, MassHealth is likely to bear greater expenses in emergency care.

3) Compliance with Mental Health Parity requirements

In March CMS issued a final rule governing mental health parity in certain Medicaid plans. The rule applies to all Medicaid MCOs regardless of how they deliver behavioral health benefits. Thus, it is clear that the federal parity requirements apply to ACO/MCO Models A and C proposed in the waiver amendment. We request that MassHealth explicitly state that the parity requirements apply to Models A and C and that the involved MCOs are responsible for ensuring compliance by the contracting ACOs. With respect to Model B, there does not appear to be MCO involvement, so unless a plan is an Alternative Benefit Plan (CarePlus) or a CHIP plan, the Medicaid parity rule may not strictly apply. However, even if parity is not required of Model B, we propose the inclusion of a parity compliance contract provision in the MassHealth-Model B ACO, as EOHHS has done with the OneCare plan.

4) Behavioral Health Community Partners

The EOHHS proposal appropriately requires that MCOs engage and contract with behavioral health organizations to serve MassHealth members with complex behavioral health needs. The behavioral health Community Partners will be critical to ACOs providing adequate and appropriate behavioral health services. Therefore, we believe it is appropriate that a significant portion of DSRIP funding be directed toward the Community Partners.

Language Access and Cultural Competency

HLA strongly concurs with the Waiver Request's statement that state and federal law "will require even experienced ACOs to make investments in new areas, including translation and

language services.”¹ It will be critical for MassHealth to ensure that ACOs offer adequate interpretation and translation services, as well as culturally competent member relations, to guarantee equal access to care for members who speak languages other than English. Improving MassHealth’s language access plan is the first step in ensuring adequate language access – we fully endorse the comments on the agency’s draft language access plan submitted by MLRI on April 18, 2016.² HLA’s clients have experienced inadequate access to medical services due to an inability to read vital documents issued only in English, as well as difficulty securing interpretation when calling customer service at the MassHealth agency and MCOs.

One mechanism to promote language access across all ACOs is to establish a social services “hub” model, which would bridge medical and social service systems, provide culturally and linguistically competent services, engage multiple social services agencies, and help to ensure access to evidence-based programs in each geographic region that address social determinants of health. Though not associated with ACOs, a similar program has been effectively instituted in Illinois, which could serve as a model for Massachusetts.³ A “hub” program should be a partnership between EOHHS and trusted community-based organizations that serve speakers of languages other than English and have expertise in working within these communities. As suggested above, DSRIP funds could be used to fund the community partners’ provision of interpretation, navigation, and even translation services for ACOs. Also, we urge MassHealth to explore the availability of enhanced federal matching funds (75% FMAP) available for interpretation services for children’s health.⁴

Ensuring a Robust Health Care Safety Net

During MassHealth’s transition to new ACO models, the Commonwealth must maintain a robust safety net to ensure access to health services and prevent medical debt. The proposed restructuring of the Safety Net Care Pool arrives on the heels of drastic changes to the Health Safety Net (HSN) that will undoubtedly increase unaffordable out-of-pocket costs for consumers and bad debt for providers. The recent eligibility cuts – introducing a minimum \$516 deductible for low-income consumers beginning at 150% of the Federal Poverty level (FPL), eliminating six months of retroactive coverage, and decreasing eligibility from 400% FPL to 300% FPL – have greatly undermined the health and financial stability of vulnerable populations such as poor immigrants and elders who experience coverage gaps caused by the HSN cuts. Restricting access to coverage restricts access to life-saving and health-preserving medical services for these vulnerable members. Thus, we once again offer our strongest recommendation to reinstate the HSN eligibility rules as they existed prior to June 1, 2016.

Medical debt is one issue that has remained a consistent problem despite the last ten years of health reform efforts at both the state and federal levels. Although health insurance coverage is nearly universal in Massachusetts, nearly fifty percent (48.4%) of low-income households experience financial or health care access problems because of health care costs, with more than

¹ The Commonwealth of Massachusetts Executive Office of Health and Human Services, *Section 1115 Demonstration Project Amendment and Extension Request*, Sec. 5.3.2.1, pg. 41.

² Vicky Pulos and Teresita Ramos, MLRI, Comments on MassHealth’s draft language access plan, April 18, 2016.

³ Illinois Immigrant Family Resource Program, <http://icirr.org/content/immigrant-family-resource-program>.

⁴ CMS, Dear State Health Official Letter, August 31, 2000; CMS issued a [July 1, 2010 SHO Letter \(#10-07\)](#) and an [April 26, 2011 Informational Bulletin](#) on the CHIPRA interpreter services matching rate.

1 in 5 (20.3%) forgoing care due to medical expenses.⁵ The HSN changes and any future reductions in funding to the safety net will only exacerbate these problems.

If the HSN changes are any indication about the direction of “value-based” delivery system reform, then HLA is extremely concerned about the fate of the safety net for the Commonwealth’s most vulnerable consumers. We cannot leave people behind in the next phase of reform. As Massachusetts moves toward incentivizing quality care, state leaders must ensure that consumers do not bear the brunt of ineffective financial management by ACOs through reduced access and greater medical debt.

Appeals and Grievance Processes

We applaud MassHealth for recognizing the need for a grievance process for ACO-specific issues and the creation of an MCO/ACO member ombudsman. Strong member rights to appeals and grievances are crucial given that ACOs will be assuming financial risk for delivering care to their members. HLA is particularly concerned about potential ACO-specific problems including denials or restrictions on referrals to providers who are unaffiliated with the ACO, limitations on services that are not reflected in members’ care plans, and restricted medical testing and assessments. We have shared our concerns on multiple occasions with the Health Policy Commission about the need for expansive appeal and grievance rights for members of risk-bearing provider organizations, of which ACOs are a subset.

Below are some elements that we believe would avoid compromising members’ quality of care by strengthening members’ rights and protections:

- Require reporting by ACOs of their appeals/grievance experience so MassHealth can monitor implementation and impact on ACO members. These required reports should include information such as the number of appeals the ACO receives, the types of appeals, and the outcome of the appeals. This information should be publically available, including through the MassHealth website;
- Require providers that share in ACO savings to provide members with a description of all possible treatment options and the basis for selecting the recommended treatment;
- Allow members to seek second opinions outside of the ACO network without additional member cost sharing;
- Ensure accessible, clear, and culturally-appropriate articulation of appeals and grievance processes. Members should receive information about the appeals and grievance processes upon enrollment in an ACO. Information about these processes should be available on MassHealth’s and ACOs’ websites, as well as in ACOs’ member handbooks;
- ACO grievances and appeals must be decided by independent reviewers and, when applicable, qualified and appropriate medical professionals;
- Clearly delineate what events may give rise to an appealable action, taking an inclusive approach;
- Require ACOs to provide timely, complete and understandable notices regarding the appeal/grievance system. MassHealth should establish timelines for when responses to member grievances must be issued;

⁵ Sharon K. Long and Thomas H. Dimmock, *Health insurance coverage and health care access and affordability in Massachusetts: Affordability still a challenge*, The Blue Cross Blue Shield of Massachusetts Foundation, November 2014, pg. 86.

- Member grievance and appeal deadlines should be generous and flexible given how new ACOs will be for MassHealth members, particularly in light of the proposed MCO lock-in that restricts consumer choice;
- Ensure that ACOs provide consumers with reasonable assistance in filing grievances and appeals. ACOs should be required to inform consumers about the availability of the newly created MassHealth ombudsman;
- Allow for full transparency and access to information for patients disputing ACO decisions regarding their care.

ACOs and the One Care Model

The Waiver Request cites the Massachusetts One Care program – the demonstration program for dual-eligible members ages 21 to 64 – as a model for effective integrated care. While One Care undoubtedly offers valuable lessons to the Commonwealth when implementing new ACO models, HLA cautions that we have worked with numerous clients who have experienced significant barriers to care within this program. These barriers significantly undermine the program’s goal of integrating and managing care for medically complicated members, particularly those with both behavioral health and physical health issues. Our clients have experienced problems, including:

- Lack of cultural and clinical competency in working with members, especially those who have mental illness;
- Understaffed and illusory care management, such as limited access to care managers and teams that meet infrequently or not at all;
- Poor continuity of care for new members who join a One Care plan and inadequate provider networks for existing members;
- A weak and understaffed ombuds program;
- Denial of services that should be covered and burdensome appeals to obtain coverage;
- Limited rights to file appeals and grievances, such as inability to appeal denial of an out-of-network provider.

We address appeals and grievances and network adequacy in other sections of these comments. Regarding care management by ACOs, we strongly recommend that the Commonwealth establish specific criteria regarding minimum staffing levels; frequency and means of member outreach; the role, composition, and activities of care teams; and staff participation in necessary cultural competency trainings about mental illness, transgender health, language access, and other member issues. Additionally, effective care integration requires assessments of members’ holistic needs for social services beyond health care. Access to such services should be included in members’ care plans. Care managers should help with referrals assist members to navigate the social services systems, including housing, fuel aid, nutrition assistance, and other supports that have an impact on health. To address social determinants of health, ACOs and the One Care program should ensure linkages with social services organizations and other community-based partners. DSRIP Funding should be available to support these community partners to promote population health in partnership with ACOs.

HLA would welcome the opportunity to meet with MassHealth leadership to discuss case specifics and potential avenues to address these problems in the One Care program and new ACO models.

PCC Benefit Reductions and the MCO Lock-In:

As previously noted, while MassHealth works to establish ACOs, it is HLA's paramount concern that the rights of MassHealth members not be diminished or impeded with the implementation of the demonstration. MassHealth must ensure that consumer protections are not jeopardized, and that all members have access to care and services that meet their needs.

As other organizations have commented, HLA is particularly concerned about proposed changes related to the Primary Care Clinician (PCC) plan and Managed Care Organizations (MCOs) which will likely restrict access to care. Though we understand that MassHealth seeks to encourage MCO and ACO enrollment, we believe the proposed policy changes – reducing PCC plan benefits and increasing member cost-sharing – will impose barriers to care and unduly penalize members who choose to remain in the PCC plan.

Specifically, HLA opposes the following changes proposed under the Section 1115 Waiver request:

- Elimination of chiropractic services, eyeglasses, hearing aids, orthotics and other state plan services available under the PCC plan;
- Increasing co-pays for PCC members;
- Expanding of the list of services to which co-pays apply;
- Potentially increasing premiums for enrollees with incomes at or above 150% FPL; and
- Imposing a 12-month lock-in period for MCO enrollees.

While we recognize the challenges that MassHealth is confronting in restructuring its delivery and payment systems, we remain concerned that, for many, these policy changes will impede access to care, reduce consumer choice, and unfairly burden members who rely on the benefits and providers available to them through the PCC plan.

Accommodations for People with Disabilities

HLA appreciates the commitment of the Executive Office of Health and Human Services in its attempts to safeguard nondiscrimination against MassHealth members who are persons with disabilities. Persons with disabilities often experience barriers in accessing health care and they are more likely to forego medically necessary treatment as a result.⁶ MassHealth member benefits and provider reimbursements become meaningless when persons with disabilities are unable to access medically necessary care.

Pursuant to Section 504 of the Rehabilitation Act of 1973 (Section 504),⁷ MassHealth providers must accommodate persons with disabilities⁸ by ensuring that patients have full equal access and opportunities.⁹ The Americans with Disabilities Act (ADA) further bars inequalities in health care services under the public accommodations provision,¹⁰ whereby providers must ensure that the quality of care and access to medical services by persons with disabilities are on par with

⁶ National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention' <http://www.cdc.gov/ncbddd/disabilityandhealth/relatedconditions.html> (page last updated 4-11-16).

⁷ Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, 29 U.S.C.A. §§ 701 et. seq. (requiring compliance by any healthcare facility that receives funding from the U.S. Department of Health and Human Services.)

⁸ See *Glanz v. Vernick*, 756 F. Supp. 632 (D. Mass. 1991) (a medical clinic that receives MassHealth reimbursements is thereby subject to Section 504).

⁹ 29 U.S.C. § 794(b)(3)(A).

¹⁰ 42 U.S.C.A. § 12182(b)(2)(A)(ii); 28 C.F.R. § 36.302.

other patients who do not have such physical or mental disabilities. Moreover, Section 1557¹¹ of the Affordable Care Act (ACA) requires that provider healthcare programs and services accommodate persons with disabilities, unless doing so would result in undue financial and administrative burden.

Useful accommodations to MassHealth members with disabilities would include communication access.¹² Medical providers are obligated to provide auxiliary aids and services, as necessary, to ensure that communications with patients who are deaf or hard of hearing are effective.¹³ Auxiliary aids, for example, benefit provider staff by clarifying their knowledge of the patient's medical condition and assist patients in receiving comprehensible instructions for follow up care or medications. However, providers may lack requisite training or the financial sources to implement such training and auxiliary devices.

Although HLA strongly supports the patient protections and provider financial assistance proposals under this section, we further suggest that federal funding also include provider trainings to ensure that medical care is provided in an accessible manner to individuals with disabilities. Additionally, each primary care clinician or ACO should be required to identify and disclose to its members an ADA Compliance Officer whose duty is to verify that the organization's programs and services are delivered in a manner that is consistent with the ADA. We urge MassHealth to institute an internal grievance procedure that would provide for the prompt, fair, and equitable resolution of patient grievances that allege provider actions otherwise prohibited under Section 1557 of the ACA.

Network Adequacy and Continuity of Care

HLA understands that delivery system reforms will require somewhat bounded provider networks due to ACOs' assumption of financial risk for managing member care. However, we are concerned about the impact of limited networks on MassHealth members' access to medically necessary covered services. MassHealth must establish – with input from consumers and other stakeholders – transparent and publicly available network adequacy standards. These standards should ensure:

- Availability of providers who deliver each of the covered services under the plan;
- Accessibility of providers within reasonable travel time and distance measures. MassHealth is required to establish such standards under recently released federal managed care regulations for the Medicaid program.¹⁴ These standards should be publicly available through MassHealth's website;
- Accessibility and transparency of information about in-network providers, including location, whether they are accepting new patients, referral requirements, and quality ratings. This information should be posted on the ACOs' websites and available through telephone hotlines and member enrollment materials;
- Ability of ACOs to execute single case agreements with providers that offer covered services that are unavailable through the plans' provider network;

¹¹ Section 1557 of the Affordable Care Act (ACA) of 2010 (stating that “[a]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance”).

¹² 56 Fed. Reg. at 35565.

¹³ 28 C.F.R. § 36.303(c).

¹⁴ 42 C.F.R. § 438.68.

- Appeal rights allowing members to challenge ACOs' denial of out-of-network care;
- Continuity of care for members who join an ACO with existing, and sometimes long-standing, provider relationships. Here, the One Care model is instructive – MassHealth should institute a similar rule about requiring good faith efforts to establish contracts with these members' existing providers.¹⁵ Sometimes, such efforts are unsuccessful but the provider relationship remains critical to ensuring care continuity due to the particular needs of the patient – for example, where the member has mental illness and has established a successful therapeutic relationship with an out-of-network provider. In this case, the ACO should have flexibility to contract with the provider for the individual member through a single case agreement or other mechanism. Where the ACO fails to take such action, the member should have the right to appeal to the Office of Medicaid Board of Hearings.

Conclusion

Thank you for the opportunity to submit comments regarding the Commonwealth's 1115 Waiver Request. HLA is eager to work together with EOHHS to ensure access to high quality care for all MassHealth members. If you have any questions about these comments, please do not hesitate to contact Staff Attorney Andrew P. Cohen by telephone at (617) 275-2891 or by email at acohen@hla-inc.org. Thank you again for your time and consideration.

Sincerely,

Matt Selig
Executive Director

Andrew P. Cohen¹⁶
Staff Attorney

¹⁵ Section 2.7(A)(8) of the Three-Way Contract between CMS, EOHHS, and One Care Plans, December 28, 2015.

¹⁶ Health Law Advocates attorneys Clare McGorrian, Caroline Donahue, and Ashley Jones-Pierce also contributed to these written comments.



July 17, 2016

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders:

HMS thanks the Executive Office of Health and Human Services (EOHHS) for the opportunity to provide comments on the draft Section 1115 Demonstration Project Amendment and Extension Request. HMS provides the broadest suite of healthcare cost containment solutions to help payers improve performance. We deliver coordination of benefits, payment integrity, and data solutions to state agencies, federal programs, health plans, and employers. Using innovative technology through powerful data services and analytics, we prevent improper payments related to fraud, waste, and abuse; and recover on inappropriately paid claims. As a result of our services, customers recover billions of dollars every year and save billions more through the prevention of erroneous payments.

In the Commonwealth, HMS has enjoyed a trusted partnership with EOHHS and the University of Massachusetts Medical School (UMMS) since 1990. We are honored to assist the Commonwealth in ensuring that services provided are necessary and provided only to those who are eligible; and that claims are billed and paid appropriately by the responsibly party. In state fiscal year 2016 alone, HMS assisted the Commonwealth save and recover a combined total of \$335 million. With that background in mind, HMS is pleased to submit comments on Massachusetts' innovative 1115 waiver proposal that focus on:

1. Leveraging Historical Claims Data for Care Management
2. Applying Payer of Last Resort Principles
3. Strengthening Premium Assistance
4. A Principled Approach to Program Integrity

Leveraging Claims Data for Care Management

Massachusetts' goals of creating and strengthening coordination among historically segregated health care delivery systems [medical, behavioral health, long term care supports and services (LTSS)] and improving the member experience within and between Managed Care Organizations (MCOs), Accountable Care Organizations (ACOs), and Community Partners (CPs) can be advanced through aggregation of, and advanced analytics on, member specific historical claims data.

To this end, HMS recommends that Massachusetts model the Centers for Medicare and Medicaid Services (CMS) MCO regulations, specifically §438.62, which requires that MCOs and states share enrollee utilization data to smooth delivery system transitions.

This data sharing is a good first step towards care coordination, care management and population health. However, we urge the Commonwealth to go further by explicitly permitting claims data aggregation which would give MCOs, ACOs, CPs and their respective network providers a more comprehensive picture of a new member, including historical member diagnosis, and provider, medication, ancillary services and LTSS information. Providing comprehensive, decipherable member utilization data will aid care coordination, care management and population health services starting day one of enrollment and even before a member consumes services. Additionally, aggregated data would allow providers to quickly identify critical conditions, avoid paying for redundant testing or ineffectual treatments, and identify potential fraud, waste and abuse, such as drug-seeking behavior. The latter can assist MassHealth achieve the fifth goal of the waiver, by addressing the opioid addiction crisis.

Through application for Delivery System Reform Incentive Program (DSRIP) funds, the Commonwealth, among other objectives, seeks to support providers in building infrastructure and care coordination capabilities for delivery system reform. Part of the infrastructure includes information technology that enables data sharing and provides tools to analyze the data shared. HMS recommends that MassHealth seek to leverage some of the DSRIP dollars or other funding to enable this historical claims data aggregation and analysis.

Applying Payer of Last Resort Principles

HMS applauds MassHealth for their consideration of access to and enrollment in other health insurance coverage. HMS agrees, that individuals enrolled in other health insurance coverage should be excluded from participation in the MCOs and ACOs, mostly out of concern that the payment models between the MCOs/ACOs and their respective Medicaid provider networks will be substantially altered making coordination of benefits with, and reconciliation of Medicaid coverage to, commercial health insurance very difficult, if not impossible.

In the waiver request, MassHealth proposes to require students to enroll in Student Health Insurance Plans when it is cost effective to do so, with premium and cost sharing assistance from MassHealth to ensure that students' out-of-pocket costs are no higher than they would be if they were enrolled in direct coverage from MassHealth. We further recommend that MassHealth explore student's access to other health insurance coverage that may be provided through a guardian or parent given the Affordable Care Act (ACA) mandate requiring insurers to provide coverage to dependents up to the age of 26. We also recommend that MassHealth investigate other health insurance coverage options via spousal plans for those students who are married. It is conceivable that parental and/or spousal coverage may be more cost effective than Student Health Insurance Plans.

HMS recommends that care provided to the uninsured and deemed "uncompensated care" be further reviewed at the claim and recipient level. Based upon HMS's experience in another Mid-Atlantic state, we identified approximately 10% of individuals who were deemed uninsured, but actually had other liable health insurance coverage that could have been billed. Given that federal and state funds to care for uninsured is diminishing, the Commonwealth can protect those limited dollars by instituting a recipient/claim review to identify other liable health insurance coverage.

Strengthening Premium Assistance

MassHealth provides supplemental coverage to approximately 44,000 working people who receive premium assistance to help pay for their employee share of health coverage through an employer.

MassHealth's premium assistance program helps Medicaid remain the payer of last resort by maximizing employer sponsored insurance (ESI). While several studies, including a September 2015 Kaiser survey of 2.1 employers, indicate continuity in employer offer rates and employee take-up rates, there are some noteworthy ESI trends, particularly around increased employee costs, that may negatively impact an individual's election in ESI in the coming years.

For example, the Kaiser survey found that premiums increased on average by 4% for both single and family coverage between June 2013 and March 2015. Additional cost sharing such as deductibles, co-insurance and co-payments also increased during that same timeframe. Specifically, 81% of employers imposed employee deductibles, up from 70% in 2010. At the same time employee deductible share rose 9% during the study period.

In addition, a large majority of employees also have to pay a portion of the cost of physician office visits. Almost 68% of covered employees pay a copayment for office visits with a primary care provider or specialist, and almost a quarter of respondents reported additional coinsurance requirements for the same providers.

MassHealth's existing premium assistance program proactively protects the Commonwealth from a swell in Medicaid enrollment should employee uptake in ESI decrease. The current premium assistance program identifies individuals who have access to ESI, but are not enrolled. Today's program is a national model, requiring participation by both MassHealth members and employers. As the Commonwealth seeks to amend and extend its 1115 waiver, HMS recommends that MassHealth look at additional measures available to incent and/or compel member response to MassHealth outreach intended to ascertain member's access to ESI. This will strengthen today's program and better protect MassHealth from potential, future changes.

A Principled Approach to Program Integrity

In the waiver request, MassHealth announces its intent to re-procure for MCOs by the end of 2016. In May 2016, CMS released updated regulations governing Medicaid managed care organizations (MCOs). These new regulations present a host of new program integrity responsibilities for states and MCOs alike. For example, MCOs have to report overpayments to the states within 60 days; states have to screen and enroll all MCO network providers, review the accuracy and completeness of encounter data, and validate medical loss ratio (MLR) annual reports.

At the same time, the final regulations provide significant flexibility to states to allow for state-specific customization. State are confronted with nuanced decision points with regard to the specific program integrity activities to undertake; the delineation of program integrity activity between the agency, MCO and other state stakeholders; which contractual and financial levers to make available to all parties regarding program integrity and more.

The regulations are complicated even in a traditional managed Medicaid environment, but in MassHealth's 1115 waiver request which envisions the use of ACOs and alternative payment models,

additional care must be taken to minimally ensure compliance, but maximally protect the program from fraud, waste and abuse.

HMS, therefore recommends that Massachusetts seek consulting expertise that:

1. Provides an assessment of program integrity activities and capabilities across contracted MCOs and MassHealth. Consider similar assessments for the Offices of the State Auditor and Attorney General.
2. Outlines requirements and decision points for MassHealth in accordance with the new MCO regulation.
3. Highlights national best practices for program integrity in a managed Medicaid environment.
4. Contemplates the role of Models A and C ACOs.
5. Leverages the above to build several program integrity models, including the advantages and disadvantages for each.

HMS applauds Massachusetts for their efforts on the current program and on this waiver. We hope that our recommendations assist in developing a more meaningful and cost effective program. HMS appreciates the opportunity to comment on the draft Section 1115 Demonstration Project Amendment and Extension Request. Should you have questions, please do not hesitate to contact Kristen Ballantine, Vice President, Government Relations at kballantine@hms.com.

Respectfully Submitted,

Kristen Ballantine
Vice President, Government Relations



July 15, 2016

Executive Office of Health and Human Services, Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Comments on Demonstration Extension Request

To Whom It May Concern,

I am writing to submit the following written comments regarding the MassHealth Section 1115 Demonstration (“Request”) to the Centers for Medicare and Medicaid Services (CMS) on behalf of the members of the Home Care Aide Council (Council).

For nearly fifty years, the Council has served as the voice for paraprofessional home care aide services in Massachusetts. Founded in 1967, we are a nonprofit trade association established to promote the growth of home care aide services, encourage the provision of quality care, and provide information about the service. Council membership includes over 150 non-profit and for-profit home care agencies that directly employ, supervise, and manage over 20,000 home care aides who provide personalized and supportive direct care services enabling elders and disabled individuals to reside in community-based settings.

The Council applauds the inclusion of language supporting the enhancement of communication through the formation of interdisciplinary teams found throughout this proposal. As our Council speaks with home care agencies throughout the Commonwealth, the challenge we hear most often related to providing care to clients with complex needs is the lack of coordination and communication between the medical community and long term care services and supports network. We also support all efforts to provide conflict-free, person-centered care coordination to all MassHealth members.

The Council also thanks the Office for including language within the Delivery Systems Reform Incentive Program (DSRIP) Investments to address scaling up statewide infrastructure necessary for reform, including targeted health care workforce development. Section 5.5.1 on pages 47 and 48 entitled “Healthcare Workforce Development and Training” begins to further define this investment stream. The current language in this section notes workforce shortages in primary care, behavioral health, and social work providers.

We respectfully request that the Office consider adding language to this section noting the current and growing shortage of home care aides (including homemakers, personal care homemakers, and home health aides). If this waiver application is successful, we urge the Administration to consider appropriating a portion of these infrastructure investments to enhance and support this workforce through new wage and benefit initiatives and the continuation of evidence-based training models such as the Massachusetts Personal and Home Care Aide Training (PHCAST) Initiative.

Home care is widely acknowledged as a high-quality and cost-effective solution to caring for elders and disabled individuals. In the next decade, the number of people age 60 and older in Massachusetts will increase by more than a quarter of a million, to nearly 1.6 million people. It is estimated that at least two-thirds of these individuals will require assistance in meeting their long-term care support needs at some point in their lives.

Massachusetts, like the rest of the nation, is already facing a shortage in the number of the home care aides needed to care for individuals in community-based settings. Addressing workforce challenges is important because home care aide employment in MA is expected to grow at a rate of 40% (2012 and 2020), due to the growth in the elder population and shift in policies supporting Home and Community Based Services (HCBS) (HCBS funding increased 61% between 2003-2008).

Home care aides are devoted to the clients they serve and are a key line of communication for clients, yet are regularly overlooked. Home care agencies face a workforce crisis fueled by low wages and benefits, the physical demands of the job, the isolated nature to the work, and the lack of adequate recognition for these essential workers. Most agencies lose 50-60% of their workforce within the first 6 months of employment.

As our health care system continues to shift to a model focused on coordinated, patient-centered care in the community, the home care network's ability to recruit and retain a qualified and trained home care aide workforce will become even more important. With the advent of Accountable Care Organizations, Community-Based Care Transitions, and Patient-Centered Medical Homes, home care aides have and will continue to play an essential role as they assist with the monitoring of conditions and provide direct daily care to consumers. Home care aides will need both enhanced initial training to meet the more acute needs of today's home care clients and continuing education to strengthen their skills, allowing them to both enhance care and to help reduce preventable hospitalizations.

Adequately supporting these workers and preparing them to meet the needs of individuals in the community, particularly those who are most vulnerable due to their risk of nursing home placement, is beneficial to the home care aides, the clients they serve, as well as the agency that employs them. By giving the workers the skills they need to perform their job, the aides have more confidence in their ability to be successful while also being more prepared to confront the challenges they see out in the field. This in turn will improve client care and also result in lower turnover rates for agencies. These outcomes have been shown to be true in the literature, with greater training leading to better care outcomes for clients, higher job satisfaction for home care aides, and better retention of workers for the agency.

In conclusion, the Council would like to thank the Executive Office of Health and Human Services (EOHHS) for providing stakeholders with an opportunity to not only comment on this proposal but also participate in public forums and share their expertise on workgroups as the state planned for the restructuring of the MassHealth program. We stand ready to continue to work in collaboration with EOHHS and the Executive Office of Elder Affairs (EOEA) to address the workforce capacity issues the state will face as it works to redesign its care delivery system.

If you have any questions regarding these comments, please feel free to contact me by telephone at 617-744-6561 or by email at lgurgone@hcacouncil.org.

Sincerely,



Lisa Gurgone
Executive Director



July 15, 2016

Daniel Tsai, Assistant Secretary for MassHealth
Executive Office of Health and Human Services
1 Ashburton Place, Room 1109
Boston, MA 02108

RE: Comments on Section 1115 Demonstration Extension Request

Dear Assistant Secretary Tsai:

On behalf of the member home health care and private-pay home care agencies of the Home Care Alliance of Massachusetts, we submit the following comments on MassHealth's request to the Centers for Medicare and Medicaid Services to extend the Commonwealth's Section 1115 Demonstration Waiver.

General Comments:

The Home Care Alliance applauds the effort of MassHealth leadership and staff to gather months of public input through various workgroups, listening sessions and meetings while also considering countless written comments and suggestions throughout the process. The extension request is a sensible, but bold proposal that will move providers towards value-based and accountable care.

In general, our organization is pleased with the emphasis on integrating Long Term Services and Supports (LTSS), as well as behavioral health, into the three models of care delivery. Home health care that offers in-home clinical services and home care that offers non-clinical supportive services have been underappreciated for their potential to reduce avoidable utilization and trim costs overall.

Throughout the stakeholder engagement process, there has been a persistent sentiment that MassHealth should avoid "over-medicalizing" LTSS. While we agree that the non-clinical side of LTSS carries huge potential if it is properly integrated, there are a substantial number of MassHealth members who require long-term clinical supports at least episodically, if not continuously. This Extension Request appears to follow that line of thought by working to ensure MassHealth members have the right care, at the right time, and in the most appropriate setting.

The Home Care Alliance joins many other organizations in full support of MassHealth's drive to establish a Delivery System Reform Incentive Program (DSRIP) and further believe that it will serve as the financial incentive compelling Accountable Care Organizations (ACO) to partner with valuable community-based providers.

The following comments are broken down by section in the Extension Request.

Goals of the Demonstration: Progress and Plans

The Home Care Alliance is pleased to see that some of the principles our organization advanced in the stakeholder process were highlighted in this section. Certainly, home health care providers are in a unique position to treat the whole person in the most comfortable setting possible. Merging physical and behavioral health needs is a goal that our members look forward to strengthening, especially.

MassHealth acknowledges that disjointed care coordination is often a barrier to integration and it is our hope that home care can be recognized as a solution for patients with both physical and behavioral health

needs. A specialty of our member agencies is placing patients on a path to self-management and the Alliance believes care coordinators should be encouraged to look to home health care to fulfill this goal.

With the Commonwealth's vision that the Substance Use Disorder (SUD) treatment system should treat addiction as a chronic medical condition, the Alliance believes that home health could have an important role to play in ensuring success of initial addiction interventions and treatments in the longer term. A minority of home health agencies have specialties in treating individuals with SUD, but the success of those agencies displays that this could be yet another strength of home health in waiting.

MassHealth Payment and Care Delivery Reform Strategy

The Home Care Alliance agrees with MassHealth's proposal to allow for multiple models of ACOs that will go further towards nurturing the appropriate relationships and partnerships while accounting for different providers with different strong points across geographies.

MassHealth's commitment to integrating behavioral health and LTSS is clear, and the Alliance realizes that accountability will be phased in over the course of the demonstration. Our organization stands ready to work with MassHealth to help develop proper accountability measures as the process progresses.

One concern is that there seems to be a varying level of obligation for LTSS integration. For example, below are what the Extension Request states of each ACO Model

- Model A: *“Over time, Model A ACOs will have financial accountability for LTSS in their scope of covered services and accountability, subject to further stakeholder engagement and MassHealth evaluation.*

A Model A ACO must demonstrate competencies and readiness in [independent living philosophy, wellness principles, and etc.] before it takes on accountability for LTSS”

- Model B: *“The ACO is accountable for the total cost of care...and for additional contractual expectations of ACOs, including BH and LTSS integration through CPs”*
- Model C: No mention of LTSS integration.

Granted, these are brief summaries of each model, but it still raises the question of the types of services and the level of services to which individuals will have access.

In terms of the priority domains for MassHealth's quality measurement strategy, the Home Care Alliance once again emphasizes how these play into the strengths of quality home health care services. Avoidable utilization, chronic disease management, and enhancing the MassHealth member experience are all domains in which home health can play a major contributing role in the success of the ACO. If home health care could be allowed by the ACO to engage in prevention and wellness activities as well as become part of the team to help treat behavioral health and SUD needs, it would only serve to benefit the reformed model of care delivery.

Under the heading “Integration of physical health, behavioral health, long-term services and supports and health related social needs, and Community Partners strategy,” MassHealth commits to member access to an interdisciplinary care team that includes an LTSS representative where needed. The Home Care Alliance applauds the idea that the interdisciplinary care team must include existing community-based LTSS entities which collectively demonstrate expertise in all LTSS populations. This was a concern our organization has voiced throughout the stakeholder process and we are pleased that MassHealth heard the

suggestion that one individual from one LTSS provider likely would not the suitable level of expertise to serve the member.

Moving to the subject of Community Partners (CP), the Alliance sees the CP designation as an opportunity to establish a formal link between ACOs and home care. However, the Alliance is concerned that most of the CP responsibility will be for waiver services (i.e. ABI/TBI) or focused solely on serving populations with disabilities. While home health agencies certainly serve those populations, the Alliance believes home health has been underutilized by those populations and hope such services are readily available under the new system.

Later in the Extension Request, under the subheading “Phasing LTSS into MCO’s Scope of Services,” it is revealed that home health and private duty nursing will be integrated through the MCO’s requirement to demonstrate LTSS competencies. The Alliance hopes that this link will be just as strong as the CP arrangement to ensure that members get the LTSS they need to remain as healthy and independent as possible. The Alliance would also note the absence of hospice and palliative care under that list (under section 4.3.1.3). It is the Alliance’s hope that both would be available to MassHealth members and actively promoted by ACOs.

Delivery System Reform Incentive Program Investments

This section moves further into defining CPs and, confusingly, the definition appears to expand. The Alliance requests clarification on CPs and what provider types could qualify as CPs.

The Alliance also suggests that MassHealth carry the “buy over build” philosophy when it comes to direct spending for traditionally non-reimbursed services to address health-related social needs (Section 5.3.2.3). Once again, this is an opportunity for ACO’s to maximize the expertise of home health for pre-acute in addition to post-acute services. With experience in falls prevention, nutrition assessment and counseling, and social work, home health agencies are ready and willing partners when it comes to addressing these and many other health-related social needs.

DSRIP funding streams for Health IT adoption and workforce adoption are of particular interest to an industry that did not receive any federal assistance through the HITECH ACT and struggles with recruitment and retention of all staff levels – from homemakers or clinicians. The Alliance supports these investments and hopes that community-based care will be a focus when it comes to assessing the needs of the Commonwealth’s health care infrastructure that will benefit members.

Conclusion

The Home Care Alliance appreciates the engagement of MassHealth and looks forward to a more collaborative and coordinated process. Our organization has commented publicly on ACO proposals for many years and hopes that home care can finally display the potential for improving quality and reducing costs that alternative payments can offer.

Again, we appreciate your collaboration and look forward to cooperatively improving care for the residents of the Commonwealth.

Thank you,



Patricia Kelleher
Executive Director

Home Care Alliance of MA

Jane Doe Inc.

The Massachusetts Coalition Against Sexual Assault and Domestic Violence

14 Beacon Street, Suite 507 Boston, Massachusetts 02108 Tel 617 248 0922 Fax 617 248 0902 www.JaneDoe.org

July 15, 2016

EOHHS Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108
Attn: 1115 Demonstration Comments

RE: Comments on Demonstration Extension Request

To Whom It May Concern:

On behalf of Jane Doe Inc. (JDI) and our 56 community-based member agencies that provide direct services to sexual and domestic violence survivors throughout Massachusetts, we thank you for the opportunity to offer comments with regard to the 1115 Demonstration Extension.

JDI, the Massachusetts Coalition Against Sexual Assault and Domestic Violence, is a social change organization committed to addressing the root causes of sexual and domestic violence and promoting justice, safety, and healing for survivors. JDI's member programs are part of a comprehensive network of sexual and domestic violence prevention and services organizations, meeting the needs of victims and survivors across the Commonwealth by providing free and confidential services to individuals, families and communities, including education, training and public awareness about these issues. As such, we direct our comments specifically to the inclusion of flexible services to address health related social needs within Accountable Care Organizations, specifically sexual assault and domestic violence services, and request that DSRIP funding be directed to support the work of these existing local programs as part of a referral network for regional Accountable Care Organizations.

Sexual and domestic violence continues to be a significant problem in MA and the connections between experiencing sexual and domestic violence and health outcomes has been well documented:

- According to a 2010 study, nearly 1 in 3 women and 1 in 5 men in Massachusetts experienced rape, physical violence and/or stalking by an intimate partner; More than 1 in 7 women in Massachusetts were raped.¹

¹Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

- Nationally, 81% of women and 35% of men who experienced rape, stalking, or physical violence by an intimate partner, reported significant short or long term impacts related to the violence such as Post Traumatic Stress Disorder symptoms and injury.²
- Women who had experienced rape or stalking by any person, or physical violence by an intimate partner were more likely to report having asthma, diabetes, and irritable bowel syndrome than those who had not.³

For survivors, health outcomes are related both the actual physical harm that they experience, as well as the other social determinants in their lives-which may include a lack of economic stability and, frequently, housing instability. Survivors often seek services first through the social services sector to begin to access the physical and mental health care that that is needed to address the trauma they have experienced-such as through a local, community based sexual and/or domestic violence program. The targeted clinical and advocacy support that is offered at local programs is critical to survivor healing. In a 2011 study in MA, 94% of domestic violence survivors served by local programs indicated that they were more hopeful about the future after having received services⁴. Hopefulness is considered a foundation of recovery from traumatic experiences by SAMHSA. Local programs are also a critical partner for the health care community to collaborate on appropriate health care screening for domestic violence.

Massachusetts providers have the expertise and foundation for this work and are positioned to work with ACO's to build protocols and best practices around screening and referral. While these systems already may interact and work well together, there are frequently limitations to the capacity of community based sexual and domestic violence programs to meet the needs of all survivors. Resources are needed to facilitate the building of these partnerships.

We are pleased to see the inclusion of sexual and domestic violence supports as part of the ACO funding purpose with regard to direct spending for traditionally non-reimbursed flexible services to address health-related social needs (section 5.3.2.3). As noted, local programs provide services free and confidentially and are significant presence in the communities in Massachusetts supporting the health and healing for individuals after having experienced significant trauma in their lives. As you work toward the implementation and distribution of DSRIP funds for this purpose, we strongly urge you to direct resources to the existing network of sexual and domestic violence programs (see the enclosed map for a listing of the current network of providers in MA). We encourage you to work with us and with the Department of Public Health, which has strong connections and funding relationships with local programs, in identifying the appropriate providers for ACOs to engage with regionally.

Additionally, strongly support that flexible services recommended also include housing stabilization and support. The intersection of homelessness/housing instability and sexual and domestic violence is well documented. For many individuals and families, stable housing is a significant factor in determining whether they will be able to achieve safety after violence and

² Ibid.

³ Ibid.

⁴ Lyon, E., et al (2011). Non-Residential Domestic Violence Services: Survivors' Experiences. The Domestic Violence Non-Residential Services and Support Study. Massachusetts Overview.

housing instability can put those families at further risk for both violence and other poor health outcomes.

We are excited about the opportunities presented by the development of ACOs and the inclusion of an approach which addresses the social determinants of health. We believe that the relationship of ACO's with sexual and domestic violence providers will enhance positive health outcomes for victims and survivors in Massachusetts.

Please feel free to contact me if you have any further questions or require further information on this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Debra J. Robbin". The signature is fluid and cursive, with a small flourish at the end.

Debra J. Robbin, Ed.M.
Executive Director

NETWORK OF SEXUAL ASSAULT & DOMESTIC VIOLENCE SERVICE PROVIDERS IN MASSACHUSETTS

CENTRAL & METROWEST REGION		NORTHEAST REGION	
AWAKE Program (Children's Hospital) Boston: 617-355-6369	HAVEN at MGH Boston: 617-724-0054	Domestic Violence Services Network Concord: 888-399-6111 <ll	Alternative House Lowell: 888-291-6228 <ll
Boston Medical Center Domestic Violence Program Boston: 617-414-5457 Boston Area Rape Crisis Center (BARCC) Cambridge: SOQ.841-8371 <ll	International Institute of Boston Boston: 617-695-9990 Passageway at Brigham & Women's Hospital Boston: 617-732-8753 Portal to Hope Salisbury: 781-306-6678	The Domestic Violence/Sexual Assault Program of Newton Wellesley Hospital Newton: 617-243-6521 Journey to Safety (JFCS) Waltham: 781-647-5327	Center for Hope & Healing (Rape Crisis Services of Greater Lowell) Lowell: 800-542-5212 <ll Community Teamwork Inc. Lowell: 978-459-0551
Casa Myrna Boston: 877-785-2020 <ll	Renewal House Roxbury/Boston: 617-566-6881 <ll	New Hope, Inc. South County/Webster. 800-323-4673 <ll	JAWC - Healing Abuse Working for Change Salem: 978-744-6841 <ll
Center for Violence Prevention and Recovery at Beth Israel Deaconess Medical Center Boston: 617-667-8141 Community Advocacy Program of CCHERS Boston: 617-373-4591	RESPOND Inc. Somerville: 617-623-5900 <ll	REACH Beyond Domestic Violence Waltham: 800-899-4000 <ll	Jeanne Geiger Crisis Center Newburyport / Amesbury: 978-388-1888 <ll
Crittenton Women's Union Boston: 617-296-2452	Safe Havens Interfaith Partnership Boston: 617-951-3980	Pathways for Change (Rape Crisis Center) of Central Worcester Worcester: 800-870-5905 <ll	Sawyer Care, Inc. Lawrence: 978-686-1300
DOVE Inc. Quincy: 888-314-36830 >	The Second Step Newton: 617-966-3999	Project We Can Talk About It", Children's Charter Waltham: 781-894-4307	YWCA of Greater Lawrence Lawrence: *877-509-9922 <ll 0844-372-9922 <ll
The Elizabeth Stone House Jamaica Plain/Boston: 617-427-9801 <ll	Transition House Cambridge: 617-661-7203 <ll	Spanish American Center Leominster: 978-534-3145	YWCA North Shore Rape Crisis Center Lynn: 800-922-8772 <ll TTY: 781-477-2315
FINEX House Jamaica Plain/Boston: 617-288-1054 (Also TTY) <ll	Violence Recovery Program (Fenway Health) Greater Boston: 617-927-6250	Voices Against Violence Framingham: 800-593-1125 <ll	YWCA Central Massachusetts Domestic Violence Services: BWR and Daybreak Worcester: 508-755-9030 <ll Leominster: 508-756-9030 <ll
Harbor COV Chelsea: 617-184-9909 <ll			

* Center for Women & Community Amherst: 413-545-0800 <ll TTY: 413-577-0940	Safe Passage Northampton: 888-345-5282 III TTY: 413-585-6066 <ll
* Elizabeth Freeman Center Pittsfield: 860-401-24250 >	Women's Shelter/Comparieras Holyoke: 877-536-1628 <ll
* NELCWIT Greenfield: 413-772-0806 <ll>	YWCA Western Massachusetts Springfield: 800-796-1711 <ll TTY: 413-733-7100
* A New Day/Penelope's Place (Health Imperatives) Brookton/Quincy: 508-588-8255 * <ll	Independence House, Inc. Hyannis: 800-439-6507 <ll>
* Nantucket Safe Place 508-588-2041 @ <ll 508-228-2111 <ll TTY: 508-228-7095	Attleboro Rauntton: New Hope, Inc.: 800-323-4673 <ll
Cape Cod Center For Women Falmouth: 508-564-7233 <ll	South Shore Women's Resource Center Plymouth: 508-746-2664 <ll 888-746-2664 <ll
CONNECT to End Violence Vineyard Haven: 508-696-7233 <ll TTY: 774-549-9659	SSTAR Women's Center Fall River: 508-675-0087 <ll
Family & Community Resources Brookton: 800-281-6498 <ll	The Women's Center New Bedford / Fall River: 888-839-6636 <ll

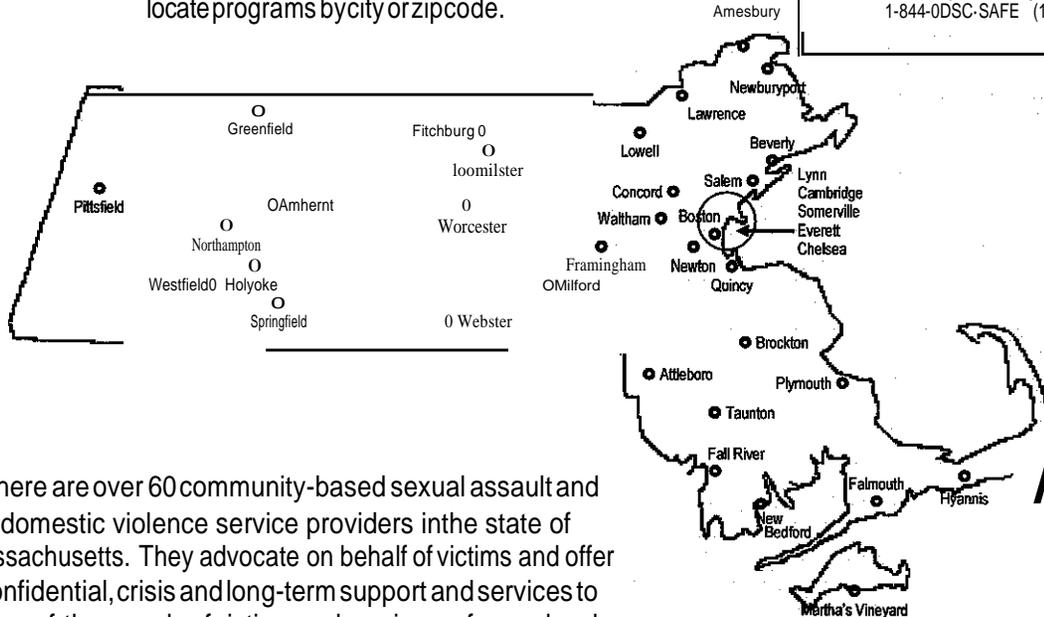
See other side for a list of statewide programs and much more.



NETWORK OF SEXUAL ASSAULT & DOMESTIC VIOLENCE SERVICE PROVIDERS IN MASSACHUSETTS

Use this map to find free and confidential support and services at a sexual or domestic violence program near you.

You can also find programs by visiting www.janedoe.org/find-help/search for an interactive search engine which allows you to locate programs by city or zip code.



1: YSI 4;		Jif {RS2,;...;}	
If you are not sure where to call for help, call 411.		© Safelink Toll-free Statewide Domestic Violence Hotline PH: 877-785-2020 < > ITT: 877-521-2601 < >	
® Asian Task Force Against Domestic Violence (ATASK) 24-Hour Multilingual Helpline 617-338-2355 < > ES	* Liflmanos y hablemos Toll-free Spanish Sexual Assault Helpline 800-223-5001	OMA Alliance of Portuguese Speakers 617-864-7600	
0 Our Deaf Survivors Center Hours: 5pm Monday -9am Saturday 1-844-0DSC-SAFE (1-844-637-2723)	0 The Networklla Red Ending partner abuse in LGBTQIT, SM, and Poly Communities PH: 617-742-4911 < > ES ITT: 617-338-SAFE {7833}	0 SAHEL : Friendship for South Asian Women 866-472-4354	

SYMBOL KEY			
⊙	Domestic Violence Program	⊙	24 Hour Free & Confidential Hotline
⊙	Sexual Assault/Rape Crisis Program	ES	Emergency Domestic Violence Shelter
JDI members in bold			

VISIT OUR WEBSITE:
www.JaneDoe.org

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14 Beacon Street, Suite 507, Boston, MA 02108
TEL: 617 248-0922 ITT: 617 263 22-00 FAX: 617-248-0902

There are over 60 community-based sexual assault and domestic violence service providers in the state of Massachusetts. They advocate on behalf of victims and offer confidential, crisis and long-term support and services to tens-of-thousands of victims and survivors of sexual and domestic violence and their families each year.

See other side for a list of programs by region.

To Whom it May Concern,

I am writing in opposition to the 1115 waiver proposal to restructure Mass Health and create ACOs. ACOs do not do a good job in controlling the cost of healthcare (see <http://pnhp.org/blog/2015/09/14/medicare-yet-to-save-money-through-acos/>). What's worse is that ACOs pull patients away from doctors they have a long-standing relationship with and force them to build new relationships with providers far from home and too busy to appropriately form a meaningful doctor-patient relationship.

Not only do I feel strongly that ACOs are wrong for our patients, I know it will be disastrous for my 12-year-old son my husband and I adopted from foster care when he was 5 years old.

My son, Andrew, spent the first three years of his life in an abusive birth home followed by 18 months in three different foster homes leaving him with a number of behavioral health issues including PTSD and reactive attachment disorder (RAD). Over the past seven years my husband and I have worked hard alongside Andrew's primary care provider and various therapists to help Andrew to heal and develop the tools he needs to live a full, productive life in spite of his mental health issues. If/when Andrew is transitioned to an ACO, I have no confidence that we will be able to keep the professionals we currently have in place that are working well for Andrew.

As healthcare professionals we know that the costs of healthcare must be controlled, but ACOs and health insurance are not the answer. I am a member of Physicians for a national Health Plan (<http://pnhp.org>) and an advocate for a Medicare-for-All, single-payer system. Medicare-for-All is the best option for providing affordable healthcare to all patients.

Be well,
Leann

Leann DiDomenico, MBA
Administrative Director
Performance Pediatrics, LLC
Partnering with Families through Childhood Milestones

www.PerformancePediatrics.com

Follow my blog: <http://www.physicianspractice.com/authors/leann-didomenico-mcallister>

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E-MAIL POLICY: Performance Pediatrics does not use e-mail to conduct patient care. Please do not send patient information via e-mail. New and established patients may contact us by phone to discuss any concerns at 508-747-8277.

Hi Monique,

I hope this finds you well.

I was wondering if there was someone at MassHealth who might be able to clarify a question on the 1115 Wavier Proposal. I have a very specific question about eye glass coverage – I am wondering if the reference to excluding coverage for eye glasses in the PCC plans refers to just the elimination of the coverage for the *hardware* of the eyeglasses or if this refers to eliminating coverage for the eyeglass *services* as well (i.e. vision exam, fitting, dispensing, etc.). I am going to submit a formal comment prior to the deadline, but was hoping to clarify this one point just to be sure the comment is relevant to the proposal. Any help clarifying would be greatly appreciated.

Thank you,
Kim

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Mark E. Nehring, Chair, Dept of Public Health and Community Service, Tufts School Dental Medicine

ACO- Design

Mounting evidence shows more causal and growing associations between poor oral health and systemic (rest of the body) diseases. [many examples in letter of evidence that cost of treating systemic disease is reduced with oral health care] ... *Oral health needs to be integrated into the 1115 Waiver Amendment request.* Those most vulnerable to disease need the knowledge base, and access to coordinated health care to: maintain health (including a healthy dentition), eat, speak, become employed and maintain dignity within social interactions.

Suggest a committee be convened composed of primary care and oral health providers, as well as stakeholders including consumer representatives, to identify necessary metrics for evaluating oral health outcomes.



Mass Home Care

Preliminary Testimony Regarding The MassHealth Section 1115 Demonstration Project And Extension Request

**Prepared by the Mass Home Care Association
June 24, 2016**

Introduction

The Mass Home Care Association is a network of 26 state-designated Aging Services Access Points (ASAPs) and twenty-two federally designated Area Agencies on Aging (AAAs). The ASAP, pursuant to state law, provide independent care coordination services in the pre- and post-acute setting to the elderly and individuals with disabilities, under contracts with the Executive Office of Elder Affairs, MassHealth, Senior Care Organizations, One Care plans, Medicare Advantage plans, and other health care entities and insurers.

Under the provisions of Chapter 19A, 4B, Chapters 118E, s. 9D and 9F, the ASAPs act as 'independent agents' as this term is defined by CMS. Our mission is to keep individuals living in the least restrictive setting possible, at their highest level of functioning possible, for as long as possible.

I. Comments on the 1115 Plan

On June 15th, Mass Health released its request to amend and extend the MassHealth Section 1115 Demonstration ("Request") to the Centers for Medicare and Medicaid Services.

The MassHealth 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs as a part of MassHealth restructuring.

Integration of Care Is An Important Goal

Mass Home Care agrees fully with MassHealth that "improving integration and delivery of care for members with behavioral health needs and those with dual diagnoses of substance abuse disorder; as well as integration of long term services and supports and health-related social services," is an important goal to pursue. We were involved with the writing of state law regarding two earlier managed care demonstrations: The SCO plan, and the One Care plan. Each of these managed care plans has provisions requiring the use of independent LTSS coordinators.

Mass Home Care Supports The Goals Of This Project

The proposed demonstration extension's goals are to: (1) enact payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improve integration among physical health, behavioral health, long-term services and supports, and health-related social services; (3) maintain near-universal coverage; (4) sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals; and (5) address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services. This proposal describes each of these goals, and the strategies to achieve them.

Creation of “Community Partners Is An Innovative Approach

From a high level, the 1115 Demonstration is a plan that gives Medicare and Medicaid per member per month capitations covering a wide range of acute and post acute services, along with behavioral health and substance abuse services, to networks of acute care providers who have less experience in the post acute and LTSS settings. We agree with the MassHealth statement that "ACOs do not have all the core capabilities needed to serve MassHealth Members." That is certainly true for LTSS.

We applaud MassHealth's proposal to create incentives for the Accountable Care Organizations—which are acute care networks of hospitals and physicians---to work with “community partners” to integrate BH and post acute with acute services. This is a constructive way to bring these two very different cultures together into one plan.

We Support Proposed Uses of DSRIP Funds & Incentives

The plan to commit DSRIP funds to these community partners is an innovative and substantive approach. We support the use of DSRIP funds for the 3 primary purposes listed:

1. to address social determinants of health
2. to support infrastructure and capacity building for improve LTSS integration
3. to invest in targeted health care workforce development

DSRIP investments “will be contingent upon an ACO partnering with BH and LTSS Community Partners.” MassHealth should require ACOs to demonstrate that they are building on existing LTSS infrastructure, and not building redundant systems.

Mass Home Care strongly endorses the use of DSRIP funds “for care management, coordination, assessments and counseling...and funding to provide independent assessments...LTSS CPs will also receive funding for their participation on the member's care team...”

Ensuring LTSS care is not ‘over-medicalized.’

Mass Home Care recommends using independent agents for LTSS to prevent the over-medicalization of community supports.

Home Care Services Should be Added To Current State Plan Services

The list of 14 “current state plan services” to be provided by MCOs includes nursing facility care, home health care, adult foster care, adult day care, and personal care services---but not home care aide services, meals, and other cost-effective home care services. MassHealth says it is “exploring avenues to potentially expand the availability of enhanced benefits...” These home care services must be the kind of “enhanced services” needed in any LTSS scope of benefits.

Keeping Frail Elder Waiver Services Outside Of The ACO Plan

Mass Home Care supports MassHealth's plan to provide FEW services "outside of ACO scope and budgets."

LTSS Partners Should Not Have To Meet All Needs For All Members

The ACO IDT should be able to "collectively demonstrate expertise in all LTSS populations, but any individual LTSS entity should be able to specialize in one or more populations. To encourage all entities to serve all populations would be duplicative and wasteful.

LTSS CP Domains

Mass Home Care supports the 6 certification domains spelled out in the plan:

1. ability to collect and analyze data electronically
2. care management and coordination
3. staff expertise and training
4. relationships with social service providers
5. quality measurements and reporting
6. cultural competency

To this list we would add a 7th domain:

7. capacity to conduct independent assessments and care planning

ACOs Must Delegate Authority to LTSS CPs

Mass Home Care agrees that ACOs must "be required by MassHealth to delegate certain responsibilities to LTSS CPs, which will include counseling and decision support on service options, LTSS and social needs assessments, patient and family support, and certain referral and navigation services for LTSS or community care." But MassHealth must require this and monitor this---something it has not done with the One Care program. And LTSS CPs must be conflict free, as discussed below.

Preserving Conflict-Free Principles

In an earlier version of the 1115 demonstration released in mid April, MassHealth said that one of the goals of the Community Partners (CP) was to "preserve conflict-free principles, including consideration of care options for consumers, and limitation on self-referrals." We support this concept, and want to see it strengthened. Massachusetts has had a long-standing relationship with the concept of "conflict free care coordinators." The home care system by law is operated by regional, non-profit agencies which are not allowed to own direct services, with a few minor exceptions. Senior Care Organizations (SCOs) are required by law to have independent Geriatric Support Services Coordinators, and the One Care program is required by law to have independent LTSS coordinators.

The federal CMS rules for the provision of home and community based services requires assessments be performed by "conflict free" entities. The theory behind independent assessments is that the person who determines your need for care, should not be the same person who provides it---so there is no financial conflict of interest or self-dealing.

In its Final Rule for the provision of home and community-based services, CMS says:

What CMS Says About Independent Assessors

- * The Affordable Care Act “requires that states use the assessment to: determine the necessary level of services and supports to be provided; prevent the provision of unnecessary or inappropriate care; and establish a written individualized service plan. To achieve the three purposes of the assessment listed above, the assessor must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns. Therefore, we proposed specific requirements for independence of the assessor.”

--Federal Register / Vol. 79, No. 11 / Thursday, January 16, 2014 / Rules and Regulations Medicaid Program; State Plan Home and Community-Based Services, Independent Assessment (§ 441.720) Final Rule

9

Conflict of Interest Standards Should Follow Federal Rules

As part of its state plan to provide home and community-based services for individuals with disabilities, states are required to define conflict of interest standards:

Title 42, Chapter IV, Subchapter C, Part 441, Subpart M

State Plan HCBS for Elderly and Individuals with Disabilities

§441.730 Provider qualifications.

(b) Conflict of interest standards. The State must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict of interest standards apply to all individuals and entities, public or private

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On May 6, 2016, CMS issued its Medicaid Managed Care Final Rule, which requires that for assessments, states “must use appropriate providers or individuals meeting LTSS service coordination requirements of the state.” 438.208 (C) (2). Treatment plans must be “developed by an individuals meeting LTSS service coordination requirements with enrollee participation and in consultation with any providers caring for the enrollee.” In a comment note, CMS says: “States have the flexibility to contract with an

independent assessment entity, but such arrangements are not required under this regulation.”

MassHealth has not yet published “LTSS service coordinator requirements,” but we believe these standards should reflect strong conflict-free provisions, similar to those EOHHS has agreed to as part of its commitment to the federal Balancing Incentive Payment program:

On January 31, 2014, Massachusetts applied to CMS for BIP funding, and as part of this application, the State agreed to make the structural changes to ensure MassHealth members receive conflict-free case management services: “Massachusetts is committed to working with our many community partners and stakeholders in a collaborative fashion to achieve the goals of this initiative and to build upon the supports that Massachusetts currently has in place to...ensure a conflict-free case management system.”

As part of its agreement with CMS to receive more than \$130 million in Balancing Incentive Payments (BIP) funding, the Commonwealth agreed to ensure that an “an individual’s plan of care must be created independently from the availability of funding to provide services,” and to make structural changes to ensure “conflict free care management services.”

CMS explains that the “design of services, rate establishment, payment methodologies, and methods of administration by the State Medicaid agency may all contribute to potential conflicts of interest. These contributing factors can include obvious conflicts such as incentives for either over- or under-utilization of services; subtle problems such as interest in retaining the individual as a client rather than promoting independence; or issues that focus on the convenience of the agent or service provider rather than being person-centered. “To mitigate any explicit or implicit conflicts of interest,” CMS writes, “the independent agent should not be influenced by variations in available funding, either locally or from the State. The plan of care must offer each individual all of the LTSS that are covered by the State that the individual qualifies for, and that are demonstrated to be necessary through the evaluation and assessment process. The plan of care must be based only on medical necessity (for example, needs-based criteria), not on available funding. “

“Conflict-free case management.” CMS continues, “prohibits certain types of referrals for services when there is a financial relationship between the referring entity and the service provider rather than being person-centered...Payment to the independent agent for evaluation and assessment, or qualifications to be an independent agent, cannot be based on the cost of the resulting care plans. CMS recognizes that the development of appropriate plans of care often requires the inclusion of individuals with expertise in the provision of long-term services and supports or the delivery of acute care medical services. As discussed previously, this is not intended to prevent providers from participating in these functions, but to ensure that an independent agent retains the final responsibility for the evaluation, assessment, and plan of care functions. The State must ensure the independence of persons performing evaluations, assessments, and plans of care. Written conflict-free case management ensures, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual,
- related by blood or marriage to any paid caregiver of the individual,
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual,
- providers of State plan LTSS for the individual, or those who have interest in or are employed by a provider of State plan LTSS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections.”

In an August, 2015 report on the use of Balancing Incentive Payment Program (BIP) funds in Massachusetts, CMS wrote: “As outlined in the ASAP Law, ASAPs may not directly provide waiver services beyond nutritional services. ASAPs may provide other Medicaid community-based LTSS that may be included in a participant’s care plan (e.g., Adult Foster Care, and Personal Care Management services). Those agencies must apply to MassHealth and receive a waiver from EOEA to provide these services.”

Implementing Independent Agents in the ACO Plan

In January of 2016, Mass Home Care proposed a straight-forward process for implementing conflict free agents in the ACO plan:

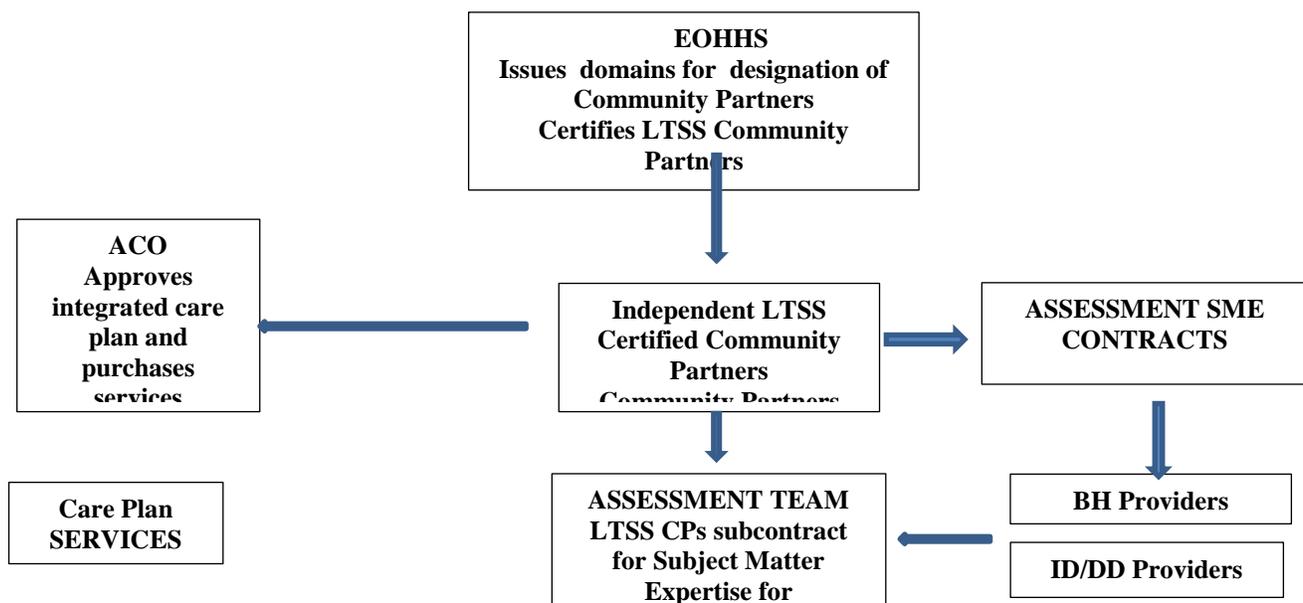
1. Each state line agency develops its independent agent protocols for the agencies under its domain.
2. Each line agency then issues an RFP for entities to become designated as an “independent agent” and not “providers” to work with MassHealth members, managed care plans, ACOs, etc. The line agencies, subject to EOHHS approval, develop the specifications and requirements for being designated as an independent agent in their domain, and the subject matter expertise an agent entity must demonstrate in order to be designated.
3. Only “designated agencies” are entered onto the list of independent agent agencies which can enter into contracts to provide independent LTSS assessment and care coordination as part of an interdisciplinary care team in either a FFS or managed care model. ACOs would be required to offer, as a standard member benefit, access to an independent LTSS agent for assessment and care coordination.
4. An independent agent LTSS entity can apply to be designated as independent agents for one or more line agencies, based on its demonstrated areas of subject matter expertise, e.g. LTSS with specialized BH expertise.
5. The conflict free entity can subcontract with local providers of BH, LTSS, DD/ID, ABI for their subject matter expertise during the assessment process, then incorporate those recommendations into the care plans submitted to the ACO for integration. The ACO issues the care plan, which can include local providers. In this way, the providers play a role in the assessment process, and then can be selected at arm’s length by the ACO, which does not own the providers.

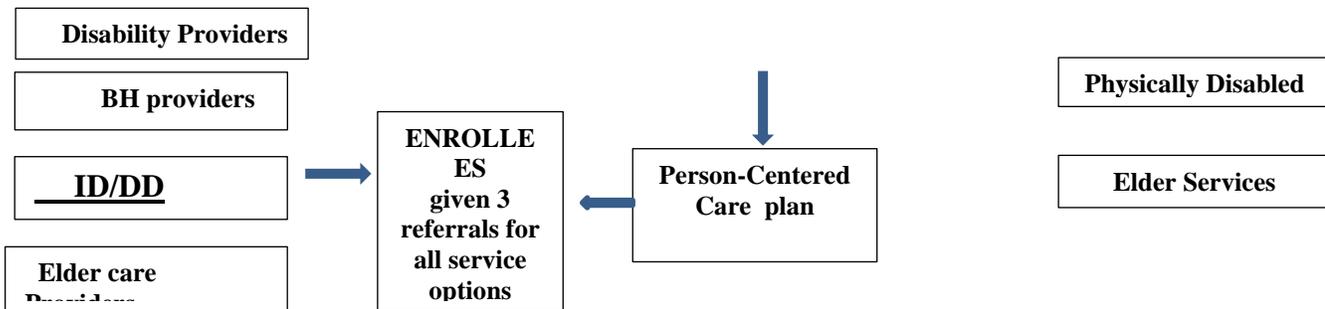
Below is a graphic representation of this care planning process:

LTSS Community Partners Assessment and Care Plan Process In An ACO Plan

Assessments are done on a conflict-free basis, with providers brought in as SME assessors, but also serving as direct service providers. This allows providers to play a role in assessments on a conflict free basis. The

ACO integrates and coordinates the overall care plan, which includes service provided. Services and assessments functions are firewalled, with the ACO deciding on care plans content based on LTSS needs and enrollee requests for care.





II. Other Issues/Questions:

Direct Service Providers Doing Self-Referrals

MassHealth has proposed that "A Community Partner can be a direct services provider but will have a limit on self-referrals." CPs must demonstrate the ability to "conduct independent assessments." But CP will be also be allowed to self-refer." MassHealth says there will be "checks and balances to avoid inappropriate self-referrals." It is not explained what an "appropriate self-referral" would be, but it appears that LTSS direct providers can apply to be CPs and refer to their own services, which weakens their ability to act in the capacity that CMS has called "independent agents" for the consumer. No specific plans have been revealed to limit self-referrals, so we cannot comment on such proposals. Mass Home Care has suggested above a model for engaging LTSS providers in the assessment process, without creating a self-referral conflict.

Lock-In Periods

Mass Home Care continues to raise concerns over "lock in periods" for the ACO plans. Members should have freedom of choice to switch ACO plans, or be enrolled in Traditional Medicare, if that is the choice that they prefer. We agree that fixed enrollment periods should be appealable, but no criteria for such appeals has yet been listed.

The Senior Care Options (SCO) plan has demonstrated that insurers can be financially successful without resorting to fixed enrollment periods. By state law, the SCO plan is voluntary. Enrollment in the SCO plan is now larger than the state's home care program. The One Care plan, which serves younger people on Medicare and Medicaid, has used "passive enrollment" to build membership—but that plan has experienced very high "opt outs" in its three year history.

Moving SCOs and One Care into ACOs

MassHealth says it plans to "move SCO and One care enrollees into ACOs." We would like clarification of what this means.

Enrollment Counseling

Enrollees need counseling to be able to pick an ACO or MCO plan, but MassHealth is not planning to use the infrastructure of the SHINE program. "MassHealth will enhance its own customer service." The Commonwealth should scale up the SHINE program to add counseling for ACO plans to their portfolio. This is an independent and free service to the consumer.

Independent LTSS Coordinator on the Team

Members will have access to an LTSS representative "where needed." The Interdisciplinary Care Team should include an independent LTSS coordinator with the same status as other teams members. If such staff will only get on the team if invited by the ACO, it suggests that LTSS is an ancillary service of lesser status to the overall well-being of the member. All members when they join an ACO should have a baseline assessment conducted of LTSS functioning, including social determinate factors This is as critical to well-being as an initial medical examination. At a minimum, all members with "complex LTSS needs" should have an ILTSS present on their team, just as certain as the presence of the PCP.

Functions of the Independent LTSS Coordinator: Continuity of Care

The plan says "The LTSS Community Partner will be on the interdisciplinary care team (where needed), and do care management, careplanning, functional assessment, care coordination, care transition, and health promotion, counseling and decision support on service options." This is a good list of the functions of the ILTSS member of the ICT. The independent agent should not be limited to the assessment phase only. Any member with complex LTSS needs should have an independent agent on their team.

The plan says Community Partners "will demonstrate expertise in care management, care coordination, and navigation to BH care and LTSS services." Mass Home Care supports this continuity of care functions to be performed by the independent agents on the team. The role of assessor and care manager should not be fragmented.

Independent Agents for Members Remaining in FFS

The plan also says Community Partners may at some point be able to serve members who are not in ACOs, which is important, because by the final year 5 of this proposal, MassHealth estimates that 40% of the MassHealth members will still be in fee for service.

Just because a member is in FFS/PCC, there is no reason why their care cannot be managed, including the deployment of an independent LTSS care coordinator to make sure their LTSS needs are being met, and that they are being cared for in the least restrictive setting. The state's home care program is an example of a successful managed FFS program.

Shared Governance

MassHealth says that ACOs and CPs will have "shared decision-making and governance." We know they have to have MOUs, but it is not clear what MassHealth expects in term of shared governance. Please clarify.

Funding For Independent Assessments/Care Team/HIT Investments

Mass Home Care supports the intention of MassHealth to provide funding for independent assessments...and funding for participation on the care team." Federal funds can also be used to expand workforce capacity and for Health Information Technology (HIT) investments and data analytics. These are all helpful initiatives.

Lack of Meaningful LTSS Metrics

The 1115 Demonstration seeks to reduce per member per month medical expenditures, and reduce hospital admissions and readmissions. There are no meaningful LTSS metrics yet for this initiative. Metrics like community tenure, reducing length of stay in institutions, and reducing the number of acute care discharges to post acute institutions, should all be incorporated into the plan before implementation.

Need To Keep FFS System in Place & Not Discriminate In Scope of Benefits

MassHealth is projecting that 60% of MassHealth members will be enrolled in ACOs by year 5, which means 40% will still be in FFS. Mass Home Care does not support leaving the PCC program with “fewer covered benefits” for members---who for whatever reason---prefer to stay in the PCC plan. People who choose the PCC plan should not lose chiropractic services, eye glasses and hearing aids. These members deserve a decent health care plan, and should not get inferior benefits because they are not choosing to be in a managed care plan. Similarly, we do not support forcing low-income members who choose the PCC plan to pay higher copayments.

Members Under 65 Living In A Nursing Facility & CommonHealth for Working Elders

Mass Home Care supports allowing members under age 65 residing in a nursing facility to be enrolled in the demonstration program, and to extend Common health eligibility to adults age 65 and older who are still working.

Conclusion

There are many thoughtful aspects of this plan that should commend it to CMS and to MassHealth members. Mass Home Care supports many of the design elements in this June 16th version of the plan. We remain concerned that the post acute care aspects of the plan seem less thought out than the acute care components; that LTSS outcomes are not in place; that the role of the “independent agent” on the care team should be more defined and stronger; that the use of home care supports should be centrally included; and that enrollment in the PCC plan should not leave members with costlier, second class inferior care.

We thank MassHelath for giving us the opportunity to submit these comments and questions.

Mass Home Care
June 24, 2016



Mass Home Care

Statement Regarding the 1115ACO Demonstration Waiver

Gregory Giuliano, President, Mass Home Care

On Friday, June 24th, Mass Home Care submitted a statement at the first listening session on the 1115ACO Demonstration plan. As the President-elect of Mass Home Care, I wish to share with MassHealth the following request regarding the need for "independent LTSS agents":

MassHealth has been given ample evidence that there is widespread support among community-based organizations who work with the elderly and disabled for the ACO plan to include an "independent agent" for LTSS on the interdisciplinary care team:

- On October 1, 2015, 112 community-based groups sent a letter to Governor Baker saying "Whatever plan emerges from the MassHealth reform discussions, we urge you to guarantee that all managed care organizations covering LTSS provide as a standard benefit for their members access to independent conflict-free care coordination."
- On December 7, 2015, Disability Advocates Advancing our Health Care Rights (DAAHR) sent MassHealth a letter asking that the ACO plan "protect consumer choice by including...an independent, conflict-free case manager or service coordinator for all enrollees in ACOs and health homes."
- On March 10, 2016, 1199 SEIU presented MassHealth with a statement endorsing the need for an "independent Long Term Support Services Coordinator..mirroring language from MassHealth's recent One Care demonstration proposal that establishes a LTSS coordinator role."
- The home care program (Ch. 19A, s4B), the Senior Care Options managed care program (Ch. 118E,9D) and the One Care managed care model (Ch. 118E,9F), all contain clear statutory language regarding the use of conflict-free coordinators.

There is a rich tradition in Massachusetts of "independent agents" in the LTSS field. The Centers for Medicare and Medicaid Services (CMS) in the final rule regarding managed care plans, give states the flexibility to provide conflict free assessments and care coordination. I urge you to review the attached documents, and strengthen the role and responsibilities of the independent, conflict free agents as a consumer protection in the ACO plan.

October 1, 2015

Governor Charlie Baker
State House, Room 280
Boston, MA 02133

Speaker Robert Deleo
State House, Room 356
Boston, MA 02133

President Stan Rosenberg
State House, Room 332
Boston, MA 02133

Dear Governor Baker, Speaker Deleo, and President Rosenberg,

MassHealth is currently engaged in an important effort to design a managed care model that will result in a plan that could ultimately integrate health care with behavioral health and long term services and supports (LTSS), controlled by large provider networks called Accountable Care Organizations.

The TSS goal of this reform should be to guarantee that all MassHealth members are able to live at their highest level of functioning possible, in the least restrictive setting possible. We believe an integrated, person-centered care plan must balance medical care with non-medical functional supports for the elderly, and individuals with disabilities.

Massachusetts is currently running two major managed care initiatives for 55,000 individuals on Medicare and Medicaid. The Senior Care Organizations and the One Care plans both have one feature in common when it comes to TSS: the statutory inclusion of an independent, conflict-free care coordinator on the member's care team. This "agent" for the member serves several key functions:

- Determine the necessary level of TSS to be provided
- Prevent the provision of unnecessary or inappropriate care
- Establish a written individualized care plan

(CFR Title 42, Chapter IV, Subchapter C, Part 441, Subpart M, s.441.720)

This important consumer protection is defined in the Affordable Care Act, and is part of the regulatory framework that CMS has created for home and community based services. It builds a firewall between the person who helps assess your needs, and the person who provides your care. The Commonwealth has already agreed to accept independent, conflict-free care coordination in return for \$135 million in federal Balancing Incentive Payments funding.

Whatever plan emerges from the MassHealth reform discussions, we urge you to guarantee that all managed care organizations covering TSS provide as a standard benefit for their members access to independent conflict-free care coordination.

Signed,



Dan O'Leary

Mass Home Care &
Mystic Valley Elder Services

Dennis G. Heaphy, Bill Henning
Disability Advocates Advancing
Our Healthcare Rights (DAAHR)

Barbara Mann
Mass Senior Action Council

Chet Jakubiak
Mass. Association of Older Americans

Larry Spencer
Cerebral Palsy of Massachusetts, Inc.

Linda Andrade
Massachusetts Council for Adult Foster Care

Julius Britto
Attentive Home Care, Inc.

Joanne Collins
Woburn Council on Aging

Paul Spooner
Metrowest Center for Independent Living

Paul Crowley
Greater Lynn Senior Services

Lou Swan
Elder Services of Worcester Area

John O'Neill

Michael E. Festa
AARP Massachusetts

David P. Stevens
Mass Councils on Aging

Lisa Gurgone
Home Care Aide Council

Mike Trigilio
Associated Home Care

Diana DiGiorgi
Old Colony Elder Services

Emily Shea
Boston Commission on
Affairs of the Elderly

Amy Vogel Waters
Worcester Commission
On Elder Affairs

Carolyn Lightburn
Director of Everett Human Services

Paul Lanzikos
North Shore Elder Services

Gregory Giuliano
Montachusett Home Care Corporation

Irene M. O'Brien

Somerville Cambridge
Elder Services

Paula Shiner
Coastline Elder Services

John Lutz
Elder Services of Berkshire County

Priscilla Chalmers
WestMass ElderCare

Vin Marinaro
Pittsfield Council on Aging

Leslie Scheer
Elder Services of Cape Cod and the Islands

Scott M.Trenti
SeniorCare Inc

Jennifer Goewey,
Sheffield Senior Center & Council on Aging

Nancy Munson
Bristol Elder Services

Rosanne Distefano
Elder Services of Merrimack Valley

Foluso Olubanjo
Seraphic Springs Health Care

Lorna Gayle
Lanesborough Council on Aging

Mary Jean McDermott
HESSCO

David Hedison
Chelmsford Housing Authority

Susan Schwager

North Andover Senior Center

Jennifer Claro
Westfield Council On Aging

Roseann Robillard
Newburyport Council On Aging

Roseann Martoccia
Franklin County Home Care

Lynne Stanton
Groveland Council On Aging

Robert Schaeffer
Multicultural Home Care

Dale Mitchell
Ethos

Rosaleen Doherty
Right at Home Boston and North

Annmary Connor
Amesbury Council on Aging

Donna M. Bys
Professional Medical Services, Inc.

Jonathan Morin
Intercity Home Care

Joan Butler
Minuteman Senior Services

Ruth Beckerman-Rodau
Springwell

Sharon Lally
Rochester Council on Aging

Anne Sylvia

Marion Council on Aging

Janice Long
Hudson Council on Aging

Elaine Massery
Greater Springfield Senior Services, Inc.

Joanne Walsh
Home Staff

Nancy Fillers
Montachusett Opportunity Council/Nutrition

Raphael Bibiu
Ace Medical Services

Catherine Hardaway
Central Boston Elder Services

Dianna Morrison
Baldwinville Council on Aging

Harriet Klayman
The Highlands Adult Day Health

Marge McDonald
Burlington Council on Aging

Rev Robert Stetson
Littleton Council on Aging

Judy Luciano
Wakefield Council on Aging

Jodi Gibeley
Topsfield Council on Aging

Mary Prenney
North Reading Elder Services

Heather Sylvia

Fairhaven Council on Aging

Marilyn L. Travinski
Tri Valley, Inc.

Sandra Lindsey
South Shore Elder Services

Trish Pope
Marlborough Council on Aging

Sandra Lamb
North Adams Council on Aging

Christine Alessandro
Baypath Elder Services

Susan Doherty
Lunenburg Council on Aging

Tim Riley
Action, Inc.

Margaret M. Hogan
Boston Senior Home Care

Deborah Thompson
Harvard Council on Aging

Carolyn Brennan
East Longmeadow Council on Aging

Nancy Levine
Friends of the Littleton Council on Aging

Tracy Nowicki
Chelsea Council on Aging

Rev. Debra Lee
New Bedford Council on Aging

Judith A. O'Connor

Dartmouth COA

Millbury Council on Aging

Jackie Coucci
Mattapoissett Council on Aging

Ann Ruder
Center for LivingY Work

Anne Shattuck
Specialty Home Care Services

Amy Tobin
Southeastern Mass Home Health Aides

June Cowen Sauvageau
Northeast Independent Living Program, Inc.

Teresa GoveArnold
Aging & Disability Resource Consortium
Of the Greater North Shore

Mary Margaret Moore
Independent Living Center of North Shore
And Cape Ann

Donna Sbardella
Anodyne Homemaker Services

Trevor R. Ruggles
Independence Healthcare Corporation

Jim Kruidenier
Stavros

Karen A. Hulette
MOC Energy Services

Alecia Lombard
Active Home Care

Linda Ravenscroft
Capital International & Home Health Services

Pamela Woodbury
Spencer Council on Aging

Stephen Pitcher
Family Services of Central Massachusetts

Julius & Sandra Britto
Attentive Home Care

William Anjos
Interim HealthCare

Lisa Krinsky
LGBT Aging Project

Susan Pacheco
Cambridge Council on Aging.

John Keegan
Door2 Door Transportation by SCM

Linda S. Cornell
VNA of Eastern Massachusetts
Visiting Nurse Assisted & Senior Living Communities

Carol Nagle
Fall River Family Services

Lisa Yauch-Cadden
Buzzards Bay Speech Therapy

Helena Hughes
Immigrants Assistance Center

Gail Fortes

Deborah Harrington

YWCA Southeastern MA

**Karen Maciulewicz
Greater New Bedford Adult Day Health**

**Kevin Hunter
Anodyne Homemaker Services**

**Marjorie Hess
Arcadia New England**

**Elana Margolis
Jewish Community Relations Council
Of Greater Boston**

Homemaker Services, Inc.

**Eartha Harrington
Help Services Network, Inc.**

**Margaret Fenander
Hancock Council on Aging**

**Jacob Waah
Victory Home Health, Inc.**

Disability Advocates Advancing our Healthcare Rights

December 7, 2015

Daniel Tsai

EOHHS Assistant Secretary and Director of MassHealth

One Ashburton Place

Boston, MA 02108

Dear Assistant Secretary Tsai:

Disability Advocates Advancing Our Healthcare Rights (DAAHR) wishes to thank you for your commitment to building a healthcare delivery system that better meets the needs of the poorest residents of Massachusetts, including people with complex physical and behavioral health disabilities, intellectual and developmental disabilities, and a variety of other chronic health conditions. We support the state's intention to secure performance incentive payments within CMS's Delivery System Reform Incentive Payment (DSRIP) program under the broad authority of the 1115 Waiver to transform the health care delivery system.

The purpose of this letter is to ask you to consider DAARHR's recommendations for transforming the system in order to build a sustainable infrastructure, with an emphasis on quality-of-life goals, to best serve MassHealth members with disabilities. We also want to state our appreciation for the many recent steps your office has taken to support innovative healthcare, including continuation of the One Care demonstration and by delaying

the inclusion of long-term services and supports (LTSS) and home and community-based services and supports (HCBS) into the ACO program currently under development.

Transformation of the service and care system for MassHealth members with disabilities requires careful design and implementation to prevent perpetuating the status quo, creating new but only marginally improved systems, or worse yet, causing harm to members. Throughout this effort, MassHealth faces a number of challenges, including ones pertaining to politics, policy priorities, and analytics. Addressing the social determinants of health by linking payments to meaningful metrics and outcomes will be essential to the reform effort. MassHealth must raise the bar for clinical care while tackling the issue of over medicalization to ensure that resources are directed to total health and wellness. Within this framework, enrollee choice will be vital.

Large systems may seek control over the flow of resources and extended control over the broader service delivery system, which can seriously dilute person-centered care and jeopardize existing community-based care and services.

Cost and value, of course, must support the vision for improved person-centered care built around total health and wellness. DAAHR asks that MassHealth use DSRIP funds to support a community-based delivery system with a strong infrastructure, investing in information technology (including provider compatibility) and workforce development, including community health workers, peer specialists and other care providers.

The administration's efforts to better compensate PCAs exhibits a commitment to community-based services and person-centered LTSS that should be replicated. CBOs must not be put in the position of balancing the books on the backs of their staff.

It is critical that this transformation effort include the points below.

DSRIP dollars should be used to support integration of service delivery systems that are central to reducing tertiary care and associated high costs. This includes ensuring that MassHealth:

1. Distribute DSRIP funds to both ACOs and community-based organizations; funds should not have to flow exclusively through ACOs.
2. Invest DSRIP funds into building provider capacity to comply with the ADA, including guaranteeing that facilities and medical equipment are accessible, with complementary policies and procedures. We can no longer embark on system transformation of healthcare for people with disabilities if the system itself is allowed to be inaccessible.
3. Invest DSRIP funds upfront into non-clinical services "beyond the clinic walls" to reduce negative social determinants of health, food instability, homelessness, housing instability, lack of access to transportation, and underemployment.

4. Invest DSRIP funds to provide adequate compensation to CBOs, especially their staff, to ensure capacity and competency in service delivery. Value-based purchasing arrangements should reflect this commitment.

ACO should have the flexibility and Infrastructure to support innovation while also being guided by a defined set of incentives and outcome requirements to protect MassHealth enrollees. It is requested that MassHealth:

5. Establish requirements that ACOs are led by a diversity of entities and that governance committees include consumers and community-based providers. AGO boards must be comprised of at least 50 percent non-hospital entities. The definition of "risk bearing" should be broad to allow for the most inclusive governance structures within ACOs.
6. Create a glide path to support the creation of alternatives to medically-driven AGO models; consider investing in behavioral health, disability and other community organizations that address social determinants of health, with a longer-term commitment to bring them to suitable scale and expertise.
7. Establish a risk-adjustment approach that accounts for social, cultural, and economic factors so that:
 - a. Resources are available to provide culturally and linguistically appropriate medical services for people who are poor, are homeless, have difficulties with English, are from ethnic and/or minority populations, and have physical, mental health, intellectual or sensory disabilities.
 - b. Resources are available to address social determinants of health, including need for food, fuel assistance, and housing assistance, with maximized opportunity to collaborate with community-based providers such as WIG, immigration organizations, and housing authorities to increase quality of care and support nutrition and housing security.

The 1115 waiver must support person-centered care and protect MassHealth beneficiaries from harm. This can be done by ensuring that MassHealth:

8. Maintain the independence of LTSS for a minimum of the first two years of the initiative, with integration occurring only after a transparent review of the suitability of integration. All ACOs must be required to create a plan for integrating community-based LTSS into their system, with participation from LTSS providers, users of LTSS, and advocates that must be approved by vote of an implementation council established for the initiative (see below).
9. Keep auto assignments to ACOs or health homes to low numbers, and any successive assignments should be informed by performance data. The salient lesson of One Care is that initiatives for people with complex service and healthcare needs should be allowed to grow to scale, not be forced to do so. Enrollment in an AGO or health home must be intentional on the part of members.

10. Protect consumer choice by including choice of plans, services, and coordination. Consumer choice is vital. This includes but is not limited to consumer access to:

- a. A delivery system that is equitable, population-based, and person-centered with services provided to consumers based on identified need, not payer.
- b. An "opt out" provision for enrollees of ACOs so they can, at the end of each month, be able to join another ACO or leave the ACO system and receive services through the fee-for-service system.
- c. An independent, conflict-free case manager or service coordinator for enrollees in ACQs, and health homes. :**
- d. A care coordinator function carried out by the person of the consumer's choosing- and not necessarily a primary care doctor.
- e. All providers outside the ACO network through single-case agreements to support continuity of care and access to expertise that may not exist within a network, ensuring that the complexity of a person's needs and/or lack of choice of specialists within a geographic area is not a barrier to care or service.
- f. In-person comprehensive assessment of enrollee needs within 30 days of enrollment in an ACO at a place of the enrollee's choosing, with preference given to assessments being done in the enrollee's home.
- g. Measurable integration of recovery principles and independent living philosophy into the development and implementation of care plans.
- h. Control over medical records, including determination of who has access to a consumer's medical records and the right of the consumer to have access to her or his medical records, including medical notes.

There also must be strict monitoring and enforcement of the requirement that ACOs not discriminate against those who request to join the group.

- 11. Establish an implementation council or similar MassHealth consumer-majority body. Its role should include guiding the overall growth and implementation of the waiver, including the review of systemic trends in collaboration with MassHealth, CMS, the various plans and providers, and an ombudsman office. The council should have access to and control over its own budget.
- 12. Establish an independent ombudsman office similar to what exists for One Care to support innovation, protect members on an individual basis, and address systemic concerns as they arise. Other consumer protections, such as rights to appeal services, must be established.
- 13. Extend enhanced benefits available to One Care enrollees to ACO enrollees. This includes the integration of oral health through provision of full dental benefits for enrollees and zero co-pays for prescriptions and all other services.

Put in place systems that support innovation in value-based purchasing and creation of transparent quality metrics:

- 14. Develop outcome measures reflecting consumer values such as independence, self-direction, employment, and integration, documenting rebalancing of spending and use of a variety of LTSS by consumers. To be effective a value-based purchasing system must include incentives that may not result in direct savings but will lead to overall enrollee wellness.

15. Create a public-facing dashboard that includes population-specific metrics and a star rating system. The dashboard should include current quality metrics and metrics to be piloted over the course of the five-year waiver. Community involvement in the determination of ACO performance criteria and transparency is fundamental. The dashboard should include objective metrics that assist consumers to make an informed choice when choosing an ACO.

We thank you very much for your consideration of our concerns and the exhaustive work that you and your team have undertaken to engage the disability community in health reform.

Sincerely,

Dennis Heaphy, DAAHR co-chair, DPC

Bill Henning, DAAHR co-chair, BCIL

Cc: Secretary Marylou Sudders

1199SEIU
United Healthcare Workers East

Independent Long Term Supports and Services Coordinator

Utilizing and mirroring language from MassHealth's recent One Care Demonstration Proposal that establishes an LTSS Coordinator role:

Home and community based long term support and services (LTSS) are critical to enabling people to live independently and to remain in their homes and communities. It is essential that MassHealth ACO care teams have a designated resource with expertise in understanding different kinds of LTSS needs and the resources available in the community to address them.

Each MassHealth ACO applying for DSRIP incentive payments will contract with an independent, qualified LTSS Coordinator from a community-based organization (CBO) such as an Independent Living Center (ILC), a Recovery Learning Community (RLC), an Aging Services Access Point (ASAP), Deaf and Hard of Hearing Independent Living Services programs, The ARC, or other key organizations expert in working with people with disabilities. MassHealth ACOs will contract with these CBOs to provide staff specifically trained to serve as independent LTSS Coordinators for their enrollees.

MassHealth ACOs will be required to maintain contractual agreements with CBOs that have the capacity and expertise to provide LTSS coordinators and to oversee the evaluation, assessment, and plan of care functions to assure that services and supports are delivered to meet the enrollees' needs and achieve intended outcomes. The MassHealth ACO shall not have a direct or indirect financial ownership interest in an entity which provides an LTSS Coordinator.

The independent LTSS Coordinator shall be a full member of the care team, serving at the discretion of the ACO enrollee. For enrollees without LTSS needs, the LTSS Coordinator need not continue on the care team; however, the ACO must make an LTSS Coordinator available at any time at the request of the enrollee, and in the event of any contemplated admission to a nursing facility, psychiatric hospital, or other institution.

Following the initial assessment, the LTSS Coordinator will work with the enrollee to address his or her ongoing LTSS needs, and to incorporate community based services and other available community resources as appropriate into the enrollee's individualized care plan. The LTSS Coordinator will connect the enrollee to services –drawing on the provider network and other resources of the ACO, as well as on community-based resources –and assist providers in securing any authorizations or service orders necessary to begin services.

MassHealth ACO will be responsible for ensuring that LTSS Coordinators meet specific qualifications, including necessary (1) training, (2) experience and (3) expertise in working with people with disabilities and/or elders in need of independent living supports and LTSS, and a thorough knowledge of the home and community-based service system. ACOs will need to verify that CBOs providing LTSS Coordinators are not providers of other services covered by the Demonstration or, institutions where this cannot be avoided, that CBOs have the necessary firewalls in place to prevent self-interested referrals.

*Massachusetts
Association of
Behavioral
Health Systems*

115 Mill Street
Belmont, MA 02478
Phone: 617-855-3520

Michele Gougeon, MSS, MSc
Chairman

David Matteodo
Executive Director

Members:

AdCare Hospital
Arbour Hospital
Arbour-Fuller Hospital
Arbour-HRI Hospital
Bournewood Hospital
McLean Hospital
Pembroke Hospital
Westwood Lodge

Associate Members:

Anna Jaques Hospital
Austen Riggs Center
Baldpate Hospital
Bayridge Hospital
Baystate Health
Berkshire Health Systems
Beth Israel Deaconess
B.I. Deaconess Plymouth
Brigham/Faulkner Hospitals
Brockton Hospital
Cambridge Health Alliance
Cape Cod Hospital
Children's Hospital
Cooley Dickinson Hospital
Emerson Hospital
Franciscan Hosp. for Children
Gosnold on Cape Cod
Hallmark Health System
Harrington Memorial Hospital
Henry Heywood Hospital
High Point Treatment Center
Holyoke Medical Center
Marlborough Hospital
Mass General Hospital
Metro West Medical Center
Mount Auburn Hospital
Newton Wellesley Hospital
Noble Hospital
North Shore Medical Center
Providence Behavioral Health
Southcoast Behavioral Health
St. Vincent Hospital
Tufts Medical Center
U Mass Memorial Health Care
Walden Behavioral Care
Whittier Pavilion

July 14, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, Ma 02108

Submitted Electronically via Email

Re: Comments on Demonstration Extension Request

Dear Assistant Secretary Tsai:

On behalf of the Massachusetts Association of Behavioral Health Systems (MABHS), we appreciate the opportunity to offer these comments on the MassHealth Section 1115 Demonstration Project Amendment and Extension Request. The MABHS represents 44 inpatient mental health and substance abuse facilities in Massachusetts. These written comments are in addition to the verbal comments I offered at the June 24 Public Meeting.

There are many positive proposals in the Waiver request as follows:

- The Request strongly emphasizes that Behavioral Health is an important component of the MassHealth delivery system and strives to fully integrate Behavioral Health into the ACO and other models of care. The Waiver Request is replete with reference to Behavioral Health and it is clear that MassHealth is strongly pushing for a better Behavioral Health system for its Members. This is very positive.
- The Request proposes to continue to provide payments for providers designated as Institutions for Mental Disease (IMDs) for recipients aged 21-64. The use of IMDs has been the practice in Massachusetts for over 20 years and it has been very beneficial for MassHealth, its Members, and providers. Massachusetts has been a model for the country in this area and we are pleased to see recognition of the value of using IMDs nationally through recent Federal CMS Regulations. We urge MassHealth to continue to support the use of IMDs.
- The strong emphasis on Care Coordination throughout the Request is very good. If implemented Care Coordination will result in better outcomes for MassHealth Members and we hope that regardless of the models used, that Care Coordination will be an integral component of the delivery system.
- The Request in Section 5.5.1 for Healthcare Workforce Development and Training is very good. For the Inpatient Behavioral Health hospitals, workforce is becoming an increasingly challenging problem. There is a need to develop more individuals to work in the Behavioral Health field as currently our hospitals are having problems recruiting sufficient personnel, particularly for physicians and nurses. We strongly urge MassHealth to continue to advocate for funding in this regard and that Behavioral Health be emphasized as having particular needs for a more robust workforce in order to meet growing demands.

- Emergency Department Boarding is addressed in Section 5.5.4: Although it is positive that MassHealth is seeking to address Boarding in the Request, we would urge that the Request be amended to include reference to the need for Specialized Units for patients who are difficult to place. Specialized Units would be a vital addition to the other services MassHealth proposes and should be included in the final Request.
- Section 7: Enhanced Services for People with Substance Use Disorder is very positive in a number of areas, especially in that it recognizes addiction as a “chronic medical condition”. The additional services; enhanced benefits; comprehensive models for coordinating care; and utilizing patient navigators and coaches are very strong initiatives called for as part of the Substance Use Disorder (SUD) 1115 demonstration proposal. We urge MassHealth to continue to request these improvements for its Members with Substance Use Disorders.

Other Areas of Comment:

Section 4.3.1.2 Plan Selection and Fixed Enrollment Periods: This proposal would be beneficial to our hospitals as currently Members can change from one MassHealth plan to another while they are in the hospital. This is problematic, especially for billing and bad debts as MCOs often will not reimburse for care they did not authorize. Our hospitals are disadvantaged when this occurs and can face administrative hurdles in getting properly reimbursed for care.

Although very positive in terms of its emphasis and incorporating Behavioral Health into the new models for the future, the Request should include reference to some of the enormous challenges there will be in fully incorporating Behavioral Health into the new delivery system. For decades, even centuries, the Behavioral Health system has been separate from the overall health system through different provider and payment systems. Even in recent years we see evidence of this separation though Health Information Technology funding from the federal government, which excluded much of the Behavioral Health system from receiving funds. This oversight has created considerable and ongoing problems for providers.

It will be a major challenge to bring the physical and behavioral health systems into a truly integrated care system; but one that if ultimately achieved would be very beneficial for MassHealth Members. The Request is a solid proposal to begin this integration: we hope that MassHealth is successful in the areas we have commented on in this letter. We also hope the Waiver programs receive the necessary funds to ensure success. Please do not hesitate to contact me with any questions. Thank you.

Sincerely,



David Matteodo
Executive Director
DMatteodo@aol.com (617) 855-3520

The Massachusetts Association of Community Health Workers (MACHW) would like to suggest the following additions to the MassHealth 115 Waiver Renewal Proposal. Created in 2005, MACHW is a professional association advocating on behalf of the 3,000 estimated CHWs in Massachusetts.

1. We ask that you add Community Health Workers (CHWs) to the list of health professionals eligible for Health Care Workforce Development and Training (p.48), including the student loan repayment program.
2. As part of the Statewide Investments, education and technical assistance should be offered to ACOs and MCOs employing community health workers. Many organizations within the ACOs/MCOs will not be familiar with the CHW models, best practices, or attributes and competencies needed to maximize the effectiveness of this workforce. MACHW would welcome the opportunity to partner with MassHealth to provide this education and technical assistance.

Thank you for the opportunity to offer these suggestions.

Best Regards,

Lisette



July 17, 2016

Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dan Tsai, Assistant Secretary
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: MAHP response to Draft Section 1115 Demonstration Waiver

Dear Secretary Sudders and Assistant Secretary Tsai:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 17 member health plans that provide coverage to more than 2.6 million Massachusetts residents, and the 6 Medicaid managed care organizations (MCOs) providing coverage to over 800,000 Medicaid and Commonwealth Care members, I am writing to provide our feedback on the 1115 Demonstration Waiver proposal, released on June 15, 2016, specifically, the proposed redesign of the program's payment and delivery system and the expansion of substance use disorder (SUD) services. We appreciate the public process by which MassHealth engaged stakeholders and thank you for the opportunity to participate and offer our perspectives.

While we continue to believe that relying exclusively on the MCOs to implement delivery system reform would be the simplest approach, be the least disruptive for MassHealth members, and yield more immediate savings, we understand this was not the direction preferred by CMS as officials look to experiment at the state level with reform efforts that are similar to, or that go beyond, current Pioneer and Next Generation accountable care organization (ACO) programs. Today, ACOs remain an unproven model and the Medicare ACO models to-date have yielded mixed results on cost savings and improvements in quality with many providers leaving the program early. On behalf of the MCOs, we want to state our ongoing commitment to the Medicaid program and our commitment to work with you collectively to find solutions to serve this population in the most cost effective manner. We share the Administration's goals to move away from a fragmented fee-for-service payment system to a system that rewards value and we believe that our MCOs are in a unique position to work with you to deliver upon that vision.

As outlined in our May 3, 2016 letter, we initially had a number of concerns and questions regarding patient access to care relative to Model B ACOs, whether ACOs would be able to restrict access to patient care through limitations on referrals, and whether Model B ACOs will

actually be functioning as health maintenance organizations (HMOs), requiring an insurance licensure under MGL 176 G similar to the same requirements established for MCOs. As details began to emerge within both the RFR for the ACO Pilot program and the Waiver materials, we believe that a number of these concerns have been addressed and/or clarified and we thank you for addressing those items. As we have shared with you, MAHP has engaged a law firm to prepare a memo that outlines the existing state statutory and regulatory provisions governing risk-bearing provider entities. The memo will summarize the criteria for when ACOs will need to obtain an insurance license in Massachusetts and identify additional statutory and regulatory provisions governing risk-bearing entities that need to be in place to provide sufficient consumer protections and financial oversight. We will share a copy of the memo with you under separate cover.

We have also raised many questions about how the program will be implemented and how it will ultimately impact patient care. Additionally, as part of our May 3rd communication, we submitted a detailed list of questions that our members believe are essential in assessing how the redesign will impact patient care, how the ACO models will be structured, and how ACOs will work with community and specialty providers, along with how certain policy and operational issues will be handled. Continuity of care for patients will remain a critical issue during the redesign implementation and we look forward to continuing this important dialogue. We will send MassHealth an updated list of open questions under separate cover. Answers to these questions will help the MCOs to be able to effectively partner with the state to implement the reforms.

As you prepare to submit the waiver request to CMS, we respectfully request that you consider the points below as you prepare your final submission:

Avoiding Unnecessary Duplication of Administrative and Systems Capacity

As MassHealth prepares to move forward with the redesign initiative and allocates the federal Delivery System Reform Incentive Program (DSRIP) dollars, the state should place a high priority on avoiding duplication of existing capabilities and infrastructure wherever possible. The Waiver documents discuss utilizing DSRIP funding for state operations and oversight capabilities and to fund vendors to help administer the program. The vendors will provide technical assistance for ACOs and Community Partners (CPs) on delivery system reform topics including, legal, actuarial, HIT, financial, performance management, and providing accessible culturally competent care. We believe that we should avoid duplicating systems and capabilities that already exist within the MCO program and we believe that the MCOs are well equipped to provide this sort of ongoing technical assistance and should be key partners in all aspects of the delivery system transformation.

MCOs have long assisted providers in moving towards alternative payment models through budgeting, population-based analytics, risk adjustments and infrastructure support. MCOs have real-time access to patient data, consultative support teams, medical management programs, information sharing, and utilization monitoring and are adept at analyzing and disseminating that data. These programs enable providers, across the continuum of care to better serve their patients by proving the tools necessary to effectively manage care. MCOs are equipped to handle the complex needs of Medicaid enrollees, have the programs and staff in place to help members manage their illnesses and navigate the health care system, and have experience in utilizing

community support services. Finally, MCOs have considerable experience developing and utilizing care management and care coordination programs and have spent many years learning how to effectively manage care across delivery settings and across diverse populations. MCOs should continue to play a strong and central role in facilitating transformation across the health care delivery system that will result in improvements to the quality and integration of care for MassHealth enrollees and lower cost for the state.

We believe that the state's formal Waiver request should include a statement that the state will leverage the existing infrastructure and expertise of the MassHealth MCOs where possible. Such a policy will additionally help facilitate greater participation by providers that do not have the resources to form more formal or complex structures and avoid driving further consolidation of the market. In this way the state can avoid expending DSRIP dollars to replicate this existing capacity both within the provider community and state government. This statement is also consistent with Speaker DeLeo's workgroup recommendations.

We share MassHealth's goals for driving meaningful transformation to provide better more coordinated care for MassHealth enrollees and to improve the integration of physical health, behavioral health, long-term services and supports (LTSS), and social services. MassHealth has set forth an aggressive framework for reform and we believe that leveraging the existing capabilities of the MCOs will best position the state's reform efforts for success.

Network Adequacy and Continuity of Care

We remain concerned about network adequacy and continuity of care within the MCO program due to the requirements around primary care exclusivity. MassHealth will require that primary care clinicians participate in only one ACO and that ACOs be limited to a single model. The policy will result in a potentially significant number of PCPs being excluded from participating in MCO networks and potentially, a number of MCOs being prohibited from operating in certain geographic regions. Such a policy could have the potential to impact members' access to providers and create continuity of care issues for MassHealth enrollees. This is particularly critical for members with serious behavioral health needs.

Expansion of Substance Use Disorder Services

Finally, we applaud the work of the Baker Administration for the strong focus you have placed on the opioid addiction crisis and we are committed to continuing to partner with you to combat this epidemic. MAHP and our member health plans are committed to ensuring that the full spectrum of evidence based treatment options are available and we support the proposed expansion of SUD services within the Medicaid program and the goals for increasing access to evidence-based care.

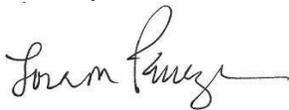
The MassHealth population is complex and the proposed expansion of services is designed to meet the unique challenges facing this population. In comparison to the general population, Medicaid beneficiaries have much higher rates of poor health, fewer resources, and lower health literacy levels and, as stated in the Wavier materials, a significant portion of the individuals battling opioid addiction are in the Medicaid program. We therefore believe that the proposed transition in coverage for the ASAM level 3.1 and 3.3 services from the Bureau of Substance

Abuse Services to MassHealth makes sense, is appropriate for this population, and enables the state to leverage the additional federal dollars to reinvest in new capacity that is greatly needed.

We fully support the focus on evidence-based treatment and the utilization of ASAM criteria, which says that effective treatment for opioid addiction is long-term and may vary depending on the unique needs of the patient; it is not a one-size-fits-all approach. The pilot of a common assessment tool is an important measure to help ensure that individualized care is being delivered in the most appropriate setting for the member, consistent with ASAM principles. Information obtained through the pilot regarding whether the tool is effective in matching patients with the appropriate ASAM level of care will be valuable and we would support the adoption of the tool across the entire delivery system to help enable providers make better decisions regarding placement of their patients.

Again, we thank you for the opportunity to provide you with these comments and for the opportunity to participate in the stakeholder process. If you or your staff have any further questions regarding these comments or require any additional information, please don't hesitate to contact me or my staff.

Sincerely,

A handwritten signature in black ink, appearing to read "Lora Pellegrini", with a long horizontal flourish extending to the right.

Lora Pellegrini
President & CEO
Massachusetts Association of Health Plans



The Massachusetts Chapter

July 15, 2016

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Daniel Tsai

Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108

RE: Comments on MassHealth Section 1115 Demonstration Project Amendment
and Extension Request

Dear Assistant Secretary Tsai:

On behalf of the Massachusetts Chapter of the American Academy of Pediatrics, we very much applaud the efforts of the State to direct its Medicaid programs toward value incentives, behavioral health integration, inclusion of social determinants, and other work to reward providers' efforts to achieve better health at reasonable cost for their patients and families.

Many of the key elements of the State's waiver proposal address pediatric issues and offer real opportunities to address important items in care for children and youth. Yet, it is critical to recognize that children and youth – who comprise almost 40% of State Medicaid enrollees – have substantially different health care needs, life course health trajectories, and social determinants that affect their health and well-being. As one example, although the Primary Care Medical Home arose from early experimentation in pediatrics, the pediatric/family medical home does differ in critical ways from the adult medical home (Stille et al., *Academic Pediatrics*, 2010). Among the key Differences are the 1) involvement of families in care of children, 2) emphasis on preventive services, and 3) different epidemiology of chronic health conditions among children and youth.

Patients and families are integral partners to the health care team. Pediatric care emphasizes prevention, based in large part on the services codified in Bright Futures and included in the Affordable Care Act. In addition to traditional pediatric issues such as screening and immunizations, prevention includes early attention to behavioral issues and to the social determinants that clearly affect a child's growth, development, and wellbeing over time.

For chronic conditions, although the general public often views children as healthy unless they had major problems as newborns or if they have cancer, in reality, 10-20% of children have some chronic condition, and the rates of serious chronic conditions among children and youth have grown by 400% over the past half century.

These chronic conditions include four common groups (asthma, obesity, mental health conditions, and neurodevelopmental conditions including autism) and a large number of rarer conditions (such as cystic fibrosis, leukemia, sickle cell disease, arthritis, and type 1 diabetes). Thus, large numbers of children and youth and their families need long term care services, as do adults and elderly populations. We strongly applaud several aspects of the waiver proposal, including:

- Expanded substance use disorder treatment, particularly the move to include residential 24 hour services
- Inclusion of social determinants of health and integration of community partners
- Better integration of behavioral/physical health

While these are laudable inclusions, there is a need for continuous pediatric provider involvement throughout every step of implementation including:

- Specific milestones for care integration and DSRIP funding
- Performance metrics for ACOs
- Outcome measures for Safety Net Provider payments
- Pediatric assessment instrument for SUD treatment
- Appropriateness of metrics used for risk shared in each of the 3 ACO models
- Quality measurement and consumer experience measurement

We ask that the State include pediatric provider involvement in these and other critical elements of the implementation of an approved waiver.

With this background, we make the following recommendations regarding the State waiver proposal:

1. Behavioral health integration - We very much appreciate the State's commitment to behavioral health integration. For children, with the real growth of mental health conditions in the pediatric population (esp., ADHD, depression, anxiety, and SUD), we must address the critical need for prevention through screening and early identification of children at risk. Massachusetts has a better track record than most other States in pediatric screening, although the support for primary care and other interventions after children screen positive has been quite limited. Massachusetts has also innovated in the development of the Massachusetts Child Psychiatry Access Program (MCPAP), an important resource for primary care providers. Effective behavioral health integration will require a) support for primary care providers to carry out early identification, referral, and initiation of treatment (in some cases), and b) co-located mental health professionals to provide care in practices and help to train primary care practitioners to expand their own skills in behavioral health. North Carolina, among other states, pioneered the provision of Medicaid payment for several initial visits, even without a specific mental health diagnosis, to aid in early assessment and treatment.

Behavioral health conditions in children are associated also with social determinants of health. Households living in poverty experience higher rates of mental health conditions; children exposed to toxic stress have much higher rates of mental health conditions.

As the State certifies behavioral health providers, it is essential that such providers document competence in addressing behavioral health needs among children and adolescents and assure access to those services in agreements with ACOs. Community partners will be required to provide six of the Home Health services as enumerated in the ACA (care management, care coordination, health promotion, transitional care, patient and family support, and referral to community and social supports).

If a Community Partner is not yet able to do so, will there be sufficient funding to ensure the partner will ultimately be able to perform all 6 activities? Similarly there will be a Community Partner certification process – will the state appropriately help certify agencies that do not meet the standards at the start of the program, and what will that look like? The accreditation or certification process should address the ability of the Community Partner to meet the needs of children and young families.

2. Childhood chronic conditions - As noted above, the child Medicaid/CHIP population includes large numbers with chronic conditions, including a smaller group with complex, LT care needs, often with multiple body systems involved. Many of these children also have behavioral health needs.

For the larger number of children with less complex chronic conditions, there is a need for active care coordination, either within practices or in the community. It will be critical to recognize and identify the specific pediatric chronic care populations, develop methods for monitoring and coordinating their care, and assess quality using specific pediatric metrics.

We applaud the State’s attention to the One Care model (person-centered, focus on independent living in community settings, culturally competent). This model is also relevant for households raising children with complex chronic conditions, and we ask that the specifications for the State program here address directly the special needs of children and youth with complex chronic conditions. Similarly, as the State certifies LTSS providers, we ask that they document their ability to provide services to children and youth with LTSS needs and assure access.

3. Network adequacy - Especially for the rarer pediatric chronic conditions, children need highly specialized care from pediatric centers of excellence, well-equipped with specialists in pediatric medicine and surgery, knowledgeable about and experienced with these relatively rare conditions. Many communities lack such specialized services. For network adequacy, pediatric needs differ in substantial ways from adult-oriented networks, where specialists are more readily available in community settings. It is critical that the network adequacy specifications for ACOs clarify services needed by children with rare conditions and assure their inclusion in the ACO. Relying on an exceptions policy for out-of-network care does not adequately address the needs of these children and families. This is particularly important also as PCPs can only participate in one ACO under the waiver. In general and perhaps in particular with respect to “referral circles,” plans could ensure that, for children, pediatric care is not replaced by that of adult specialists except in rare circumstances. This also speaks to the importance of accurate provider directories. The AAP has additional guidance on network adequacy in the Network Adequacy | Advocacy Action Guide (<https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/NetworkAdequacyGuidance.pdf>).

Telemedicine, when appropriately monitored and paid, can greatly improve access to pediatric subspecialists, either directly or through consultation with the PCP. This also applies to behavioral health. Payment for telemedicine services that are connected to the medical home should be covered (possibly as part of a global payment as part of an ACO).

4. Value and metrics - We agree with the move toward value-based payments in the State ACO plans. Here, too, it is critical to recognize that measures of value for older populations will not work for the children and youth population. Measures of quality, coordination, integration, and total cost should be pediatric-specific for the pediatric population. Some work from CMS and AHRQ supported pediatric Centers of Excellence and has led to more effective metrics, and the American Academy of Pediatrics has drafted consensus metrics for use in pediatrics. Of note, the pediatric community, very much in agreement on the need to address social determinants, has begun as well to consider newer measures of value, such as school readiness at age 5, literacy at age 8, and high school graduation. We ask that the State define metrics of value for the pediatric population, in consultation with the pediatric community in the State.

Timely and accurate data regarding Medicaid recipients and their utilization is of course critical both to document value but also for providers to best manage resources and implement changes in care to improve quality and health. ACOs in Model A should have access to and control over their own data; for other models, contracts with the MCOs should specify requirements for accurate and timely data shared with providers.

5. Social determinants - The State notes that the DSRIP plan includes investments in certain defined, currently non-reimbursed “flexible services” to address social determinants. Such services are critically important to child health. Children are particularly vulnerable to effects of toxic stress, which is often caused by poverty, parental unemployment, community and domestic violence. Such social determinants impact not only health during childhood, but they also lead to serious long-term adult disease. Providing services that address social determinants in practice is critical to giving children a healthy start in life. Practices need flexible services to help identify family psychosocial needs and then to link families with community services to address those needs.
6. Attribution - Substantial work has addressed methods to attribute patients to specific practices as their major source of care. Essentially none of this work has addressed pediatric practices and networks, and it is not clear that attribution methodology developed for adult populations will work for pediatrics. We ask the State to work with the pediatric community to determine best methods for attribution as networks develop. Attribution that works fairly and accurately is needed to assure appropriate payment in global arrangements and for assignment to practices. For families, we ask that the attribution system assure the ability to keep all children in the same PCP practice.

7. Benefit/Cost sharing changes – The waiver would require students to enroll in student health plans whenever feasible. The State indicates there will be a benefit wrap and cost sharing assistance, but would want to ensure children/youth continue to receive EPSDT services to age 21 (while there is no indication otherwise, this provision should be stated explicitly). Moreover, this wrap around creates the need for appropriate patient education to ensure that students and families are aware of these additional benefits and cost sharing reductions, and understand how to appropriately obtain treatment when a given service is not covered under the student health plan.
8. Support Advocate and Member Advisory Committee – The waiver indicates in Section 3 that this committee will be created. The provision should explicitly ensure that family representation includes family members with children who utilize pediatric care through the program, in particular families of children with special needs.
9. Need for significant enrollee/member education – This is important as families transition to new models. Customer service and enrollee navigation efforts should be provided through multiple modalities so that families truly understand changes to models and how to access care. The State should reexamine these efforts in subsequent years to make improvements to consumer outreach and education, taking learnings from first years of the waiver.
10. Maintenance of existing relationships and transitions to new providers – In the Pilot ACO section, the State indicates it will pay special attention to existing provider/patient relationships. It is critical to maintain existing provider/patient relationships throughout the rollout of ACOs whenever possible, as the State transitions to new ACO models and bids out new MCO contracts. In addition, the State should provide a transition period for families to continue existing courses of treatment with providers during a transition to a new ACO.

Small and mid-size pediatric practices must be able to fit into these models at some level. Auto-assignment has been an issue. If not done fairly and accurately, auto-attribution will be a barrier for smaller practices to continue to see Medicaid patients when they are no longer the primary care provider (in the eyes of the payers) and will not get paid for these visits.

Pilot ACOs offer an important testing ground for the State to learn what works and what doesn't as it transitions to a wider roll-out of the ACO models. The State should examine and provide reporting on the impact of the Pilot ACO model on children, since such a large percentage of the Medicaid population is comprised of children. This should specifically include reporting on children with special health care needs in these new referral circles.

11. ACO Accountability – The waiver discusses accountability for avoidable utilization, reductions in spending, and improvements in quality, with improvements in performance in these areas yearly. It should ensure that high performing ACOs that make substantial improvements are not penalized in subsequent years by a reset baseline that then makes it difficult to capture new improvements.
12. Statewide Investments Funding Stream – In Section 5.5, the State indicates it will fund up to 10 “high priority initiatives in alignment with overall DSRIP goals,” and then lists a number of possible initiatives. Given the high proportion of children and youth in Massachusetts Medicaid (~40% of recipients), a reasonable number of these initiatives should specifically address the needs of children and young families.

13. Access to Care Monitoring – The waiver indicates the state will monitor access to care in Section 10.1. The State should specify how it will do so and assure inclusion of metrics for significant populations, including children and young families, as they shift to new models of care. Among other items, the network adequacy guide noted above can serve to provide some metrics.

We see many potential benefits in the State's efforts to improve the care of Medicaid patients, and we look forward to working with you to help ensure the optimal physical, mental, and social health and well-being for all infants, children, adolescents and young adults in the Commonwealth.

If you have any questions about these comments, please contact Cathleen Haggerty at chaggerty@mcaap.org or at 781-895-9852.

Respectfully,

A handwritten signature in black ink that reads "DeWayne Pursley". The signature is written in a cursive style with a large initial "D".

DeWayne Pursley, MD, MPH, FAAP

President

The Massachusetts Chapter of the American Academy of Pediatrics



Two Willow Street
Southborough, MA 01745

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Section 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai,

On behalf of the Massachusetts Dental Society, thank you for the opportunity to submit our comments on the proposed section 1115 demonstration project amendment and extension request. The Massachusetts Dental Society is comprised of approximately 5,200 Massachusetts dental professionals who are committed to furthering the oral health of the residents of the Commonwealth. It is well documented that oral health plays an integral role in overall health. Due to the separation of the dental program and medical program, however, it is not prudent, at this moment to integrate the MassHealth dental program into Affordable Care Organizations (ACOs).

As reflected in the 1115 waiver request, the MassHealth dental program should remain as is for the time being. The Massachusetts Dental Society supports the waiver request in its current form, which also stipulates that oral health metrics be added to the ACO quality measure slate. Until issues such as quality metrics, integrated records, and payment methodologies, etc., are defined, it would be premature to integrate the MassHealth dental program into the ACO models.

We anticipate that in the future, the dental program will be integrated into the ACO models, but recognize it will require time and further study to better understand

the complexities of this transition and have strategy in place to address these differences before this can be accomplished.

Thank you for the opportunity to offer our comments on the proposed section 1115 waiver request. Prior to taking the step of adding the dental program into ACOs, we must address all of the relevant challenges and develop the most appropriate plan that will ensure the success of the overall program. We look forward to working together to ensure Massachusetts residents continue to receive the oral health care they deserve.

Sincerely,

A handwritten signature in black ink, appearing to read "Raymond Martin". The signature is fluid and cursive, with a prominent flourish at the end.

Raymond Martin, DMD
President
Massachusetts Dental Society

Ronald E. Kleinman, MD
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Tel: 617.724.2911 Fax: 617.643.5330

Physician in-Chief
Chair, Department of Pediatrics

Charles Wilder Professor of Pediatrics

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108

RE: Comments on MassHealth Section 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai:

Please find below comments from the Department of Pediatrics at the MassGeneral Hospital for Children regarding the State's proposed 1115 Medicaid waiver.

We very much applaud the efforts of the State to direct its Medicaid programs toward value incentives, behavioral health integration, inclusion of social determinants, and other work to reward providers' efforts to achieve better health at reasonable cost for their patients and families. Many of the key elements of the State's waiver proposal address pediatric issues and offer real opportunities to address important items in care for children and youth. Yet, it is critical to recognize that children and youth – who comprise almost 40% of State Medicaid enrollees – have substantially different health care needs, life course health trajectories, and social determinants that affect their health and well-being. As one example, although the Primary Care Medical Home arose from early experimentation in pediatrics, the pediatric/family medical home does differ in critical ways from the adult medical home (Stille et al., *Academic Pediatrics*, 2010). Among the key differences are the 1) involvement of families in care of children, 2) emphasis on preventive services, and 3) different epidemiology of chronic health conditions among children and youth. Pediatric care emphasizes prevention, based in large part on the services codified in Bright Futures and included in the Affordable Care Act. In addition to traditional pediatric issues such as screening and immunizations, prevention includes early attention to behavioral issues and to the social determinants that clearly affect a child's growth, development, and wellbeing over time. For chronic conditions, although the general public often views children as healthy unless they had major problems as newborns or if they have cancer, in reality, 10-20% of children have some chronic condition, and the rates of serious chronic conditions among children and youth have grown by 400% over the past half century. These chronic conditions include four common groups (asthma, obesity, mental health conditions, and neurodevelopmental conditions including autism) and a large number of rarer conditions (such as cystic fibrosis, leukemia, sickle cell disease, arthritis, and type 1 diabetes). Thus, large numbers of children and youth and their families need long term care services, as do adults and elderly populations.

With this background, we make the following recommendations regarding the State waiver proposal:

1) Behavioral health integration. We very much appreciate the State's commitment to behavioral health integration. For children, with the real growth of mental health conditions in the pediatric population (esp., ADHD, depression, anxiety, and SUD), there is a need to address the critical need for prevention through screening and early identification of children at risk. Massachusetts has a better track record than most other States in pediatric screening, although the support for primary care and other interventions after children screen positive has been quite limited. Massachusetts has also innovated in the development of the Massachusetts Child Psychiatry Access Program (MCPAP), an important resource for primary care providers. Effective behavioral health integration will require a) support for primary care providers to carry out early identification, referral, and initiation of treatment (in some cases), b) co-located mental health professionals to provide care in practices and help to train primary care practitioners to expand their own skills in behavioral health. North Carolina, among other states, pioneered in providing Medicaid payment for several initial visits, even without a specific mental health diagnosis, to aid in early assessment and treatment.

Behavioral health conditions in children are associated also with social determinants of health. Households living in poverty experience higher rates of mental health conditions; children exposed to toxic stress have much higher rates of mental health conditions.

As the State certifies behavioral health providers, it is essential that such providers document competence in addressing behavioral health needs among children and adolescents and assure access to those services in agreements with ACOs.

2) Childhood chronic conditions. As noted above, the child Medicaid/CHIP population includes large numbers with chronic conditions, including a smaller group with complex, LT care needs, often with multiple body systems involved. Many of these children also have behavioral health needs.

For the larger number of children with less complex chronic conditions, there is a need for active care coordination, either within practices or in the community. It will be critical to recognize and identify the specific pediatric chronic care populations, develop methods for monitoring and coordinating their care, and assessing quality using specific pediatric metrics. We applaud the State's attention to the One Care model (person-centered, focus on independent living in community settings, culturally competent). This model is also relevant for households raising children with complex chronic conditions, and we ask that the specifications for the State program here address directly the special needs of children and youth with complex chronic conditions. Similarly, as the State certifies LTSS providers, we ask that they document their ability to provide services to children and youth with LTSS needs and assure access.

3) Network adequacy. Especially for the more rare pediatric chronic conditions, children need highly specialized care from pediatric centers of excellence, well-equipped with specialists in pediatric medicine and surgery, knowledgeable about and experienced with these relatively rare conditions. Many communities lack such specialized services. For network adequacy, pediatric needs differ in substantial ways from adult-oriented networks, where specialists are more readily available in community settings. It is critical that the network adequacy specifications for ACOs clarify services needed by children with rare conditions and assure their inclusion in the ACO. Relying on an exceptions policy for out-of-network care does not adequately address the needs of these children and families.

4) Value and metrics. We agree with the move toward value-based payments in the State ACO plans. Here, too, it is critical to recognize that measures of value for older populations will not work for the children and youth population. Measure of quality, coordination, integration, and

total cost should be pediatric-specific for the pediatric population. Some work from CMS and AHRQ supported pediatric Centers of Excellence and has led to more effective metrics, and the American Academy of Pediatrics has drafted consensus metrics for use in pediatrics. Of note, the pediatric community, very much in agreement on the need to address social determinants, has begun as well to consider newer measures of value, such as school readiness at age 5, literacy at age 8, and high school graduation. We ask that the State define metrics of value for the pediatric population, in consultation with the pediatric community in the State.

Timely and accurate data regarding Medicaid recipients and their utilization is of course critical both to document value but also for providers to best manage resources and implement changes in care to improve quality and health. ACOs in Model A should have access to and control over their own data; for other models, contracts with the MCOs should specify requirements for accurate and timely data shared with providers.

5) Social determinants. The State notes that the DSRIP plan includes investments in certain defined, currently non-reimbursed “flexible services” to address social determinants. This proposal addresses a critical need in pediatric health. With the vast amount of data indicating the importance of experiences in the early years of life, along with data that document how early toxic experiences lead to serious long-term adult disease, we believe it is critical to provide services that address social determinants in practice. Innovations here include the use of medical-legal teams in practice and the Health Leads program, but the basic message is that practices need flexible services to help identify family needs and then to link families with community services that can help address those needs. We recommend that the ACO models require the use of these funds to support practice-based staff who can help to address social determinants, including building links with effective community providers.

6) Attribution. Substantial work has addressed methods to attribute patients to specific practices as their major source of care. Essentially none of this work has addressed pediatric practices and networks, and it is not clear that attribution methodology developed for adult populations will work for pediatrics. We ask the State to work with the pediatric community to determine best methods for attribution as networks develop.

Thank you very much for the opportunity to participate in the review of the State’s 1115 waiver proposal.

Very sincerely,



Ronald E. Kleinman, MD

Etc

Cc: Alexy Arauz Boudreau, MD, MPH
Peter Greenspan, MD
James M. Perrin, MD
Kim Simonian
Elsie Taveras, MD, MPH

The leading voice for hospitals.

July 8, 2016

Daniel Tsai
Assistant Secretary and Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: Comments on 1115 Demonstration Extension Request

Dear Assistant Secretary Tsai:

On behalf of our member hospitals and health systems, the Massachusetts Hospital Association (MHA) offers these comments for your consideration as the Executive Office of Health and Human Service (EOHHS) prepares to submit its proposed amendment on the state's 1115 Medicaid waiver to the Centers for Medicare and Medicaid Services (CMS).

MHA and its members appreciate the significant effort that EOHHS has put into this program, including the extensive stakeholder engagement, EOHHS presentations, and public comment process. We believe these efforts have allowed the broad healthcare community to better understand and support many of the concepts of the new MassHealth ACO program. MHA also appreciates the waiver's proposed funding to support ACOs and safety net hospitals, though we believe more information is needed to understand the proposal and provide effective feedback. We look forward to discussing the proposal further and working with EOHHS, CMS, and our Congressional delegation to ensure that the waiver agreement will allow Massachusetts hospitals and health systems to be successful in caring for low-income patients under these new models of care management.

ACO Program & Risk Options

As we have stated earlier during the stakeholder process, implementing a global payment system and risk-based payment methodologies will be a major undertaking for MassHealth and healthcare providers. MassHealth is probably the most complex program in our healthcare system, providing health coverage to a very diverse population including low-income children, families, pregnant women, disabled people, and seniors. Many of these individuals have significant chronic medical and behavioral conditions. And there is a significant amount of

ongoing change, or “churn,” in the MassHealth population as some people gain other coverage options while other newly uninsured individuals become eligible. This presents significant challenges when moving toward a risk-based system.

Payment assumptions and principles that are currently used or are being developed for the private sector will not necessarily translate one-to-one to the MassHealth program given these unique circumstances. MassHealth currently pays below the cost of care for many providers, especially hospital, physician, and behavioral health services. Factoring in downside risk on services that are underpaid significantly increases the risk for being further underpaid. This could jeopardize the financial well-being of some providers and potentially destabilize the proposed ACO program.

The data, payment, and risk methodologies will not have been validated in the “real world” and thus may be unreliable. Similar financial uncertainty existed in the development and implementation of the OneCare program, which began with six Integrated Care Organizations (ICOs), three of which dropped out before the program went live and another one last year due in significant part to the financial instability and risk associated with the new program. Both EOHHS and CMS commendably revised many of the risk assumptions and capitation rates for the remaining two ICOs; however, this challenging experience should serve as a reminder to proceed with extreme caution as we implement new care management and reimbursement methodologies for the larger MassHealth population.

It is our hope that in the interest of encouraging provider participation and introducing some stability, MassHealth considers other risk options for those providers that would like to participate in these models. Our understanding of New York State’s Delivery System Reform Incentive Payments (DSRIP) program is that it includes different risk options for provider movement to value-based payments over five years, including both upside only as well as upside/downside risk. This program does not appear to have any requirement to move to downside risk over the five-year period, although it is one of the options. We believe this is a wise and appropriate approach given the varying provider circumstances and uncertainties with this new initiative. Requiring health systems to take on downside risk during the introduction of this demonstration is a mistake in our opinion.

DSRIP Requirement between ACOs & Certified Community Partners

EOHHS states that to qualify for DSRIP funding, ACOs will have to have a formal relationship with certified “community partners” that will focus on behavioral health as well as long-term services and supports. MHA agrees that more can be done to promote relationships between medical and community-based providers. State government has substantial relationships through its health and human services programs and is positioned to make those relationships more

efficient for medical and community-based providers to connect. Promoting greater awareness of community resources is a worthy goal.

However, MHA believes this portion of the proposal requires further explanation and possible modifications to address the variability in terms of the roles, capabilities, and capacity among ACOs and community-based providers across the state. The premise seems to be that ACOs do not provide any community-based services and therefore should “buy” rather than “build” those services. However, some of these services already have been built-into ACO models and these should not be considered less of a resource than those of an independent entity. The roles of care coordination and management of the population will need further explanation as they relate to the required agreement between these entities; flexibility should be a key principal in defining the roles so that ACOs and community-based partners can use the strengths of each rather than conforming to a government-defined relationship. Finally, since outcome measurements will be a determinant in earning DSRIP funding, transparency on quality measurement for community-based partners in addition to ACOs will be needed.

Safety Net Financing

The waiver renewal includes a number of requests for financial support for safety net hospitals, which MHA greatly appreciates. These providers will need the support of state and federal governments given that less funding is available from private insurers and because many face financial barriers that limit access to capital in the private market.

While the waiver proposal offers a lot of detail in many areas, it is lacking in this area which makes it very difficult to comment appropriately. MHA respectfully asks that EOHHS offer more specific details about this proposal to allow stakeholders to gain a clear and accurate understanding of what will be proposed and negotiated with CMS.

EOHHS also states in the waiver that it “proposes to align its policies with CMS’ principle of financing “charity care” for individuals lacking health insurance beyond a state’s DSH allotment with a new Uncompensated Care (UCC) Pool. Massachusetts and CMS are working together to determine the overall size of the new UCC Pool, with the input of providers.” Such policies pose significant implications for all hospitals – especially safety net hospitals – and therefore we respectfully request EOHHS work with MHA and the hospital community to ensure funding that supports hospital uncompensated care is fully protected.

MassHealth Managed Care Organizations & PCC Program

More than 800,000 MassHealth members today are in Medicaid Managed Care Organizations (MCOs), representing the great majority of members where Medicaid is the primary payer in the MassHealth program. The Primary Care Clinician (PCC) program, which has approximately 370,000 individuals, also serves those whose primary insurance is MassHealth. Given the

differences in the size of these populations, MHA believes EOHHS must offer further clarification on how the different MassHealth ACO models will interact and the roles MassHealth MCOs will play in the ACO program.

For instance, while it has been widely understood that Primary Care Physicians (PCPs) will be associated with a single ACO, more information is needed in how these PCPs can interact with MassHealth patients who are in MassHealth MCOs or the PCC program outside the ACO. The waiver proposal states, “Affiliated Primary Care Providers may also participate in MassHealth FFS and in all MCOs, ACOs and the PCC Plan *for non- primary care services (e.g. specialty services).*” This raises a number of questions, as today these PCPs provide primary care for both MassHealth PCC and MCO members. MHA requests MassHealth clarify whether PCPs in an ACO will only be able to participate as a MassHealth provider of primary care services to MassHealth patients that are attributed to that ACO – and not for other ACO eligible MassHealth members. If so, MassHealth should also provide guidance on whether it plans to move a PCP’s patients to his or her ACO (potentially out of, or to, a Medicaid MCO) so the PCP can continue to provide primary care to their patients.

It is also unclear if providers will choose one of the MassHealth ACO models or will be able to serve in two models thereby serving MCO and non-MCO members. As mentioned, MassHealth providers today serve both MassHealth members in the PCC program as well MCOs. Per the PCP issue above, it remains unclear whether PCPs will provide primary care for both groups of patients. The waiver does state other providers in an ACO will be able to provide care to those in either the MCO or PCC program. Therefore, we believe if an ACO is willing and capable of participating in more than one model it should be permitted. While some ACOs may find it more efficient to participate in only one model, others may want to take advantage of the shared savings that their efforts will yield related to both MassHealth MCO and non-MCO enrollees. An ACO that operates in only one model will likely produce savings related to patients in the other model it does not participate in since care coordination and management efforts will apply to all patients. If it is exclusive to one model, this also may present complications for ACOs wishing to participate and serve all the patients in their communities.

MassHealth Benefits and Cost-Sharing Proposed Changes

EOHHS proposes to seek waiver authority to change benefits for those that are not enrolled in an MCO or ACO and instead choose the PCC plan. EOHHS plans to seek permission to offer fewer benefits to those in the PCC plan and gives examples that include removing benefits for chiropractic services, eyeglasses, and hearing aids. It is unclear if other optional Medicaid benefits such as physical therapy, speech therapy, and occupational therapy would be affected by the proposal. EOHHS also proposes to modify its co-payment policy so that members in the PCC plan will pay a higher co-payment compared to those in an ACO or MCO. MassHealth states it will also expand copayments to other provider services.

Because the waiver narrative only offers examples and isn't specific, MHA is very concerned the requested authority is too broad and open-ended on such important services. More importantly, we oppose the restriction or elimination of coverage for important healthcare services and medically necessary devices that allow people to become healthier and less dependent on more intensive, costly services. We also do not believe this approach provides the appropriate incentives for people to participate in MassHealth ACOs, all of which will be newly formed and an unfamiliar concept for enrollees. Instead, we recommend encouraging member participation through added benefits and better patient experiences to attract enrollees to the new models.

We have similar concerns with differential co-payments and do not believe the waiver authority on this important issue should be open ended. There may be legitimate reasons for a MassHealth enrollee to maintain enrollment through the PCC program. Requiring a low-income person to pay additional out-of-pocket expenses from limited financial sources is not fair or productive public policy. Also, while it is intended to be an enrollee incentive, we believe it is simply going to translate into bad debt to providers as there is ultimately no enforcement mechanism. MassHealth providers today are required to provide services even if the patient cannot afford to pay for the co-payment.

For these reasons, MHA cannot support the EOHHS request to reduce benefits and charge higher co-payments for a segment of MassHealth enrollees.

MassHealth Coverage related to Treatment of Substance Use Disorder

EOHHS proposes to adopt a standardized American Society of Addiction Medicine (ASAM) assessment across all providers by the start of FY2020 to address substance use disorder. MHA looks forward to working with EOHHS in implementing this plan as well as the broader effort to address the state's behavioral health system.

In this waiver proposal, EOHHS is seeking authority to expand Medicaid coverage for additional treatments, specifically Transitional Support Services and Residential Rehabilitation Services (ASAM Level 3.1) and High-Intensity Residential Services (ASAM 3.3), including those provided at Institutions of Mental Diseases (IMDs). Certain ASAM services are covered by MassHealth today through the current waiver. MHA supports expanding MassHealth coverage for these services.

Hospital Role in Funding Role in Funding DSRIP Investments

This October, the existing Health Safety Net assessment on acute hospitals will be increased by an additional \$257.5 million. Chapter 115 of the Acts of 2016 established the increased assessment and creates the MassHealth Delivery Reform Trust Fund to receive the funding. The

increased hospital assessment will return to \$160 million on October 1, 2022, to coincide with the end of this waiver's DSRIP funding.

Such an increase in the state assessment on hospitals was very difficult to accept since approximately half of acute care hospitals will be net payers. These hospitals are currently paid far below the cost of care for Medicaid patients, yet are now asked to pay an added assessment of which they will recoup only a portion. The payment mechanism is also viewed with caution by the hospital community given that it is redistributive in nature and exposes the hospital community to added financial risk if the payments are not fulfilled. At the same time, the need for federal funding through the waiver is important to the MassHealth program and is critical to safety net hospitals.

Given this significant contribution by hospitals and how much they have at stake, we ask to work collaboratively with you and your team to address these issues and to ensure the financing plan is successfully fulfilled as intended. The issues are complex and important, so working together should be to the benefit of all concerned. MHA looks forward to working with EOHHS and the legislature in achieving a fair and effective outcome on this important contribution from hospitals that directly supports the MassHealth ACO program and waiver financing.

Hospital Cost Protocol

The existing Medicaid waiver requires a hospital "cost protocol" to define the hospital costs related to Medicaid and uninsured patients. At a high-level, Medicaid payments for medical services, including certain supplemental payments such as Health Safety Net, are compared to these costs. Performance and incentive-based payments, grants, etc. are not part of the analysis. FY2015 is the first year the cost protocol went into effect and the cost protocol is expected to continue in the amended waiver.

MHA is pleased to have worked with EOHHS in advocating for a cost protocol that reflects the costs hospitals incur to care for the uninsured that are not fully represented in Medicare cost reports. We also appreciate the recent educational sessions and guidance EOHHS has provided to hospitals on the protocol. As EOHHS begins to receive the cost information from hospitals, we hope that we can work together to minimize any negative effect on hospitals in the form of unnecessary recoupments. In FY2017, this will be particularly important given the \$257.5 million-to-\$265 million in additional hospital Medicaid payments that will be paid to hospitals. The higher Medicaid payments, funded by hospitals themselves through the \$257.5 million increased assessment, will unfortunately mean more hospitals than today will approach the cost protocol ceiling and will be in jeopardy of losing their Health Safety Net payments. We believe the state should fully explore all alternatives to avoid such an outcome.

Second, an outstanding issue related to critical access hospitals remains with the cost protocol. As required by section 253 of Chapter 224 of the Acts of 2012, MassHealth and the Health Safety Net must reimburse these hospitals 101% of cost assuming a Medicare cost methodology. We note the Medicare program similarly reimburses critical access hospitals above cost. In order for these hospitals to be protected as intended, we believe they should be exempt from the cost protocol as their Medicaid payments by design are intended to reimburse the hospitals above cost.

Thank you for the opportunity to offer these initial comments. MHA appreciates the opportunity to work collaboratively with EOHHS on this important and ambitious initiative. We will offer further comment throughout the waiver and MassHealth ACO implementation process.

Sincerely,

A handwritten signature in black ink, appearing to read "Timothy F. Gens". The signature is fluid and cursive, with the first name being the most prominent.

Timothy F. Gens
Executive Vice President & General Counsel
Massachusetts Hospital Association

Dear Assistant Secretary Tsai:

Thank you for this opportunity to comment on MassHealth's Section 1115 Demonstration Waiver amendment and extension request, as well as for my previous participation in MassHealth's Health Homes Stakeholder Workgroup. It is very encouraging to see issues which were raised during our Workgroup meetings included in MassHealth's request. More specifically, thank you for the inclusion of "flexible services to allow ACOs to address the social determinants of health" within the primary purposes for the requested \$1.8 billion in Delivery System Reform Incentive Program (DSRIP) funding.

As you are aware, access to affordable housing is a significant social determinant of health and directly impacts health care costs for low-income individuals and families. In a February 2016 study published by Center for Outcomes Research and Education (CORE), Medicaid claims data for previously homeless individuals and families showed in the year after they were housed: a 20% increase in primary care utilization, an 18% reduction in emergency department (ED) visits, and a 12% overall reduction in Medicaid expenditures. MassHealth's own Community Support Program for People Experiencing Chronic Homelessness has documented similar outcomes.

For MassHealth members, particularly those with complex behavioral health needs, who are housed but struggling and at-risk for eviction, the availability of flexible services is critical to maintaining their housing. To that end, MassHousing, the Department of Housing and Community Development, and the Executive Office of Health and Human Services are investing additional state resources to pilot an "upstream" expansion of the Tenancy Preservation Program (TPP), to engage at-risk households at the first signs of lease violation and support/stabilize the household before the situation further deteriorates, leads to Court and possibly eviction. If Accountable Care Organizations could be encouraged to use DSRIP flexible services funds to similarly invest in "upstream" TPP services, then those MassHealth members can avoid the health-compromising trauma of eviction and homelessness, while MassHealth and the Commonwealth also avoid those associated costs.

Beyond this specific initiative, we are also very interested in continuing to explore opportunities for partnerships among housing and health care providers. Housing presents the health care system with a unique opportunity to access members/patients to better coordinate and integrate physical and behavioral health services, long-term services and supports, and other health-related social services, literally under one roof. In the previously referenced CORE study, properties with on-site health services experienced the greatest reductions in ED visits and Medicaid expenditures. While these types of on-site health services are generally beyond the scope of traditional multi-family rental housing, future partnerships may present opportunities for collaboration which emphasize affordable housing with integrated health services and coordinated care for all.

Thank you for your time and consideration.

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MHSA's Response to Section 1115 Demonstration Waiver Extension Request

The Massachusetts Housing and Shelter Alliance (MHSA) and its statewide partners thank you for the opportunity to provide comments on the MassHealth Section 1115 Demonstration Project Amendment and Extension Request. We are also appreciative of your efforts to expand CSPECH statewide and ensure that this important service is available to all Medicaid enrollees who need it.

While we see much in the Extension Request that is desirable in terms of a more cost-effective and coordinated system of care, we wish to point out what we consider to be a significant omission in the document that needs to be addressed.

As you know, the Center for Medicare and Medicaid Services issued a bulletin in June of 2015 that articulated how states can use Medicaid funding to provide services to help address the problem of homelessness. The Massachusetts Interagency Council on Housing and Homelessness (ICCH) is committed to ending chronic homelessness. MHSA believes that MassHealth should work in synchronization with the goals of the ICCH and unfortunately, we do not see evidence of this in the current Waiver Request.

Specifically, we point out the following:

- CSPECH is not currently a covered service for all MCOs other than through the Massachusetts Behavioral Health Partnership (MBHP) and the Pay for Success Program. Without this being a covered service, an ACO would not be mandated to provide it in the future.
- There is no specific mention of the homeless population as a priority group in the document. This runs counter to recent CMS clarifications that Medicaid services can be used to help end homelessness. For example, ACOs are specifically required to have expertise in providing services to the behavioral health and substance use populations as well as the disabled but not to the homeless.
- ACO Care Coordination is required for physical health, behavioral health and substance use populations but not specifically for the homeless population. (While it is true that homeless individuals may have all of the above problem areas, the lack of permanent, low-threshold supportive housing makes successfully treating these problems almost impossible.)
- Certified Community Partners (CP) are created for the behavioral health and long-term services and supports (LTSS) but not for the homeless population.
- The Waiver creates payment tiers for reimbursing ACOs that serve high-risk populations, but homeless is not mentioned as one of the criteria that would drive this designation.
- There is no requirement that ACOs include CSPECH providers in their provider network.
- There is no requirement for a homeless services provider to be on mandated care teams and no requirement to assess an individual's housing status as a key component of their health.
- MassHealth still lacks a way to designate individuals as homeless within the Medicaid data system. The waiver does not address this.

Finally,

- The Waiver Request does nothing to end the revolving door of discharge from a hospital, psychiatric facility or detoxification facility to homelessness. MassHealth will never meet its cost

containment goals until this key gap is filled with the provision of permanent, low-threshold, supportive housing for these individuals.

We encourage MassHealth to review the entire Waiver Request from the perspective of homeless individuals and their unique needs and ensure that ACOs recognize and provide services tailored to this population. Specifically, we make the following recommendations for inclusion in the Waiver:

1. Make CSPECH a covered service for all MCOs now. This insures that CSPECH will be covered by new ACOs as they come on board. Without this being a covered service, an ACO would not be mandated to provide it in the future.
2. Create a homeless individual designation in the data that is collected by MassHealth that can be updated on an annual basis to track homeless individuals and allow them to be identified by ACOs.
3. Make homeless individuals an explicitly distinct population that needs to be served by ACOs, similar to that of physical health, behavioral health and long-term services and supports. This includes ACOs having expertise in this area.
4. Create a Certified Community Partner that is specific to the needs of homeless individuals. This will ensure that DSRIP dollars will flow to Housing First providers.
5. Make homeless services providers a mandated part of the integrated care team for individuals identified as homeless.

We would be happy to discuss these suggestions with you, and we look forward to making the Waiver Request a more inclusive tool for addressing the homeless population in Massachusetts.

July 16, 2016

Executive Office of Health and Human Services
Office of Medicaid
Attn: 1115 Demonstration Comments

MassHealth.Innovations@state.ma.us

Dear Assistant Secretary Tsai,

On behalf of the Massachusetts Law Reform Institute thank you for the opportunity to comment on the Section 1115 Demonstration Project Amendment and Extension Request. We know this proposal is the product of many months of tireless effort on the part of you and your staff. As a legal advocacy organization representing low income families, MLRI offer the following comments in the interests of our MassHealth clients.

We support the goals of the demonstration: promoting integrated and coordinated care, improving integration of services, maintaining near universal coverage, supporting safety net providers and expanding access to services to address substance use disorders. The great unknown is how these goals can be achieved by holding providers accountable for quality and the total cost of care as the demonstration proposes to do.

A demonstration must promote the objectives of the Medicaid Act. 42 USC § 1315. The Act itself states its purpose: “to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” 42 USC § 1396-1. Our comments focus on the specific changes requested to the current Demonstration in section 8 and how the proposed changes will affect the MassHealth member’s experience of care and promote the objectives of the Act.

8.2 Advancing Accountable Care

Massachusetts requests authority to implement a program to contract with and pay ACOs under the models described in Section 4, including for an ACO Model B pilot starting this year.

Two of the three payment models will involve Managed Care Organizations where consumer protections are well-defined. See 42 CFR Part 438. It is our understanding that the state is not seeking to waive or avoid compliance with the Medicaid managed care rules applicable to MCOs, PIHPs, and PCCMs. However, the broad authority sought for Model B ACOs with which the state will be entering into risk-based contracts that may allow or require shared savings or losses to be passed on to direct service providers, and for advanced Model B ACOS that involve pre-paying ACOs in lieu of paying direct service providers raise many concerns. It is not clear the extent to which Model B will be subject to the requirements or protections in 42 CFR Part

438. It appears that Model B will continue to employ a PIHP for behavioral health, but not clear if it, or the ACO, will also be regulated as a PCCM entity. Our fear is that Model B will fall into a regulation-free zone. Further, existing managed care consumer protections are not enough. They do not address the risk that if direct providers have a financial stake in the shared savings or losses of the ACO, it may lead them to stint on care in ways that will not be visible to their patients.

If Model B is authorized under § 1115 “expenditure authority,” it should specifically cross-reference to essential consumer protections in 42 CFR Part 438 to the extent applicable to the role of the ACO. Among these essential protections are: §§ 438.10 (anti-gag rule), 438.52-.54 (enrollment rights), 438.100 (enrollee rights, information on treatment options), 438.206-.210 (access to services, second opinion, out of network services, language access), 438.400 et seq. (notice and appeal rights). With respect to risk at the direct provider level, it should include only upside risk for meeting or exceeding quality targets. Individual provider decisions should be driven by expected outcomes not costs.

8.3.1 Benefit Differences Across Delivery Systems

In order to encourage eligible MassHealth members to enroll in an MCO or ACO rather than the PCC Plan, MassHealth proposes to provide selected fewer covered benefits to members who choose the PCC Plan, such as chiropractic services, eye glasses and hearing aids. MassHealth seeks to expand its existing waiver of comparability provisions established under Section 1902(a)(10)(B) of the Act to support this proposal.

We strongly oppose this proposal. It does not promote the objectives of the Act to deny low income families with children, and individuals with disabilities access to state plan services based on their choice of managed care plan. The proposal gives examples of the kinds of benefits it would not provide to members enrolled in the PCC Plan, but seeks authority to exclude any type of benefit, mandatory or optional, to anyone enrolled in the PCC Plan, child or adult, categorically eligible or not. It proposes to set aside fundamental precepts of the Act-- that categorically eligible individuals are entitled to all state plan services, that children and youth under age 21 are entitled to all optional Medicaid services under EPSDT, and that people enrolled in managed care are entitled to the same services as those enrolled in fee for service--but advances no reasonable hypotheses for doing so.

Under the Medicaid Act, the state must provide all state plan services to categorically eligible individuals in its Medicaid program. 42 USC § 1396a(a)(10)(B). The state currently has a limited waiver of this provision but it is for the purpose of providing enhanced benefits in managed care not fewer benefits. Section 4.4 provides the following examples of services: chiropractic, orthotics, eye glasses and hearing aids. These are all optional services that the state has elected to provide through its state plan to categorically eligible individuals. In Massachusetts the categorically eligible include pregnant women, children, parents, individuals with disabilities, the elderly, and other adults. They are entitled to all state plan services regardless of their choice of managed care. See, 42 CFR § 438.206 (a).

Further, under the Medicaid Act, categorically eligible children and youth under the age of 21 are entitled to Early and Periodic Screening Diagnostic and Treatment (EPSDT) services that include all mandatory and optional Medicaid services, whether or not a state has otherwise

elected to offer such services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). In the specific context of managed care, CMS has informed the states that EPSDT provides that children enrolled in all types of managed care, including PCC Plans, “are entitled to the same EPSDT benefits they would have in a fee for service Medicaid delivery system.” EPSDT--A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, June 2014, (pp.29-31 requirement s of EPSDT in Managed Care). Children and youth are entitled to chiropractic services, orthotics, eye glasses and hearing aids even if these services were not in the state plan.

The State’s proposal also violates state law. The services identified to date were all services provided in the PCC Plan in Jan. 1, 2002. Under state law, the MassHealth agency is not empowered to offer fewer services than those covered in Jan. 1, 2002 except with respect to dental services. M.G.L.c. 118E, § 53 as amended by GAA SFY 2017, Acts of 2016. In January 2016, the Governor proposed legislation for the state fiscal year 2017 budget that would have authorized the agency to “restructure” any benefits notwithstanding c. 118E, § 53. Both the House and the Senate rejected the Governor’s legislation and it was not enacted. The demonstration proposal to deny services to those enrolled in the PCC Plan would violate state law, and the Secretary has no authority to waive state law.

The proposal would penalize beneficiaries who choose a managed care option the state has elected to make available. The proposal is testing a new delivery model, ACOs, but the punitive restriction of benefits is being applied only to the PCC Plan not to MCO network physicians who are not in an ACO. The agency has advanced no reason to show why the PCC Plan is a less desirable option than an MCO.

In terms of quality, annual HEDIS reports measure quality in both the PCC Plan and the MCOs, and the PCC Plan performs as well or better than at least one or more of the MCOs on all but one measure.ⁱ Thus, HEDIS scores provide no reason to think the PCC Plan provides lower quality care than the MCOs. The proposal also summarizes the results of the CAHPS survey for five of the MCOs in 2014. The results show significant variation in consumer satisfaction depending on the MCO with some scoring at just the 25th percentile on such important factors as “Getting Needed Care.”ⁱⁱ

Historically, the PCC Plan has been preferred by people with disabilities, and, when given the tools to do so, it manages their care well. The HEDIS report shows that while 11.6% of all MassHealth members required to participate in managed care are disabled, 20.5% of PCC Plan members are disabled, a much higher proportion than any of the MCOs. A 2013 analysis for the Delivery Model Advisory Committee shows the per member per month cost of care for medically complex “very high risk” members in the MCOs was 135% of the costs of care for very high risk patients in the PCC Plan.ⁱⁱⁱ Further, the Partnership has initiated many innovative programs for people with complex medical needs such as housing supports for chronically ill and homeless adults, recovery peer navigators for repeated users of detox services, an integrated care management program for members with complex medical and/or behavioral needs, and primary care clinicians have participated in alternative payment arrangements such as the Primary Care Payment Reform Initiative.

The Medicaid agency sets rates. All acute hospitals in Massachusetts participate in Medicaid at Medicaid set rates and are available to members in the PCC Plan. However, the same is not true for the MCOs and access to certain hospitals is increasingly problematic. This includes hospitals that provide specialty care important for people with disabilities and complex medical needs as well as hospitals that dominate the market in rural parts of the state. Further, when costs increase unexpectedly, such as with the introduction of high cost drugs able to cure Hepatitis C, the MCOs adopted illegally restrictive medical necessity standards. The fact that the agency administered its own drug benefit enabled members in the PCC Plan to obtain these drugs and eventually led to the agency resolving the access impasse with MCOs.

Medicaid officials have said that the PCC Plan is not able to control costs as well as the MCOs. However, it is the agency that determines what tools to control costs will be employed on the medical side of the PCC Plan. It decides when a PCC referral is required. No referral is required for chiropractic services, eyeglasses or hearing aids, for example. The agency determines whether or not to require prior authorization for a medical service like home health which until recently did not require prior authorization. The agency determines which medical providers can participate. If the MassHealth agency cannot manage the PCC Plan, how can it effectively monitor MCOs and ACOs as it proposes to do in the demonstration?

8.3.2 Enhanced Benefits to Treat Substance Use Disorder

We strongly support this timely and important expansion of services for MassHealth beneficiaries across all delivery systems. It should also extend to those eligible based on being age 65 or older, and we request confirmation that this is the case.

8.3.3 [Flexible services]

MassHealth also requests authority to include additional flexible “in lieu of” services, as described in Section 4.2.2 in the Demonstration and offer these benefits under managed care, including through MCOs and Model A ACOs.

We support the provision for flexible services but request clarification of several features. In Section 4.2.2 the description of flexible services seems to apply to all ACOs including Model B ACOs which we support. However, § 8.3.3 only refers to MCOs and Model A ACOs. Will DSRIP-funded flexible services also be available to Model B ACOs?

42 CFR § 438.3(e) authorizes “in lieu of” services by MCOs and PIHPs if certain criteria are met. The utilization and costs of such services are taken into account in developing the capitation rate. Its criteria are similar, but not identical, to those listed in the Proposal at 4.2.2. One requirement of the regulation that is not included in the Proposal is the provision that an enrollee cannot be *required* to use the alternative service or setting. 42 CFR § 438.3(e)(ii). This provision for voluntary use of flexible services should be included in the Proposal as well.

The state criteria require that flexible services be cost-effective alternatives to covered benefits and likely to generate savings. We suggest revision of this language by changing the conjunction from “and” to “or” and substituting “likely to reduce the use of more costly covered services” than “generate savings.” There may be instances where an “in lieu of” service is literally substituting for a covered service, for example a tablet substituting for an Alternative and Augmentative Communication device (AAC) where one service is an alternative for another.

However, for other services such as an air conditioner to reduce heat-induced seizures, or assistance with social service needs, a reasonable expectation of reduced use of other covered services is a more appropriate test.

8.3.4 Cost Sharing Differences Across Delivery Systems

As described in Section 4.4, MassHealth proposes to implement differential copayments depending on whether a member is in the PCC Plan or FFS, or enrolled in an MCO or ACO. ...MassHealth seeks waiver authority to implement these premium and costs sharing requirements to the extent that they exceed limits established under section 1902(a)(14) of the Act and implementing regulations.

The authority requested to charge premiums and copayments in excess of those permitted under the Medicaid Act is not presented with sufficient detail to enable meaningful comment. Federal regulations require a comprehensive description of the § 1115 application or extension with “sufficient level of detail to ensure meaningful input from the public including: ...the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State’s current program features.” 42 CFR § 431.408(a)(1)(i)(B).

In § 8.3.4 the proposal states that differential copayments will remain nominal (as required by the Act), and refers to updating cost sharing in accordance with the ACA, yet it seeks authority to disregard the limits established under the Act. Section 4.4 refers to updating the out of pocket cost sharing schedule including premiums and copayments in 2018, eliminating copayments for those under 50% FPL, recalibrating the premium schedule for those over 150% FPL and expanding the list of services to which copayments apply. However, nothing explains what aspect of the premium and cost sharing provisions incorporated by reference in § 1902(a)(14) would not apply to whatever changes the agency has in mind.

Congress has provided detailed standards for premiums and cost-sharing and given the states substantial flexibility within prescribed parameters. It has also limited the Secretary’s power to authorize cost sharing under any waiver unless the demonstration satisfies five specific conditions including testing a unique use of copayments, a 2-year limitation, benefits to recipients that outweigh risks, and use of a control group. 42 USC § 1390o(f). See, *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011) (Secretary’s approval of Arizona co-payment demonstration is unlawful). The proposal does not describe how it will satisfy these conditions.

We oppose any explicit waiver of Medicaid premium and cost-sharing protections or any implicit waiver under the expenditure authority.

8.4 Extending CommonHealth for Working Adults Age 65 and Older

We support this proposal for all working disabled seniors eligible under the current state rule at 130 CMR § 519.012. However, the proposal should be clarified because it sometimes describes the eligibility criteria more narrowly than the current rule which we understand was not the intent.

8.5 Student Health Insurance Program (SHIP): ensuring MassHealth is “payer of last resort”

We support the availability of premium assistance for student health plans and the proposal to provide continuous eligibility to coincide with the student health insurance coverage period. However, we oppose the proposal to make premium assistance mandatory. For students who require behavioral health services, premium assistance is likely to reduce their access to affordable care. This is because, except for students under age 21, when MassHealth is secondary, the beneficiary is enrolled in fee for service. MassHealth fee for service refuses to allow licensed mental health practitioners, other than psychiatrists, to enroll as participating providers of therapy services. This means a student will have great difficulty obtaining therapy services from a provider who participates in both MassHealth and the student health plan. If a student sees a provider who does not participate in MassHealth, the student will bear the entire cost of the deductibles, copays and other cost sharing in the student health plan. This situation could be remedied by the agency, but until it is, premium assistance for students should not be mandatory. Students should be able to decide for themselves whether the advantages of the private plan outweigh the likely added costs for seeing a therapist in private practice.

8.6 Requested changes to the Safety Net Care Pool

We support the requested authorization for ConnectorCare subsidies for cost sharing in addition to premium subsidies.

We request clarification whether the proposal contemplates any change to the rules of the Health Safety Net Uncompensated Care Program at 101 CMR Parts 613 and 614.

Other questions and concerns

12-month lock-in, ACOs and Model B. We have previously written to EOHHS about our deep concerns with the proposal to deny MassHealth members the ability to change MCO plans, and we will not repeat those concerns here except to say the complexity of the choices in the new environment are a further reason members should be able to freely change plans.

We request clarification how the lock-in will operate in the context of the new models of care. Models A and C will involve MCOs. Presumably members will be locked into the MCO, but will members be able to change primary care providers within a Model C MCO if it means leaving the ACO but remaining within the MCO? Will members also be locked into the choice of a Model B ACO, and, if so, how does this affect their ability to change primary care provider?

Default assignment. Currently members required to participate in managed care who do not select a plan by a deadline are assigned by default into the PCC Plan or one of the MCOs; the assignment takes into account past plan enrollment but otherwise distributes members to each plan in turn. If enrolled in an MCO, a member must select a PCC and if he or she fails to do so, the MCO will assign a PCC. Under the proposal, the delivery system will include the PCC Plan (with its disadvantages in benefits and cost sharing), MCOs (with PCCs who are not in an ACO), Model A ACO(MCO), Model B ACO, and Model C MCO-ACO. What will be the basis for default assignment now? For MCOs that operate both in Model C and without an ACO, what PCC assignment rules will they employ?

Language access. The proposal has many references to cultural competence but few to language access. A significant portion of MassHealth members are limited English proficient (LEP). Communicating with LEP individuals and engaging them in their care will require the use of interpreters and translation services. When LEP members seek care, their plans and providers will also require the use of interpreters and translation services. Interpreters and translations must meet quality standards and of course entail costs. We recently submitted comments on the Office of Medicaid’s draft Language Access Plan. It has been in draft form since 2011. The draft fails to address what the expectations are of providers and plans to communicate with LEP patients or how MassHealth is prepared to assist them with technical support and appropriate reimbursement for the costs of these ancillary services. Language access should be given more attention in the proposal and in the implementation of delivery system reforms.

Concurrent measures of quality and access. Quality measures based on claims data are not available until one to two years after the time services are provided. It is important that concurrent measures be in place to detect problems earlier. We strongly encourage MassHealth to use direct member experience measures such as “mystery shopper” surveys to assess network adequacy. Tools like these most closely resemble the consumer’s experience of care.

Primary care providers, ACOs and Fee for Service. The proposal states that primary care providers can participate in only one ACO, but can participate in fee for service and in other delivery models as a specialist. Please clarify that a primary care provider in an ACO can participate in fee for service as a primary care provider. If not, beneficiaries with no managed care or ACO options such as students and others with MassHealth as secondary coverage will be at a serious disadvantage.

Ongoing stakeholder engagement in implementation. We appreciate that the proposal recognizes the need for ongoing stakeholder engagement in the implementation process and refers to convening technical advisory groups and advisory groups of advocates and members. We think it is important that any such groups be structured so that they can actually offer advice as a group. While there have been many opportunities to hear presentations on the development of the DSRI proposal to date and many forums for public comment, there has not been a forum for stakeholders to talk to one another, ask for information, arrive at a consensus or majority view and offer advice as a group.

Thank you again for the opportunity to comment.

Yours truly,

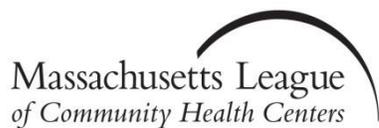
Vicky Pulos, Senior Health Law Attorney
vpulos@mlri.org

¹ MassHealth Managed Care HEDIS® 2015 Report, U. Mass. Medical School, Feb. 2016 (reporting on calendar year 2014). It reports on nine measures across three domains: Preventive Care, Chronic Disease Management and Behavioral Health. On the nine measures, the PCC Plan scored above the 75th percentile on six measures, on two of which it scored above the 90th percentile; it out-performed from one to all six of the MCOs on eight of the nine

measures; it was lowest on only one measure (anti-depressant medication management) a measure on which five of the six MCOs were also below the 75th percentile. Of the other two measures where it scored below the 75th percentile, in one (Diabetes screening for people with schizophrenia or bipolar disorder) none of the MCOs scored higher than the PCC Plan, on the other (comprehensive diabetes care) all the MCOs supplemented claims data with record reviews but the PCC plan did not and still outperformed two of the MCOs.

ⁱⁱ The summary table shows percentiles achieved against national benchmarks in eight categories. While the “Rating of Health Plan” percentile was high for all five plans, many of the other measures show significant variation. For example, for “Getting Needed Care”: three plans scored under the 75th percentile, two at just the 25th percentile; for “Getting Care Quickly,” three plans were at the 50th percentile or below; for “Customer Service,” three plans were at the 50th percentile or below.

ⁱⁱⁱ Navigant, presentation to the Medicaid Delivery Model Advisory Committee, April 10, 2013 (slide 14, risk adjusted baseline costs).



40 Court Street, 10th Floor Boston, MA 02108 phone: 617-426-2225 fax: 617-426-0097 www.massleague.org

July 16, 2016

Submitted by email to MassHealth.Innovations@state.ma.us

Daniel Tsai
Assistant Secretary for Medicaid
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Comments on the MassHealth Section 115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai,

The Massachusetts League of Community Health Centers is pleased to comment on the above-referenced Waiver Request. We greatly appreciate the many opportunities you provided for the League and our members to provide input during the stakeholder engagement process, and we look forward to continuing to work closely with you to ensure that the Commonwealth's goals are met.

We strongly support provisions intended to increase access, including insuring funding for much-needed support for priority initiatives which include sustaining and expanding the primary care workforce, providing targeted technical assistance and promotion of clinical/community linkages; insuring the continuation of the Health Safety Net and the Uncompensated Care Pool; ensuring the sustainability and affordability of the ConnectorCare program; assuring the sustainability of the CommonHealth program; providing continuous eligibility for members receiving Premium Assistance for the Student Health Program; expanding MassHealth substance use disorders treatment services; and eliminating copayments for some MassHealth members.

We strongly oppose the proposal that members whose coverage is through the Primary Care Clinician Plan (PCC) would lose coverage for certain optional services as well as face increased copayments. We anticipate that implementation of the sweeping changes, and consolidation of provider networks that are at the heart of the Proposed Waiver will be a time of great confusion to consumers, and that no matter how well implemented will cause instability in the system. Members should not be "forced" out of existing relationships in order to obtain the services they require. Doing so will have very little impact on success, while at the same time causing hardship and resentment by members.

We appreciate MassHealth's reaching out to advocates and providers regarding their intention to "lock in" members to MCOs for twelve months, but still have some reservations about this policy. Our major reservation is that while it may cause disruption in current care patterns, it does not solve the "churn"

problem, a far greater part of which is caused by eligibility changes than MCO changes. We strongly recommend that the state should in its request to CMS the option of providing 12-month Medicaid eligibility for anyone enrolled in an MCO, and as they are formed, an ACO. A serious look should be taken as to the cost/benefit of doing so as according to a number of studies there is a benefit. And doing it would provide a 'carrot' to patients currently in the PCC program far greater than the proposed 'stick.'

We also request that MassHealth provide out-stationed eligibility workers to the health centers and/or funding for health center outreach and enrollment staff. We have found that the presence of MassHealth and ConnectorCare staff at the health centers has been very helpful in assisting patient to access and maintain their health care coverage and would like to increase this activity. In addition, except for limited grant funding, the health centers bear the entire cost of over 400 Certified Application Counselors. System consolidation will make accurate and effective communication even more necessary with patients whose first language is often not English and/or whose literacy and electronic communication skills are often limited, so we request consideration be given to increasing funding for this workforce.

Our other concern with the "lock in" provision, is that in many parts of the state served by community health centers, both MCO and PCC patients frequently seek care at a community health centers that are not within their existing network. As you are aware, under Federal grant provisions, community health centers are required to see patients regardless of their "ability to pay," and are therefore not allowed to turn patients away because they are not enrolled in their existing MCO, PCC, or ACO. To date, it has been relatively easy to "switch" them to a MCO that the health center does contract with, or to the health center's own PCC. Although we are hopeful that in most cases network adequacy within both the MCOs and the ACOs, as well as the provisions which would allow a person to change networks, will be sufficient to minimize this problem, in cases where the problem remains, it will threaten the financial viability of many health centers, and result in an unprecedented call on their Federal grant funding.

Therefore, at the very least, we request Mass Health to provide a mechanism for payment by the MCO or ACO to out-of-network FQHCs for medically necessary services that are immediately required due to an unforeseen illness, injury or condition to enrollees of an MCO or ACO in compliance with 42 U.S.C. § 1396b(m)(2)(A)(vii), and that these be paid at no less than Medicaid rates. To this end, Mass Health could adopt the mechanism contemplated under 42 U.S.C. § 1396a(bb)(5) for the provision of wraparound/supplemental payments to FQHCs to ensure they receive full and timely PPS payments for services rendered to any Mass Health enrollees. Although we recognize that federal requirements for Medicaid programs to insure that health centers are paid their reasonable costs (PPS/APM rates) were written to apply to MCOs, the legal principle is that Federally Qualified Health Centers (FQHCs) do not become 'short changed' by state Medicaid agencies. We strongly request that this principle, and practice, apply so that FQHCs engaged in the ACOs do not forego their rate protections because of what is in effect a change of name for a "managed care organization."

Our other comments with respect to MCOs are related to expectations that they will be "key partners" in the new models. As part of this partnership we request that provisions around ACO/MCO contracting

should be strengthened; that the state should set requirements for homogeneity between MCOs and ACOs for data and other reporting including a model contract and requirements for a common set of outcome metrics and a MassHealth developed Value Based Payment (VBP) framework that all MCOs must comply with; and that actual providers should be given a decision-making role in deciding where care-management functions should be located.

We support provisions which would waive prior approval for substance use disorder treatment, and also request the opportunity to discuss the possibility of “carving out” certain community health center services, including but not limited to School-based Health Center services, where prior approval processes actually interfere with the provision of cost-saving services.

Areas in which we hope to have further clarification are: how MassHealth has defined the population eligible for Long-term support services (LTSS); what the requirements are to become a Certified Community Provider (CCP) and Certified Behavioral Health Provider (CBHP); how funding will flow from the state and from the ACOs to LTSS, CCPs and CBHPs; how pharmacy services, particularly 340b pharmacy services, will be handled; the amount of flexibility that will be allowed to ACOs with respect to their services; the decision rules related to the use of Safety Net care funds, in particular the extent to which health centers, as safety net providers, will receive them; and other details on how MassHealth plans to align the Health Safety Net with MassHealth programs. With respect to behavioral health, many community health centers currently provide mental health and substance use disorder services and are concerned as to how they will fit in under the certification process. Others which have Elder Service Plans/PACE programs have similar questions regarding their services to the elderly.

The most serious concern by our members about the current Waiver Proposal is the requirement that a provider can be a member of only one ACO. The secondary, but also important concern is that members who are for various reasons, with rural locations being the major one, are not able to form or participate in any one ACO. In the late 1980’s attempts were made to apply limit provider participation in only one Managed Care Organization (MCO) and quickly failed because of the access issues these caused to members and the financial issues these caused to providers. A much harder look should be taken to prevailing patient care patterns before imposing such a stringent requirement.

At a minimum, we recommend that if a primary care provider organization has the Medicaid patient volume and managerial capability to participate in more than one ACO, it be allowed to do so. We request clarification of how a provider organization can be a member of an ACO while also providing services to patients of, and being reimbursed by another ACO or MCO. We also request that technical assistance and waiver-related supplementary funding be provided to community health centers, and possibly other types of providers, who, due to local conditions are not able to form ACOs or to join ACOs that meet the needs of their patients, but which are able to design programs which will meet the Commonwealth’s goals of improving quality and controlling costs.

Another major concern is the relative bargaining power of primary care providers, and specifically community health centers, compared to tertiary care providers. Although we are heartened by MassHealth’s plans to attribute ACO membership based on a member’s use of primary care providers,

this in itself does not change the relative bargaining power, particularly given the state's existing health care system. For example, within the past year two major hospitals discontinued their contracts with two MCOs which covered a large number of health center Medicaid patients, leaving the only options for those patients to either cease using those hospitals or enroll in the PCC program. If a hospital or health system chooses to exclude particular health centers, what would the options be for their patients? Or, if a hospital or health system based-ACO offers disadvantageous terms for participation, the health center would have little leverage. We are also concerned that health centers whose commercial insurance contracts run through physician-hospital organizations will be forced to terminate those contracts if they opt to be part of a different ACO, again giving the system that "holds" these, disproportional bargaining power.

Finally, we would again urge that consideration be given to including dental services, if not at this time, at least during the duration of the demonstration. Given the disproportionate use of high-cost emergency room services by Medicaid patients, and given the difficulty of dealing with a host of medical conditions because of poor oral health care, we believe including it would result in cost reduction and quality improvement. The League would be very happy to assemble a group to work with you on developing a plan to this end.

Thank you again for the opportunity to comment on the Waiver proposal, and especially for the openness and receptivity you and your staff have shown to our input as it was under development. We hope to continue this important work in concert with you into the future.

Very truly yours,

Patricia Edraos
Health Resources/Policy Director



July 11, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108

RE: Section 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai,

On behalf of the Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation (“the Foundation”), we are pleased to submit comments regarding MassHealth’s draft 1115 waiver extension request.

The mission of the Foundation is to expand access to health care for low-income and vulnerable populations. As a program of the Foundation, MMPI seeks to promote the development of effective Medicaid policy solutions through research and analysis and by broadening understanding of the Massachusetts Medicaid program and the important role it plays in providing coverage and financing of health care services for low-income residents.

We commend the overarching goals outlined in MassHealth’s 1115 waiver extension proposal. In particular, we support the goals of enacting payment and delivery system reforms that promote member-driven, integrated, coordinated care and maintaining the advances in coverage achieved in our state. The expansion of substance use disorder treatment services as well as the opportunity to expand access to mental health services and community-based long term services and supports are also critical to MassHealth members. We are encouraged by the growing recognition – emphasized in your proposal – of the importance of social factors on health. We appreciate the aspects of the proposal – such as the funds available for flexible services – that aim to link members with social services.

We also commend MassHealth for the extensive stakeholder engagement process this past year. We look forward to more of this engagement going forward as you undertake the significant effort of determining the programmatic and operational details through your procurements and other implementation efforts. Critical to this ongoing engagement will be making publicly available timely data on access, quality and financial performance. We note your commitment in the waiver extension proposal to publishing annual reports on ACO performance, but ask you to consider also developing more frequent and timely dashboards of information and data as a means to engage key stakeholders through transparency.

We also support your requesting that some of the Delivery System Reform Incentive Program (DSRIP) funding goes towards increasing MassHealth staff resources to conduct robust oversight of the program. All too often state administrative resources are stretched too thin. Sufficient state staff resources are needed to ensure careful monitoring and stewardship of public funding and to ensure evaluation of and learning from the new innovations. A key premise of the demonstration is accountability. The state will need sufficient staff resources and expertise to hold ACOs accountable to quality, access and financial performance and to implement corrective actions as needed.

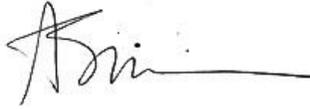
Finally, there is one area where we would urge your careful consideration going forward. This relates to MassHealth's request for authority to implement premium and cost sharing requirements that exceed current federal limits established under section 1902(a) (14). We appreciate that there will be a public process regarding the specific changes to MassHealth cost sharing prior to your implementing them in 2018.

Related to increasing premium levels for some MassHealth members – we point out that such a policy change could adversely impact the waiver goal of maintaining near universal coverage. Increasing premiums could result in reduced retention of existing coverage as MassHealth members and families may have to choose between meeting basic living expenses (e.g., paying rent) and paying higher MassHealth premiums. In addition, some eligible but unenrolled residents may opt to not take up MassHealth coverage if the level of premiums are viewed as a barrier. This assertion is borne out by empirical research and captured in literature on this topic. Summarizing 11 studies, the Kaiser Family Foundation found that “premiums and enrollment fees have been shown to act as barriers to obtaining and maintaining coverage for low-income groups.” (See below for a listing of literature reviews of the many studies analyzing the impact of premiums and cost sharing on Medicaid and low-income populations.)

Related to cost sharing, in addition to the proposed cost sharing differentials by delivery system type (i.e., PCC Plan vs. ACO and MCO), the proposal indicates MassHealth plans to expand the list of services to which copayments will apply. While such policies are likely aimed at reducing unnecessary care, we point out that there is considerable research that shows that the impact of cost sharing on low-income populations often does not have that intended effect. Summarizing 20 studies, the Kaiser Family Foundation found that “while studies have shown that cost-sharing does reduce the use of less-essential services, these studies have also shown that individuals are just as likely to reduce the use of essential and effective services. Cost-sharing can act as a financial barrier to accessing care, particularly for those with low income and significant health care needs. Such individuals often end up either delaying care or not seeking needed care that in some research has shown to result in adverse health outcomes.”

In closing, we want to thank you for all of your efforts aimed at improving the MassHealth program in its ability to effectively serve its members. We stand ready to assist you in that important effort.

Sincerely,



Audrey Shelto
President
Blue Cross Blue Shield of Massachusetts Foundation



Kate Nordahl
Executive Director, Massachusetts Medicaid Policy Institute
Blue Cross Blue Shield of Massachusetts Foundation

Literature Reviews Summarizing Studies of the Impact of Medicaid Premiums and Cost Sharing

Laura Snyder and Robin Rudowitz of the Kaiser Commission on Medicaid and the Uninsured. *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*. February 2013. Located at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf>

Lauren Frohlich, Kendall Swenson, Sharon Wolf, Suzanne Macartney, and Susan Huan of the Assistant Secretary for Planning and Evaluation. *Financial Condition and Health Care Burdens of People in Deep Poverty*. July 2015. Located at: <https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>

David Machledt and Jane Perkins from the National Health Law Program. *Medicaid Premiums and Cost Sharing*. March 2014. Located at: http://www.nationaldisabilitynavigator.org/wp-content/uploads/resources-links/NHELP_IssueBriefMedicaidCostSharing_03262014.pdf



July 15, 2016

RE: Comments on MassHealth Section 1115 Demonstration Project Amendment and Extension Request

The Massachusetts Medical Society appreciates the opportunity to provide comment on the MassHealth Section 1115 Demonstration Project Amendment and Extension Request. We applaud the transparent and inclusive process Assistant Secretary Tsai and his office has undertaken over the past many months to ensure ample stakeholder engagement.

The Medical Society has long been a proponent of the Medicaid program in Massachusetts as a vital source of health care coverage to many of our most vulnerable populations. We have watched closely as the growth trajectory of the program spending has increased markedly over the past few years, and appreciate that change must occur to ensure the sustainability of the system without significant reductions to eligibility or services covered.

The Medical Society supports many aspects of the waiver application: the expansion of substance use disorder treatment, the emphasis on behavioral health integration, and many initiatives through the DSRIP funding will serve the patients of the Commonwealth well while helping strengthen the health care delivery system. The Medical Society has concerns about other portions of the waiver: the reduction of PCC plan benefits and the 12-month lock-in could offset many of the improvements and jeopardize the care provided to this vulnerable population. Still other portions of the waiver—including new member attribution, the allocation process for the DSRIP funding, and data reporting requirements—have insufficient detail to be able to provide robust comments.

We are pleased to detail these areas of interest through the following comments:

- 1) While the Medical Society supports the innovations and the promotion of integrated, accountable care as a valuable option in the MassHealth program, the MMS does not believe that they should come at the expense of the PCC plan.**

The Medical Society opposes the increase of co-payments and reduction of services in the PCC plan—including the elimination of chiropractic services, orthotics, eye glasses, and hearing aids—as a means by which to shift the source of care to ACOs. MassHealth should incentivize transition to ACOs by making the programs attractive to patients and physicians, not by stripping away benefits from the PCC plan. The latter approach penalizes patients who for many reasons may remain in a PCC plan. It further jeopardizes the continuity of the primary care physician-patient relationship: some physicians with small MassHealth panels may not ultimately choose to join an ACO. Their longstanding patients should not be put in a

position of weighing the termination of their longstanding physician with a reduction in benefits and increase in out-of-pocket expense.

2) The Medical Society applauds the expansion of the coverage of substance use disorder treatment through the Substance Use Disorder 1115 demonstration proposal.

The Medical Society strongly supports the expansion of coverage to include the full continuum of substance use disorder treatment, from initial detoxification through long-term residential rehabilitation services. MMS also supports the expansion of combined detoxification and behavioral health stabilization in the same setting for adolescent patients. We hear often from our members of the particular difficulties that many of these dual diagnosed patients and their families face in finding access to and coverage for appropriate care. The MMS is also pleased to see the commitment of nearly 400 beds in FY17 and over 450 new beds in FY18.

The Medical Society noted the commitment to continue the admirable policy of not requiring referrals for those seeking behavioral health care. We urge MassHealth to adopt a similar policy for substance use disorder treatment across all MassHealth plans. At a recent meeting of the Massachusetts Society of Addiction Medicine, several MassHealth physician participants referenced this issue as a barrier to care for patients who have finally decided to seek treatment.

Additionally, the Medical Society supports the emphasis throughout the waiver on primary care-centered behavioral health integration and patient-centered care coordination for members with long-term support and services and social needs.

3) A primary concern of the Medical Society remains the continuity of the primary care physician-patient relationship.

The Medical Society appreciates the primary care physician based attribution model whereby patients will be placed in the MassHealth plan for which their PCP participates. The Medical Society looks forwards to additional detail about how new MassHealth enrollees without an existing primary care physician will be assigned to a plan.

4) The Medical Society is concerned about the 12-month lock-in provision, especially in light of the complex plan design changes proposed in the waiver.

The Medical Society has concern with the proposed change to implement 12-month lock-in periods for members. While we appreciate the difficulties that high rates of patient churn may pose, removing the flexibility could pose challenges to providing good medical care. Pediatricians have expressed concern, for example, about siblings who are unintentionally assigned to different primary care physicians. The Medical Society is thus opposed to the enrollment lock-in; though if the policy change is an inevitability we would strongly support expanding the specified reasons for disenrollment to include extenuating circumstances such as the sibling inconsistency cited above.

The concerns about the enrollment change are exacerbated given the complexity of the health care

delivery reforms that are proposed, including: multiple ACO models with varying involvement by managed care organizations, a retention yet reduction of the PCC plan, and the inability for dually eligible patients to partake in these ACOs. It is an understatement to say that it will be incredibly challenging for patients to fully understand the effects that these reforms would have on their primary care physician, on their plan design, and on their specialty medicine, behavioral health, and LTSS networks. These complex changes will undoubtedly cause many patients to find themselves with care design that they would like to change: this does not seem to be the most opportune time to limit flexibility of patients' plan choice.

5) MMS believes that a physician's participation in one ACO should not disqualify the physician from participation in another ACO.

The Medical Society appreciates that the waiver indicates that specialists will be able to participate in more than one ACO: we think this is vital to ensuring adequacy of networks for specialty care. Further, the Medical Society acknowledges the importance of ensuring that primary care physicians have a sense of loyalty to their patient's ACO to ensure that care is coordinated and provided pursuant to the established network to the greatest degree possible. In light of this, the Medical Society offers the suggestion that some flexibility be provided for primary care physicians participating in multiple ACOs with the understanding that referrals will be made within the patients ACO to the degree possible. Some details would need further attention under such a proposal, such as clarifying to which ACO a patient would be assigned in their primary care physician belongs to multiple ACOs.

6) MMS strongly supports many of the proposed uses of the DSRIP funding under the "ACO funding stream" but requests modification to ensure that funds are dispensed to hospitals and physician organizations of all sizes, with particular emphasis to small and medium-sized physician practices.

The Medical Society welcomes the \$1.8 billion requested to fund the many capital expenses required to properly transition to alternative payment models. It is often said that Massachusetts health care delivery systems are built on a fee-for-service chassis. Many expenses not imbedded in reimbursement will be required to help change the underlying structure needed to provide optimum population health and accountable care.

Conceptually, the Medical Society strongly supports many of the proposed uses of the "ACO funding stream" DSRIP funds. Infrastructure funding to improve information technology, population health management capabilities, or to promote co-location and integration of behavioral health are all worthy uses of this money. However, in order for the DSRIP funding to truly inform care transformation to allow sufficient physician participation to provide network adequacy, the funding must reach the physician provider organizations who have the most acute capital needs. Small and medium sized physician organizations are often interested in joining ACOs but cannot due to their inability to comply with data reporting, or provide care coordination that adequately controls the costs of their patients. The Medical Society urges MassHealth to find specific venues or accountability structures to ensure DSRIP money flows to small and medium sized physician organizations. Participation of these physicians will be critical to the success the reform efforts.

7) The Medical Society strongly supports several other DSRIP funding purposes under the Statewide Investment funding stream.

Specifically, MMS was pleased to see additional commitments to student loan repayment programs for full-time physicians employed at community health centers, in exchange for two year service commitment. Additionally, the Primary Care Integration Model which would fund one-year projects related to accountable care implementation, as well as the Alternative Payment Methods Preparation fund which would help aid physicians looking to transition from fee-for-service are both welcome proposals, though many of the sentiments conveyed in #6 above would apply to ensure this money is provided to all physician provider types.

Lastly, the Medical Society believes the investment in primary care residency training is a vital component of the long-term sustainability of the MassHealth program.

8) The Medical Society supports the promotion of oral health, as well as the emphasis on addressing social determinants of health.

MMS believes that oral health is an important component of the optimum health management of MassHealth patients. In 2009 the Commonwealth released a report, 'The Status of Oral Disease in Massachusetts' with a commitment to improving and promoting the oral health of our residents. Promoting good oral health improves overall health and nutrition, reduces costs, and can improve the quality of life of all individuals, especially underserved and vulnerable populations. MMS supports the emphasis placed on oral health, and encourages additional creative solutions through this waiver to improve the status of oral health and the integration of oral care in the Commonwealth.

The Medical Society also supports the flexible spending serves as a means by which to improve the health of MassHealth enrollees and to address social determinants of health. The ability to use these funds for medically tailored meals, housing stabilization services, and employment supports provide great potential for evidence-based solutions to promote wellness. The Medical Society notes that additional flexibility on the ACO flexible spending criteria would be preferable: static "cost-effective" requirements may preclude well-established interventions such as housing stabilization and nutrition, which many not immediately conform to the current proposed requirements. The ability to use these funds for medically tailored meals, housing stabilization services, and employment supports would provide great potential for evidence-based health improvement interventions.

9) MassHealth should work with the Centers for Medicare and Medicaid Services to ensure maximum alignment with impending changes to the Medicare program.

The Medical Society has been actively engaged with CMS to provide comment about MACRA, a similarly ambitious and complex payment reform proposal for Medicare. Alignment in payment and delivery structure and in quality and reporting metrics will be essential to ensuring ample participation and successful retention of physicians to provide care under each program.

10) Much of the long-term success of health care delivery and payment reforms proposed in the 1115 waiver will ultimately rest upon the details of the implementation of the accountable care organizations.

MMS acknowledges that many of these details are outlined in the Health Policy Commission's ACO certification, for which we provided extensive comment.

The best designed MassHealth ACO will not be a sustainable model if the global budgets are not set at adequate rates that include special risk adjustment not just for physical health status but for mental health co-morbidities, long-term support and service needs, and social determinants of health. Funding for these global budgets need to be sustained over time, and must adjust for increases in wages, supplies, etc. Funding for other support services, such as the flexible funds that can be used for housing vouchers and medically appropriate foods, must be sustained as separate funding streams in the long-term, as well.

Additionally, the quality and reporting standards should be consistent with other payers including Medicare, and physicians should be informed of the performance measurement expectations of an ACO, in order to best determine if they can meet or exceed expected quality and performance benchmarks that are outlined by the ACO.

The Medical Society greatly appreciates the opportunity to provide these comments, and welcomes further discussion of any of these considerations.



July 16, 2016

PRESIDENT

MARY COAKLEY-WELCH, PH.D.

Marylou Sudders, Secretary of Health and Human Services
Massachusetts Executive Office of Health and Human Services

PRESIDENT-ELECT & SECRETARY

LORI AZZARA, PSY.D.

Re: MassHealth Section 1115; Comments on Demonstration Extension Request
MassHealth.Innovations@state.ma.us

PAST PRESIDENT

STEPHANIE MONAGHAN-BLOUT, PSY.D.

Dear Secretary Sudders,

TREASURER

BRENDAN C. LYNCH, PH.D.

Thank you for the opportunity to comment on the MassHealth Demonstration Extension Request. As neuropsychologists, we applaud the move toward integration of behavioral health, substance use disorder, long-term supports, and health-related social services in alternative payment methods and ACO models. We are providing comments on behalf of our statewide, non-profit professional organization, the Massachusetts Neuropsychological Society (MNS), and the consumers who need access to our services.

TREASURER-ELECT

KELLY C. KARL, PSY.D.

We would like to emphasize that meeting the healthcare needs of MassHealth enrollees requires access to the full range of behavioral health services and that psychological and neuropsychological assessment services, in particular, will play a crucial role in achieving healthcare system goals in new care-delivery and payment models.

MEMBERS-AT-LARGE

THOMAS LAUDATE, PH.D.

PATRICIA LEE, PH.D.

FLANNERY MURPHY GEIER, PSY.D

HOPE E. SCHREIBER, PSY.D., ABPP/CN

JEFFREY B. SHEER, PH.D., ABPP/CN

EMILY K. WILNER, PSY.D.

To provide truly integrated care, ACO provider networks need experts on how physical and behavioral health conditions interact. Many individuals, especially the highest-risk enrollees in our healthcare systems (including those needing long term services and supports {LSS}), present with a complex web of physical and psychological symptoms. Neuropsychologists' expertise, focused on brain-behavior relationships, is exquisitely suited for integrated care. Neuropsychologists identify and treat the brain-based cognitive and emotional symptoms of various behavioral health and physical health disorders AND identify and treat brain-based cognitive or emotional symptoms that may be preventing patients from following treatment plans.

STUDENT BOARD MEMBERS

ERICA APPLEMAN, M.A.

SAGAR LAD, M.S.

We offer the following points for your consideration:

- **The evidence base for the predictive and diagnostic validity for various psychological and neuropsychological assessment measures is strong.** With efforts underway to curb spiraling healthcare costs, accurate diagnosis provided by psychological and neuropsychological assessment results in improved treatment efficacy, since interventions then target the appropriate condition. These assessments identify specific cognitive strengths and deficits, as well as psychological symptoms and characteristics, so that the most effective, empirically-validated interventions are implemented.



- **Neuropsychological and psychological assessments have significant clinical utility in many health care populations and, for some individuals, they are essential for diagnosis and treatment planning.** These assessments include norm-referenced, evidence-based tests which objectively identify and quantify symptoms. They are used in diagnosing dementia and other neurologic conditions; depression, anxiety and other psychiatric conditions; and neurodevelopmental conditions such as autism. These tests assess cognitive dysfunction in patients with traumatic brain injury, stroke, neurodegenerative disorders, major mental illness, neurodevelopmental disorders, and chronic medical conditions such as cardiovascular disease and diabetes. *They assess the functional ability to work and identify factors that will facilitate success on-the-job in people with cognitive deficits or severe emotional symptoms. The tests predict self-help and independent living skills, driving ability, and academic success – especially important for individuals struggling to stay employed or join the workforce and who need skills-training to do so; and they predict outcome after surgery for seizures.*
- **In a transformed healthcare system, the early detection of emotional or cognitive symptoms in children and adults through routine screening that is followed up as needed with brief or comprehensive assessment should be an expected and typical procedure.** Early identification and intervention keep problems from escalating and improve outcomes. For example, earliest childhood detection and treatment for autism can result in significantly better short-term and long-term symptom reduction. Similarly, early detection of cognitive decline in older adults expands treatment and planning options, which in turn improves the quality of life for individuals with dementia and their families – including delaying placement in long-term care facilities.
- **Interventions with children are of primary importance since many risk factors observed in adults can be detected in childhood. Early intervention can change the trajectory of those symptoms.** Childhood *physical and mental health problems* are both associated with poorer adult health.
- **Healthcare providers in clinical practices need to identify and implement evidence-based treatments.** As licensed psychologists with specialized, post-doctoral clinical and research training, neuropsychologists are well-qualified to read, interpret, and use the evidence-based practice literature. They can apply the science appropriately in clinical work, supervise its proper use by less highly trained healthcare providers, and, having been trained as members of multi-disciplinary treatment teams, they can educate healthcare teams in effective use of evidence-based practices to treat patients with emotional and/or cognitive symptoms stemming from behavioral, neurologic, and/or other medical conditions

Thank you for considering these comments. Please call if you have questions, or if you need more information.

Jeffrey Sheer, PhD, ABPP-CN
Licensed Psychologist; Neuropsychologist
Chair, MNS Professional Affairs Committee

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MOAR

Massachusetts Organization for Addiction Recovery

www.moar-recovery.org

617 423 6627

29 Winter Street ~ Boston, MA 0210

July 16, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108

Submitted via email to MassHealth.Innovations@state.ma.us

Re: Comments on 1115 Medicaid Demonstration Extension Request

Dear Assistant Secretary Tsai,

Thank you for this wonderful opportunity to provide written comments on the 1115 Demonstration Extension Request. The Massachusetts Organization for Addiction Recovery (**MOAR**) Board of Directors, staff, and volunteers believe that this transparent and systematic engagement process is critical to the successful re-design and implementation of the 1115 Waiver. We look forward to assisting the Commonwealth to shape this very important (and lifesaving) initiative. In the meantime, please see below for our thoughts on areas of proposal strength and areas for future consideration.

MOAR's mission is to organize recovering individuals, families, and friends into a collective voice to educate the public about the value of recovery from alcohol and other addictions. Over the last 25 years, MOAR has worked to: 1) organize people in recovery, their families, and their friends; 2) educate policy makers and the general public about recovery; and 3) demonstrate that recovery is real and a real asset to all communities. MOAR is governed by the recovery community and a 10 member Board of Directors. Our organization engages over 5000 **MOAR** members statewide, and we partner with numerous allied organizations (regionally and statewide) to represent the expanding voice for recovery. We educate people in recovery, families, and treatment and community partners about the importance of recovery as well as share tools and resources to support individuals to overcome recovery barriers. For instance, our **MOAR** "Mini Guide," "**MOAR** on Recovery Capital (Telling Your Story in Recovery)," and "How to Educate Policymakers Guide" a **MOAR** published resources that are shared routinely during community events and 1:1 Recovery Coach interactions. Our *AREAS groups*, held weekly in Boston, New Bedford, and Springfield by trained facilitators with lived experience, provide recovery support to individuals in various stages of recovery. **MOAR** is engaged in a wide range of coalition building activities to combat stigma surrounding recovery, including our work with the Good Samaritan

Campaign to address the opioid overdose epidemic. Finally, **MOAR** provides Recovery Coach services through Massachusetts- Access to Recovery (SAMHSA MA-ATR) grant; we just received a managed care contract for recovery coaching, and a contract with a local hospital to provide recovery coaching. We look forward to sharing our lessons learned to inform the Waiver design and implementation.

Areas of Proposal Strength

MOAR applauds the Massachusetts Executive Office of Health and Human Services (EOHHS) for its informed vision and approach to address addiction. We have learned, through our own lived experience, that the pain of stigma is the largest hurdle to treating addiction as a chronic medical condition. We will work tirelessly with EOHHS and its stakeholders to shift the paradigm so that members are provided a spectrum of treatment options and recovery supports (including Medication Assisted Treatment, Opioid Treatment Centers, enhanced care management, recovery navigation, and recover coaching) that allow for individualized treatment within a recovery-focused community of care. While we recognize the urgent need to address the Opioid epidemic, we agree with EOHSS that the Commonwealth needs sweeping SUD systems transformation to address the broad range of addiction recovery needs beyond the Opioid epidemic. Might we, also, add the need for recognition of peer specialists on the mental health side with blended opportunities.

MOAR applauds EOHHS for integrating and/or coordinating physical health (PH), behavior health (BH), long-term services and supports (LTSS), and social factors to meet the needs of the whole person. Members' recovery is often dependent on complex factors that reach far beyond their addiction, and recognizing this in outreach, assessment, care planning, and service delivery will improve members' health, quality of life, and cost outcomes. **MOAR** and our partners will be available to assume an important role in educating the member on the interrelationship of non-medical and medical factors, as already demonstrated through our AREAS, Recovery Messaging (telling your recovery story emphasizing strengths gained from the recovery process.)

MOAR applauds EOHHS for recognizing the critical importance of engaging Community Partners in the Model of Care. EOHHS' approach to not only engage Community Partners, but also to financially support their infrastructure development and to hold ACOs financially accountable for meaningful engagement of Community Partners will be important for effective model implementation. All MCO/ACOs need to understand and build upon the wealth of information and experience possessed by Community Partners and grasp the crucial role they can play in effective member outreach and engagement.

Areas for Future Consideration

Recognize multiple pathways to recovery. The model of care, and the training for ACOs/MCOs, providers, and integrated care teams should recognize that members may choose one or more multiple pathways to recovery and that members should not be forced into "cookie cutter" treatment. Member, provider, and ACO/MCO education and materials should recognize and support members' choice in pathway and allow members' flexibility to choose the treatment model and recovery support services that best meet their needs, which may change over time.

Ensure ACO and MCO financial incentives align with long-term recovery goals. As a part of this systems redesign, we need to ensure that safeguards are in place to provide members a continuum of care and to ensure members are not forced into low cost treatment options for the sole purpose of cost savings. **Members should receive care based on their presenting needs, not short term cost outcomes.** ACOs/MCOs must be required to support local partners to build capacity within treatment models for to fully assure a member's recovery goals.

Consider broadening the definition of BH Community Partner. Currently, the BH Community Partners are limited to providers that will perform the 6 Health Home services as defined by the ACA Section 2703. We recommend that EOHHS adopt a more flexible definition for BH Community Partner, similar to that of the LTSS Community Partners, to allow a wide range of BH partners to access DSRIP funding and come together to provide all six health home services.

Ensure ACOs/MCOs and providers understand complexity of SUDs. There are numerous factors that influence members' risk for SUD and their long-term recovery, including stigma; barriers associated with housing and employment; trauma; and complex co-occurring needs associated with medical and/or mental health diagnoses. The Waiver's success is dependent on ensuring medical professionals making treatment decisions and MCO/ACOs allocating treatment resources have a proper understanding of the complexity of SUDs and the barriers to recovery. All treatment providers that participate in this Waiver should be certified and monitored by the BSAS in addition to MCOs/ACOs. While the ACO/MCOs may have their own credentialing process, their credentialing processes and requirements must be aligned with BSAS and national best practices and must be streamlined to minimize administrative burden for treatment providers

Ensure appropriate engagement of the peer recovery community in advisory groups. Given the addiction treatment and recovery focus of this initiative, it will be imperative that the peer recovery community be actively engaged in MassHealth advisory groups as well as ACO/MCOs' advisory groups to ensure the recovery voice is meaningfully involved in the Waiver design, implementation, and improvement. MOAR is prepared to support MassHealth, MCOs, and ACOs to seek peer recovery representatives and to support their engagement in advisory groups.

Work closely with the peer recovery community to develop recovery training for LTSS and Community Partners. Both the BH and LTSS Community Partners (in addition to ACO/MCOs) should receive comprehensive training on the recovery model, wellness principles, factors influencing addiction, and barriers to members' recovery (including stigma and social-economic factors). The training should be provided at multiple levels, including for ACO/MCO leadership, for Care Managers and Integrated Care Team participants, and providers.

Ensure Recovery Coaches are available to all members requiring recovery supports, not just members who require "additional support." Recovery Coaches, when trained and mentored appropriately, can provide members a low-cost, culturally-responsive service as an alternative to high cost facility care. Recovery Coaches, as members of Integrated Care Teams, can assume a role of member advocate and peer support provider, assisting the member to identify his/her unmet needs, overcome hurdles to community living (e.g., housing and employment), and make healthy lifestyle decisions. Recovery Coaches can establish a trusting relationship with the member, over time, which supports the member to develop and access timely and effective wellness plan (inclusive of recovery plans, crisis, and relapse management, and being able to get the right service at the right time to avoid unnecessary high cost facility use). All BH and LTSS Community Partners must be required (through their Memorandums of

Understanding and to receive DSRIP funding) to engage Recovery Centers and Recovery Coaches as a part of their models.

Work closely with the peer recovery community to ensure Recovery Coaches are trained, receive the support they need, and are engaged in multiple settings. Successful systems transformation will be dependent on EOHHS' ability to work with multiple partners to ensure that Recovery Coach assets are appropriately recognized, supported, and placed across the recovery services continuum. EOHHS should work with the peer recovery community, ACOs, MCOs, and treatment providers to develop a comprehensive training and certification process, continuing education and mentoring approach, and ACO/MCO requirements to engage Recovery Coaches within Integrated Care Teams (e.g., as member advocates, to conduct outreach, and to perform Recovery Coaching) and within the wide range of settings of care (e.g., Emergency Departments, hospitals, community-based treatment centers, and Recovery Centers).

Ensure DSRIP workforce development funds and statewide investment initiatives include funding earmarked specifically for Recovery Coach Workforce development. EOHHS should work directly with the peer recovery community to develop Recovery Coach workforce development initiative(s) (e.g., through an earmarked grant program) that include Recovery Coach certification and training. DSRIP workforce development funds and statewide investment initiatives should ensure ACO/MCOs are informed of recovery principles and Recovery Coach services. This means that Recovery Coaches are being effectively integrated into the model of care and a wide range of care settings.

Ensure Recovery Coaches are appropriately integrated into enhanced diversion models of care. EOHHS plans to implement and/or expand Emergency Department Boarding that ensures members are receiving the right care at the right time (e.g., through Mobile Crisis Intervention Teams, Telemedicine and Telepsychiatry, and Urgent Care and Intensive Outpatient Programs). EOHHS and its stakeholders should work directly with the peer recovery community to identify ways in which Recovery Coaches can be used in each of these models and to ensure Recovery Coaches receive the appropriate training and ongoing support to be effective in their roles.

Support innovation to meet the needs of unique populations. DSRIP funds should be used to pilot and expand tailored assessment, care coordination, and supports to meet the needs of unique populations, such as members experiencing homelessness and members recently engaged in the criminal justice system. We need to understand how the Waiver may impact models already created to address the needs of unique populations, and need to support effective licensed long term recovery homes. Recovery Coaches must be allocated for members who are being paroled and members engaged in drug courts.

Work closely with SUD professionals and recovery advocates to understand the implications of a uniform assessment tool. While a uniform assessment tool, when appropriately applied, can ensure members receive the right care at the right time, it is important to recognize and appropriately plan for ways in which an assessment tool may hinder timely and appropriate member access. For instance, the assessment (or follow-up re-assessment) needs to be conducted with members once they are stabilized to ensure an accurate picture of the member's needs or barriers. The tool must be used at a frequency driven by the member's changing needs to ensure the member has access to the services and supports required to address his/her changing needs. We want to stress that when it comes SUD Professionals recognition of The Licensed Alcohol and Drug Clinician I is very important. It is the only helping

profession requiring addiction counseling skills, education, and practice. The Integrated Care Plan must then be flexible enough to adapt to the member's change in unmet needs and personal preferences.

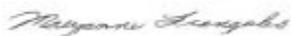
Ensure that DSRIP funds for flexible services include flexibility to meet the unique needs of members with SUD. EOHHS should work with the recovery community to identify ways in which to ensure flexible services are available to support members' recovery. For instance, flexible funds will be needed to support members in recovery to access affordable housing, transportation, healthy food, and self-care. We strongly support all Mass Health recipients to have full dental and eye care. It is important to take care of the whole person. Not having these provisions takes away from quality of life and basic needs.

Ensure Accountability Score and ACO/MCO quality domains/measures include topics associated with member recovery. DSRIP funding will be informed by annual accountability scores driven by avoidable utilization, spending, quality, and progress towards integration across PH, BH, and LTSS. We believe this accountability score should be, most importantly, driven by ACO/MCOs' ability to meeting members total care needs as identified by the member and through the assessment process. We believe that MCO/ACOs success with quality benchmarks should be publicly shared with stakeholders through quality dashboards. The development of accountability scores must be transparent and stakeholder groups must be actively engaged in the design of measures influencing the accountability score.

Support providers to effectively transition to MassHealth managed care payment system. Many providers, including small groups currently providing Bureau of Substance Abuse Services-funded recovery support services, will have no experience with MassHealth and managed care billing practices. EOHHS will need to allocate ample time for providers to be trained, receive technical assistance, and test their billing capabilities to ensure timely and effective reimbursement. ACOs/MCOs should work closely with BSAS, EOHHS, and providers to assess the transition needs of providers and to provide the support they need to ensure a smooth transition prior to implementation. Quality of care must remain paramount, and determined by the people that receive the care..

Again we thank you for this opportunity to participate in this transparent and systematic engagement process to support a successful re-design and implementation of the MassHealth 1115 Waiver.

Sincerely Yours,



Maryanne Frangules
MOAR Executive Director



Thomas J. Delaney
MOAR President

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
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One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Comments on MassHealth 1115 Demonstration Project

Dear Assistant Secretary Tsai,

On behalf of the Massachusetts Public Health Association, we thank you for the opportunity to comment on the MassHealth Section 1115 Demonstration Project Amendment and Extension Request (“Waiver Request”).

We are excited at the opportunities in the evolving health care financing and delivery landscape – including the evolution of ACOs - to focus our collective attention on how to most effectively keep people healthy and prevent the onset of expensive medical conditions. We believe that ACOs in Massachusetts can be a powerful force to promote health, reduce costs, promote equity, and lead the nation. ACOs have a unique ability to provide necessary medical services, as well as to provide care coordination, patient support, and wellness services to address the health needs of members. ACOs also have an important role to play in address the underlying social determinants of health which drive health outcomes and contribute to significant inequities in health outcomes across race, ethnicity, and income.

In these comments, we would like to highlight four key areas that we believe are essential to the ability of MassHealth to effectively address population health, as well as to contribute to eliminating health inequities.

While the Waiver Request outlines a framework for changes to MassHealth’s payment system and its delivery of care, implementation will be the true test for the success of the proposed redesign. The Waiver Request as just the start of a much longer implementation process, which will require close monitoring and input by members, stakeholders, and affected communities. We urge MassHealth to continue the open, collaborative process as implementation proceeds.

1. Population Health and Community Partnerships

Social determinants of health and community-clinical linkages

We strongly support MassHealth’s proposal to integrate community-based partners and linkages to social services in an effort to address social determinants of health. Given that many populations face significant social, economic, and environmental barriers that substantially impact their health, it is critical that ACOs support their members with accessing community resources in their area. The ability of ACOs to provide flexible services – such as housing stabilization services, utility assistance, non-

medical transportation, and other services – offers an important pathway to address underlying barriers to good health.

Specifically, we support MassHealth’s clear expectations for ACOs and community partners to address social determinants of health, including an assessment of members’ social service needs, inclusion of social services in members’ care plans, making referrals to social service organizations, and providing navigational assistance for accessing social services. We further support that a portion of DSRIP funding to ACOs will be explicitly designated for “flexible services” to fund members’ social service needs. In determining whether the criteria has been met to pay for such flexible services, we urge MassHealth to take a broad and flexible approach to encourage ACOs to innovate around how to use DSRIP funds to address social determinants of health.

As MassHealth does not plan to designate social services providers as “certified” Community Partners, as is proposed for behavioral health and long-term services and supports (LTSS) providers, we seek clarification on how ACOs will be held accountable for ensuring that collaboration with social services providers is both meaningful and robust. We recommend that MassHealth require ACOs to detail their plans for these collaborations and use of flexible funding in their RFP responses and in ACO/MCO and ACO/MassHealth contracts.

While the Health Policy Commission’s initial proposed ACO certification criteria contained a requirement that ACOs collaborate with social services and community-based organizations, this requirement was removed in the final approved ACO criteria. **As one key reason for removing the criteria, the HPC staff indicated that MassHealth ACOs would have “robust requirements” for collaborating with social services providers. It is critically important for the MassHealth ACO program to live up to this promise.**

We also seek clarification as to how DSRIP funds will reach social services providers. While DSRIP funds will clearly be directed to BH and LTSS CPs for infrastructure and care coordination, social service providers do not receive direct DSRIP funding as they are not “certified” CPs, and instead may receive DSRIP funding indirectly through the ACO flexible services funds. It is critical that adequate DSRIP funding reach social services providers to ensure meaningful, strong and ongoing collaboration between ACOs and community-based social services agencies. For example, social service providers will need upfront investments in order to participate in two-way referral systems with ACOs, building on DPH’s community e-Referral system being established under the state’s State Innovation Model (SIM) grant and the Prevention and Wellness Trust Fund (PWTF).

The PWTF can serve as a model for community-clinical linkages across the Commonwealth. PWTF mutually reinforces MassHealth’s efforts to improve the health of its members while containing health care spending by seeking to coordinate clinical and community health efforts and address the social determinants of health. We recommend that MassHealth consult with the Department of Public Health (DPH) and incorporate lessons learned from PWTF with respect to community partnerships. Through the experience of implementing PWTF for three years, we have learned that effective linkages between clinical providers and community organizations take significant time and effort to build and maintain. In PWTF, infrastructure was supported to establish these connections and ensure their ongoing functionality. For PWTF, this includes the role of the coordinating partner to manage relationships, communications, responsibilities, and workflow across multiple

organizations, as well as the time and effort needed to establish new working relationships between organizations with different organizational cultures, methods of operating, and referral technology. Because DPH has gained considerable experience with clinical-community linkages, we recommend that MassHealth collaborate with DPH to provide upfront technical assistance and support to ACOs to ensure that the data systems, work flows, staff training, and connection to community prevention programs occurs and that it builds on the knowledge and best practices built into PWTF and other programs.

MassHealth should encourage ACOs to support evidence-based prevention programs such as those funded by PWTF as part of its Waiver Request and contracting process. All PWTF community interventions are currently not covered by health insurance, and all have an evidence base for their efficacy and cost effectiveness.

Another promising model to ensure members have the broadest access to social services agencies is through a social services “hub.” Such a hub can offer a single point of coordinated access to a wide range of social services which have a documented impact on health outcomes and on reducing the cost of care. This would be particularly helpful for small, specialized agencies (such as a group that focuses on a single immigrant community) that may not have the capacity to contract with multiple ACOs, but could work with hubs to allow them to assist members in many ACOs. A hub model could work with multiple ACOs to bridge medical and social service systems, providing culturally and linguistically competent services, engaging multiple social services agencies, and providing access to medically beneficial, evidence-based programs in each geographic region.

Community level support and investments

Prevention and public health are critical to lowering health costs and improving quality. In addition to promoting community-clinical linkages, ACOs should look beyond their members to address the public health needs of the service area or community where the practice is located. By focusing on the underlying social determinants of health at the community-wide or geographic level, ACOs have an opportunity to work towards truly improving health outcomes and advancing health equity. As part of this model, ACOs should collaborate with external partners and community members to address community-based drivers of poor health. While social service providers are key partners to address individual and family needs, addressing geographic-based social determinants of health will require partnership with other community resources, including community-based service providers, legal and social services advocates, public health agencies, and community action agencies.

We support that under the HPC’s ACO certification criteria, ACOs will be required to report on how the ACO uses the socio-demographic information gathered on its patient population to develop and support community-based policies and programs aimed at addressing social determinants of health to reduce health disparities within the ACO population. We urge MassHealth to take this one step further and require ACOs to perform an assessment of community assets and challenges (e.g., high levels of violence, housing insecurity, poor access to healthy food) to better understand community needs and target partnerships/interventions. This could come through an assessment conducted by the ACO or through an existing community health needs assessment. This will provide a basis for medical practices and public health agencies to work together towards improving health at the individual, delivery system, and community levels.

Community expertise and ACO governance

We applaud MassHealth for including in the Waiver Request a requirement that all ACOs include patient/consumer representation in their governance structure. Patients and consumers are the heart of the health care system, and must be valued members of ACO design and governance teams. Patient and family-centered care means bringing the perspectives of members and families directly into the planning, delivery, and evaluation of health care, and thereby improving its quality and safety.

Since ACOs will have responsibility for identifying and addressing the health-related social needs of their members, it is important that ACO governance structures also include expertise in community needs and resources. This role may not always be served effectively by individual consumers. Instead, representatives of community-based organizations and multi-service providers should be considered to fulfill this need.

2. Community Health Workers and Care Coordination

Community health workers (CHWs) are frontline staff who are trained to work with low-income, underserved patients with the goal of bridging communication, cultural, and other barriers to accessing care. ACOs have the opportunity to promote public and community health through strengthening the role of CHWs in connecting people to care resources and promoting overall health. Research has shown that placing CHWs as part of health care teams contains costs by reducing high risk patients' use of urgent and emergency room care and preventing unnecessary hospitalizations. CHWs also improve quality of care and health outcomes by improving use of preventive services, chronic disease self-management support, maternal-child home visiting and perinatal support.

Aside from the brief acknowledgment that ACOs can utilize CHWs as one of several potential strategies to enhance member communication and follow-up, the Waiver Request barely mentions the CHW workforce. We urge MassHealth, in consultation with DPH, to make clear that CHWs are an accepted and encouraged member of the care team. We also recommend that the role of CHWs be more formally incorporated into the ACO models. For example, MassHealth could require – as a condition of contract – that ACO systems demonstrate how they will integrate CHWs into interdisciplinary teams for high-risk/high need patients. Indeed, we shared with Mass Health senior staff specific recommendations for models MassHealth could use (please see email from Rebekah Gewirtz on behalf of MPHA, Health Care for All, and the Massachusetts Association of Community Health Workers, dated June 30, 2016 to Ipek Demirsoy and Michael Kelleher).

Care teams and care coordination

As recognized in the Waiver Request, care coordination should be a core component of all ACOs and is vital to managing an individual's care, reducing fragmentation and improving outcomes. We applaud MassHealth for prioritizing seamless and easily navigable care coordination. True member-centered care will require ACOs to implement payment methodologies that pay for coordination, wellness and prevention services that are currently not traditionally reimbursed, such as the Health Homes opportunity for behavioral health CPs. We support the Waiver Request's emphasis on interdisciplinary care teams and care coordination, including engaging members in their care. ACOs should be required to document how they are pursuing a team-based approach to care. Complex and high-risk members

need and will benefit from care management the most, and attention to these populations will result in the best potential for costs savings and improved health outcomes. Among other professionals, CHWs should be engaged as key parts of care coordination teams.

3. Data Collection and Risk Stratification

Comprehensive data collection

Collecting data on key sociodemographic factors is a critical first step for effectively managing the health of an ACO's patient population, identifying and addressing risk factors that lead to poor health outcomes, and appropriately targeting interventions.

We support that under the HPC's ACO certification criteria, each ACO will be asked to report on how it screens for the needs and preferences of its patient population with regard to race, ethnicity, language, culture, literacy, gender identity, sexual orientation, income, housing status, food insecurity history, and other characteristics, and how it uses this information to inform its operations and care delivery to patients. We urge MassHealth to ensure that each ACO meets this requirement so that ACOs understand key barriers to health and how those barriers are distributed across its member population.

Having a comprehensive set of sociodemographic data for the ACO's patient population is also necessary to effectively conduct risk stratification, implement targeted population health programs, engage in ongoing collaborations and referrals with community-based organizations and providers, and partner with and invest in community health programs.

Risk stratification

To achieve more equitable health care outcomes, it is crucial that ACOs incorporate disparity reduction goals into overall quality improvement goals and adopt tools that support disparities measurement and interventions. Outcomes and other quality indicators should be stratified by social determinants of health indicators in order to appropriately target population health interventions, uncover and address health disparities, and improve how ACOs deliver care.

We recommend that ACOs also include social determinants of health in approaches for risk stratification of its member population, which could include factors such as homelessness or unstable housing, age, primary language, race and ethnicity, geography, gender identity and sexual orientation. We also think it's important to stratify data based on functional status, activities of daily living, instrumental activities of daily living, and health literacy. Once collected, this information should be made available publicly. Reporting this data will allow MassHealth and the public to assess how well ACOs are serving the entire spectrum of ACO members. As more risk stratification tools are developed and tested over time, ultimately ACOs should use a standardized methodology for risk stratification in order to be able to make meaningful comparisons across ACOs.

This data should be used to target programs at improving health outcomes for its patient population addressing social determinants of health, as called for in the HPC's ACO certification criteria, which MassHealth ACOs will also be required to meet. ACOs should describe how programs address the specific identified needs of social determinants of health for their population.

4. Risk Adjustment and Social Determinants of Health

It is crucial that ACOs employ effective risk adjustment methodologies to ensure that sufficient resources are available to serve the highest need members, as well as to eliminate incentives to limit needed care for these members.

Costs of care vary substantially among individuals with similar medical conditions but varying social and economic profiles. If these factors are not taken into account, ACOs will face increased risk from caring for more vulnerable or disadvantaged members. Payment adjustments must guard against ACO providers refusing to care for high-risk members or limiting care. We recommend that the ACO payment models incorporate some of the social determinants of health when risk adjusting for total cost of care.

In addition to adjusting payments based on socioeconomic status and other sociodemographic factors, MassHealth should also consider making similar appropriate adjustments to some ACO quality metrics used in payment. The decision made by the National Quality Forum (NQF) to endorse adjusting outcomes measures based on these factors reflects the concern that a provider should not be penalized as a poor performer because it serves more vulnerable patients. For example, a recent study found that Medicare readmission rates varied significantly based on the patient population. The researchers concluded that “Hospitals serving healthier, more socially advantaged patients may not have to devote any resources to achieving a penalty-free readmission rate, whereas hospitals serving sicker, more socially disadvantaged patients may have to devote considerable resources to avoid a penalty.”

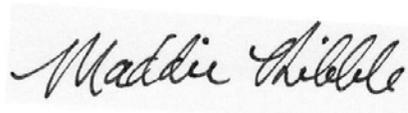
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We appreciate your leadership and attention to addressing population health, prevention, and the social determinants of health in the MassHealth redesign process. We stand ready to collaborate with MassHealth, consumers, and providers to achieve our common goals of healthier people, healthier communities, and health equity for all residents. If we can be of any further assistance, please contact Maddie Ribble at mribble@mapublicheath.org or 617-697-2107.

Sincerely,



Rebekah Gewirtz, Executive Director



Maddie Ribble, Director of Public Policy

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July 15, 2016

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Mr. Daniel Tsai, Assistant Secretary
Executive Office of Health and Human Services, Division of MassHealth
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Boston, MA 02108

Re: MassHealth Section 1115 Demonstration Extension Request

Dear Secretary Sudders and Assistant Secretary Tsai,

I am writing to you on behalf of the Massachusetts Society of Optometrists (MSO), which has a membership of over seven hundred licensed optometrists, representing the largest group of primary eye care providers in the Commonwealth. Optometrists currently render care in a variety of practice settings from standalone independent office clinics to community health centers and urban hospitals. As care delivery is shifting through the adoption of alternative payment methodologies (APMs) and implementation of new health care delivery models, such as Accountable Care Organizations (ACOs), the MSO respectfully urges the Executive Office of Health and Human Services to embrace and incorporate the high value services delivered through independent, cost effective, community-based providers, such as optometrists.

In review of the proposed EOHHS Section 1115 Demonstration Project Amendment and Extension Request, the MSO notes the proposed elimination of eye glass coverage in the PCC ACO Plan as referenced in the Executive Summary and Section 4, MassHealth Payment and Care Delivery Reform Strategy. The MSO supports this initiative to the extent that the proposed coverage elimination mirrors other MassHealth programs such as MassHealth Essential, ConnectorCare + Health Safety Net and Emergency Aid to the Elderly, Disabled, and Children.

The MSO strongly recommends that the Executive Office of Health and Human Services (EOHHS) not eliminate optometric services as occurred approximately 15 years ago. There are many eye care and vision services that may occur in connection with a patient seeking to obtain eyeglasses. The elimination of the coverage for the hardware, in and of itself, is an incentive for patients to seek alternative delivery, such as through an ACO. That said, for patients who remain on the PCC plan, comprehensive eye examinations, for example, that are critical to early diagnosis and treatment of eye disease should remain

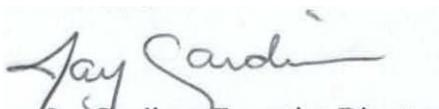
part of the coverage offerings available through MassHealth. The unfortunate elimination of all optometric services 15 years ago led to an unnecessary disruption of care for the neediest citizens of the Commonwealth.

The MSO also recommends that the EOHHS work to eliminate barriers to care and prevent unfair marketplace competition by recognizing and addressing the issues caused by contractual carve-outs of *certain* claims to third-party administrators (TPAs). ¹ As in the behavioral health realm, eye care services *provided by optometrists* are frequently carved out to a third party claims administrator that requires its own contract with different coverage rules and often grossly disproportionate reimbursement fee disparities. Oddly, when the *same* eye care services are provided by a *different* provider type under the same insurance policy, such services are not required to be carved out to a TPA and are reimbursed at a higher fee. As has been discussed in meetings with MassHealth and the HPC commission hearings, carving out services perpetuates health care siloes and creates barriers to integration and coordination as well as fee disparities that are directly at odds with the goals and principles upon which ACOs are founded. EOHHS should require its ACOs to eliminate contractual arrangements that perpetuate carve-outs for some providers and not others. In the alternative, if MassHealth permits ACOs to accept carve-out arrangements with a third party, *all* providers of the same services (as defined by CPT and ICD-10) should be subject to the carve-out to minimize an anti-competitive healthcare marketplace. The MSO respectfully requests that this policy be included in the 1115 Waiver application in order to provide a strong foundation upon which the new ACO health care delivery models will be established.

As primary eye care providers serving MassHealth patients throughout the Commonwealth, the MSO membership has a keen interest in providing a broad array of high quality services in the most efficient manner. The recommendations above aim to preserve state resources while also ensuring that the MassHealth program accurately reflects the current scope of optometric services covered by MassHealth.

Thank you for considering the aforementioned recommendations, which the MSO respectfully submits as part of its mission to partner with the Commonwealth in further enhancing transparent and value-driven health care delivery. Please feel free to contact me with any questions.

Sincerely,



Jay Gardiner, Executive Director

¹ Insurers are more and more frequently "carving out" specific services provided by one provider type and *not* carving out those same services when provided by a different provider type.

July 15, 2016

By email only: masshealth.innovations@state.ma.us

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: Comments on 1115 Medicaid Demonstration Extension Request

Dear Assistant Secretary Tsai:

On behalf of Medical-Legal Partnership | Boston (MLPB), we are grateful for this opportunity to reflect on the June 15, 2016 *draft* Section 1115 Demonstration Project Amendment and Extension Request (“the Request”). While we have (or will have) signed on to two sets of multi-organization comments (one submitted by Health Care for All, the other submitted by Action for Boston Community Development, Inc.), we submit these additional independent comments to (a) celebrate features of the Request that would generate momentum on prevention; and (b) encourage further emphasis on prevention goals and strategies throughout the Request. We believe the Request is a unique opportunity to advance both health equity and cost savings over time.

MLPB’s mission is to equip healthcare and human services teams with legal problem-solving strategies that promote health equity. We do this by integrating a “low dose” of legal advocates into healthcare teams featuring a “high dose” of allied health professionals (e.g., social workers, case managers, community health workers, etc.) who help patients address health-related social needs (e.g., housing insecurity, food insecurity, unlawful denials of disability benefits and services, etc.). We provide our services on a project-based, contract basis, meaning the bulk of our funding comes from healthcare and human services entities that understand and support our consumer-driven mission. Our view reflects almost 25 years of experience, including participation in multiple randomized controlled trials that *measure* – and in the case of the one such RCT whose findings have been published, *confirm* – how thoughtful, titrated integration of non-traditional workers into the healthcare team can resolve core challenges in healthcare quality and costs. (<http://www.mlpboston.org/news/298>) We have a seasoned, mission-centered “lens” on the opportunities and challenges that lie ahead in revising current healthcare delivery structures to meaningfully and accountably treat The Whole Patient. Against this backdrop, we have prioritized the following observations:

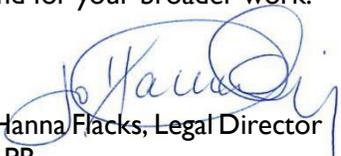
- **We are heartened by the Request’s careful planning to assure that the transition to value-based care accounts for extra costs borne by Disproportionate Share Hospitals.** The Request candidly acknowledges that payer reimbursements do not always cover providers’ full costs of delivering care, especially for particularly complex or vulnerable populations. The vision for a “sustainable safety net” reflects a form of “macro” risk stratification and systemic adjustment that will assure adequate resources to address the health needs of some of the state’s most medically-involved consumers. We are interested in learning more about the design of a “glide path” that is truly sustainable and equitable and does not leave those providers with a higher proportion of Medicaid members with insufficient resources to provide quality care. Member mixes may evolve over the 5-year period and it is essential that any glide path be flexible enough to adjust equitably to demographic shifts across ACOs.
- **We strongly support the proposed investment in Healthcare Workforce Development & Training.** The Request envisions a workforce equipped to meet the increasing need for social work, behavioral health, and primary care services. Community health centers are the heartbeat of such efforts and the Request wisely takes aim at current barriers to pursuing careers in these disciplines and at these institutions.

The student loan repayment, primary care integration models and retention strategy, and CHC program expansion components are each laudable for many reasons we need not detail here. Instead, we wish to punctuate the wisdom of the Workforce Development component given new (positive) pressures on providers to “treat” members’ SDH. With the right support for the changing healthcare workforce, we may see sickle cell episodes averted because a social worker can see that an oil tank is filled, while a Fuel Assistance application is pending. A social worker can pay rent for a patient confronting eviction while a public benefits appeal is pending. A lawyer can consult to assure the appeal is supported by a strong showing of relevant evidence. A pregnant woman who is spared homelessness because of this integrated care has an increased chance of full-term delivery and decreased risk of post-partum depression – advances toward health equity that correlate highly with better health outcomes and lower healthcare costs for mother and baby. This is the promise of health care reform and we applaud the features of the Request – *especially investment in workforce development given the skill-building and professional culture change required* – that build in this direction.

- **We applaud the clarification that DSRIP funds can flow to appropriate social services providers either through the ACO (or ACO/MCO) or via Certified Community Partners.** The Graphical Overview at p. 33 was extremely responsive and helpful.
- **We applaud the member-centered revisions to the flex spending criteria.** We appreciate, at p. 32, the bifurcation of what was once a single criterion that characterized eligible services as those that: “[a]re . . . likely to generate savings [and] [a]re to improve health outcomes or prevent or delay health deterioration.” The new text, which distinguishes a causation standard for cost savings from the relevant standard for advancement of health outcome improvements and prevention/delay of health deterioration, is an important step in the right direction.
- **We reinforce our recommendation of a feasibility standard for public funding “availability.”** At the same time, we note that the flex spending criterion that requires that “funding is not available from other publicly-funded programs” remains unchanged. Referring back to our written comments dated May 2, 2016, we are all too aware that members’ immediate health and safety needs often are not addressed by *technically* “available” resources. While a member may be legally entitled to have their publicly funded landlord install an air conditioner as a reasonable modification acknowledging a health vulnerability, the process of requesting said modification through the housing authority administrative process (and, potentially, housing court appeal process) sometimes means that an air conditioner is “available” only several inhalers, missed school and work days, and even hospitalizations down the line. It is critical that flexible funds be available flexibly to meet member’s real-life needs, and a feasibility standard would support this approach.
- **We continue to encourage a bias for a member-centered, life-long view regarding authorization of DSRIP investments.** Behind every member in the 5% that accounts for 50% of costs, there are thousands of members in the quintiles below them who soon will repopulate that highest-cost, highest-risk 5% if a value-based health care (rather than sick care) system does not invest in preventing that trajectory. If flexible funds to address SDH are only deployed to address the needs of the 5%, the system will effectively tread water vis-à-vis cost and quality. We encourage that the Request be as explicit as possible about the value of upstream investments to address members’ SDH. Where these investments may prevent the onset of disease over time, not to mention disease progression, then we will make true progress toward health promotion, health equity, and healthcare cost containment. Indeed, we can take a page from HIV/AIDS prevention experts who have promoted stable housing as a prescription not only for prevention of opportunistic infections among those who have developed AIDS symptoms, but also for prevention of HIV transmission.¹ The integration of this wisdom into health care reform can yield cost savings and health equity gains across populations.

Thank you very much for your consideration of these comments, and for your broader work.


Samantha J. Morton, Executive Director
MLPB


JoHanna Flacks, Legal Director
MLPB

MLPB is a fiscally-sponsored program of Third Sector New England, Inc.

¹ <http://nationalaidshousing.org/PDF/FactSheet.pdf> and <http://www.doorwayshousing.org/about-housing-hiv/housing-and-hiv/>



PHILLIP KASSEL
EXECUTIVE DIRECTOR

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July 14, 2016

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: 1115 Demonstration Extension

Request Dear Sir/Ms.:

Mental Health Legal Advisors Committee (MHLAC), an agency under the Massachusetts Supreme Court that represents low-income persons with psychiatric challenges, applauds many elements of the Waiver Request proposed by the Office of Medicaid. However, if integration of behavioral and physical health care and payment reform are to produce the outcomes desired by all stakeholders, the request must be modified to:

- Eliminate the 12-month lock-in of members (see attached comments of April 21, 2016);
- Provide for continuity of care and access to timely and appropriate services through out-of-network single-case agreements;
- Mandate ACO adoption of One Care privacy principles and best practices;

- Cover out-of-network, independent second-opinions for the purposes of appealing a denial of services by an ACO or its provider at no additional cost to the member;¹
- Eliminate financial and service penalization of FFS members;
- Close monitoring of under-utilization and outcomes for each ACO through standardized data reporting of service utilization and outcomes, which data is available to the public, and
- Meaningful participation of members and their advocates² in the development of outcome measurements,³ ACO governance, and MassHealth oversight.

MHLAC strongly supports:

- The funding and use of flexible services and expenditures to address social determinants of health;
- The recognition that person-centered, Recovery Models of care that provide culturally and linguistically competent services⁴ are fundamental to positive outcomes;
- Inclusion of housing supports in ACO services⁵;
- Representation of community health workers on teams as equal colleagues;⁶

¹Financial incentives in the waiver may encourage providers to reduce costs by denying services that are medically necessary but do not increase costs to the ACO in the short-term. Therefore, the definition of an appealable action must include the refusal of an ACO provider to refer a member to a provider or order services or equipment for a member.

²Token representation is not meaningful; representation of members and their advocates must be substantial in terms of number and ability to represent member perspectives.

³ Patient Reported Outcome Measurements are valuable measurements of the success of any pilot. Please see pages 4-6 of MHLAC's April 30, 2016 comments, attached, for suggestions on quality criteria.

⁴ Person-centered care can only be actualized if members are given choice of services and providers. The sparseness of linguistically and culturally competent mental health providers reinforces the need for single-case out-of-network agreements.

⁵ The Veteran's administration study of its Housing First implementation found that with the initiative, emergency room visits decreased 27%, total inpatient costs decreased 54.3%, and overall healthcare costs decreased 32%. Montgomery, et al., U.S. Dep't of Veterans Affairs, Housing First Implementation Brief (April 2014). See also, Guerin, City of Albuquerque Housing First Cost Study Final Report (Institute for Social Research 2011)(outlining cost savings of Housing First in various locations, including Massachusetts).

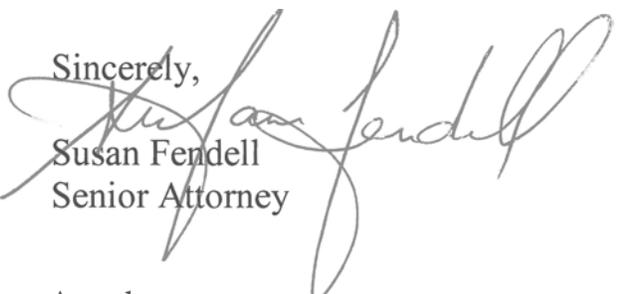
⁶ Of course, members should have ultimate control over who of their providers are included in their health care team.

- Perpetuation of the goal of keeping care in the community rather than institutional settings;
- Investment in community-based LTSS⁷;
- The expansion of substance abuse services.

Additional detail on some of the items above and further suggested modifications are included in prior MHLAC comments that are attached to these comments and in two other sets of comments on the waiver request that MHLAC has co-signed.

Integration of behavioral health and physical health services does not in and of itself reliably reduce costs or improve outcomes.⁸ The same is true for pay-for-performance and value-based purchasing. However, with modifications to ensure innovative service funding, protection of member choice, and careful monitoring of ACOs to both protect against under-utilization and promote best practices, the Section 1115 Demonstration Project Amendment and Extension Request has the potential to improve quality of care and be financially viable.

Sincerely,


Susan Fendell
Senior Attorney

Attachments

⁷ We are concerned that peer services are not going to receive sufficient investment and utilization given the certification requirements for Behavioral Health Community Partners. Whether as Community Partners or in other capacities, it should be clear that peer services must be available to ACO members. In addition, DSRIP funds should be available to invest in peer respites, which are cost effective alternatives to hospitalization, but of which only one exists in the Commonwealth.

⁸ See, e.g., Reilly, et al., *Collaborative care approaches for people with severe mental illness*, Issue 1 (Cochrane Database of Systematic Reviews 2013) (While improvement in the mental health component of quality of life improved, collaborative care showed no statistically significant improvement in the physical component of quality of life or a statistically significant difference in the cost of care compared to standard care.)



PHILLIP KASSEL
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Comments of Mental Health Legal Advisors Committee on Exceptions to Closed Enrollment Period (Lock-In)

April 21, 2016

Mental Health Legal Advisors Committee supports the ability of MassHealth MCO members to enroll or dis-enroll from an MCO at any time. We believe that prohibiting changes in enrollment undermines quality care by limiting member choice and reducing MCO incentives to provide person-centered care. Members will not dis-enroll from an MCO if quality of care is high and access to desired services is provided.

If MassHealth makes the decision to limit disenrollment to a 90-day period, we encourage MassHealth to add or modify the following exceptions:

Enrollee is in continuing care with a provider who is no longer contracting with the MCO for reasons other than malpractice or fraud. Continuing care is established if the enrollee has been seen by this provider in the past three months;

This exception is particularly important for members with psychiatric challenges. The therapeutic alliance is the single most accurate indicator of successful

outcomes. Unnecessarily breaching this alliance diminishes quality of care and decreases the likelihood of recovery.

Enrollee demonstrates that the MCO has not provided the enrollee with access to a health care provider that meets the enrollee's health care, geographic, and temporal needs in a timely manner, even after the enrollee has asked the MCO for help;

The enrollee should not have to prove that he or she has been denied access to care for more than one condition or to more than one provider who meets his or her needs. The denial of access to just one needed provider is sufficient to warrant disenrollment. Furthermore, the needs of an enrollee include the ability to meet with a provider who has hours that are appropriate for the enrollee, ¹ in a place that is viable for the enrollee, and who can see the enrollee without undue delay. From MHLAC experience with MassHealth MCO enrollees, waiting periods for culturally and linguistically competent mental health care providers are excessive.

Enrollee adequately demonstrates to MassHealth that the MCO violated a provision of its contract in relation to the enrollee;

It is unclear what is meant by "substantially" in this context. If it means that the MCO *effectively* violated a material provision of its contract even though it did not violate the contract if the contract is read strictly, then that should be clarified.

However, any violation of the contract in relation to the enrollee should warrant the ability of the enrollee to dis-enroll. The interpretation of "material" is subject to variation. It should be clear that a violation of the contract sufficient to motivate an enrollee to dis-enroll from an MCO is de facto material.

The enrollee has successfully appealed to MassHealth for coverage of a service that the plan denied or modified;

An enrollee should not be required to maintain her or his relationship with an MCO with which she has had to fight for a service that MassHealth has affirmed as necessary.

The enrollee needs related services (for example a caesarean section and a tubal ligation) to be performed at the same time; not all related services are

¹Certain medications and conditions make morning appointments inappropriate. Evening hours may be necessary for members who experience their greatest difficulties after sunset.

available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would be less effective, subject the enrollee to unnecessary risk or subject the enrollee to prolonged treatment or additional discomfort;

Unnecessary risk is an obvious reason for disenrollment. Provision of less effective care or requiring an enrollee to undergo lengthier treatment or additional discomfort to receive in-network care are just as valid reasons for disenrollment.

Enrollee demonstrates that their language, communication, or other accessibility needs are not met by one or more relevant providers within the MCO;

The exception should clarify that accessibility within the network of just one relevant provider is sufficient. An enrollee should not have to be denied a variety of services or access to more than one needed provider to dis-enroll.

Enrollee is unable to access desired treatment providers due to a change in MCO network, unless the MCO contracts with the desired treatment provider for the enrollee's care.

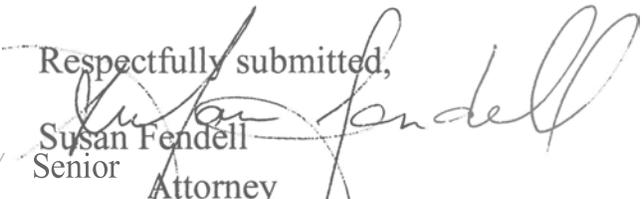
Enrollee decisions on what MCO to choose are based on information at the time of enrollment, including the network composition. If that network composition changes, enrollees also should be able to change their enrollment decisions.²

Attached please find an MHLAC white paper on the importance of choice of providers and services to positive outcomes. We understand the interest of MCOs in the stability of its enrollees. However, providing high quality person-centered care, access to services, and adequate networks of providers, which can be supplemented by single-case agreements when necessary, will ensure stability of enrollees because such MCOs will retain satisfied members.

²It is highly unlikely that enrollees will change plans unless a particularly desired provider who is relevant to their care leaves the MCO network and the enrollee is sufficiently dissatisfied with the rest of their care.

We look forward to working with you to improve health care delivery to MassHealth recipients.

Respectfully submitted,


Susan Fendell

Senior Attorney

Mental Health Law Advisors Committee

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MHLAC Comments on

MassHealth Delivery System Restructuring

April 30, 2016

Thank you for the opportunity to comment on MassHealth's proposal to restructure its delivery system. There are many elements of the restructuring plan that are positive:

1. DSRIP funding for services not traditionally reimbursed as medical care to address health-related social needs;
2. A portion of DSRIP funding designated for "flexible services" to address social determinants;
3. Funding for BH and LTSS community organizations;
4. An explicit requirement that ACOs partner with **BH** and LTSS Community Partners;
5. Building of linkages with social services;¹

¹ Social service linkages and case management should not be limited to referrals. The same is true for Community Partner "navigational assistance for accessing social services." (37) Members with physical

alternative services (i.e., not traditionally included in the medical model of care);

10. Under ACO Model B, shared savings/losses paid out proportionally to ACO quality scores (25);

11. Financial incentives based on quality (which should be measured by member experience and outcomes).⁴

Suggestions to improve elements of the restructuring plan

Member privacy

Integration of physical and behavioral health care, while a laudable goal in theory, will only be a positive move if done with the recognition of the potential for negative impact on care delivery to persons with psychiatric challenges.

MassHealth is aware of the research verifying that stigma against persons with psychiatric diagnoses exists within the health care profession and jeopardizes the quality of physical health care. Members should therefore have the right to choose between risks of receiving inferior care, for different reasons, due to sharing or withholding psychiatric information from health care providers. For this reason, ACO contracts should include adherence to the Privacy Principles and Best Practices formulated by MassHealth, OneCare members, advocates, and the OneCare plans. Adherence to these principles and best practices also should constitute part of the quality measures used to allocate DSRIP funds and shared savings.

Member protections

We are glad that MassHealth recognizes that a delivery system in which providers are incentivized to cut costs requires an increase in member protections (16). An ombudsman office is helpful to members if members can receive help waging appeals and grievances. Because providers are subject to pressure or have a direct financial interest in cutting costs, denials and limitation of services and referrals by an ACO provider must constitute an appealable action. Members must have access

⁴ Quality measures are explored more fully *infra*.

to free and independent second opinions to support their appeals of service/referral denials or limitations to MassHealth.

Quality metrics

We agree with MassHealth that member experience is a vital indicator of quality of care.⁵ (24) CARPS, however, does not address key elements of that experience. While it tangentially addresses the stigma experienced by persons with psychiatric challenges in health care settings, it does not elicit information about whether the member has a psychiatric diagnosis or history that would allow for correlation of survey responses to questions about "respect" and whether the provider "listens."⁶ A question that goes to a provider's cultural competency in treating persons with behavioral health challenges might be "Provider views me as more than a 'case' or a diagnosis, and treats me as a whole person with a body, mind, and emotions." This question points to whether the provider unduly emphasizes a member's psychiatric diagnosis to the detriment of his or her physical health care or ignores the emotional and mental experience of members in treating physical illnesses.

The survey also should be supplemented to address access issues, such as:

- the ability to get medical advice/care after normal business hours (not just being told where to get care after normal business hours⁷),

⁵ MHLAC is delighted that patient experience is part of the quality domain. Indeed, patient experience, including experience of recovery and wellness, should be the most heavily weighted quality indicator. It is one of the major reasons we oppose annual enrollment lock-ins. Please see attached comments previously submitted to MassHealth on the lock-in issue.

⁶ Persons with psychiatric histories frequently report that providers do not respect or listen to them, to the detriment of their physical health care. Given the early death rate of persons with psychiatric challenges due to avoidable causes, the correlation of these metrics to psychiatric diagnosis should be monitored and used to inform quality improvement initiatives.

⁷ As previously stated, many members may not be able to effectively access care on their own, and this is particularly true if the member is seeking service after normal business hours and is in the midst of a crisis. Referrals to other providers require the member to make an additional phone call to a stranger and/or potentially finding one's way to a location with which the member is not acquainted. People utilize emergency departments, in part, because they are familiar, open at all hours, and their locations are known. To avoid this pattern of ED use, after hours care should be available at the member's usual care location or the ACO should arrange the appointment and investigate whether the member needs transportation assistance, providing it to the member when necessary. In some instances, individuals also need peer or other support to accompany them to care.

- whether care is provided in a manner that accommodates his or her disabilities or challenges (e.g., "The provider offers individualized services to meet my unique needs."⁸);
- whether the member was given or referred to the services s/he desired;
- whether the provider helped arrange appointments to which the member was referred and whether the provider helped the member get those appointments in a timely manner.

Member experience of *outcome*/ is perhaps the most important indicator of quality of care.¹⁰ A serious omission of the CARPS survey (24), and one that goes to outcomes, is whether the person thought the doctor's recommendations were helpful and assisted in achieving wellness. Any primary care provider survey should include components of the Recovery Enhancing Environment Measure (REE), also known as the Developing Recovery Enhancing Environment Measure (DREEM) (attached), in order to capture member experience and progress toward wellness (i.e. outcomes) with respect to behavioral health issues in the primary care setting. Individuals often receive mental health care from primary care clinicians. Some basic measures that can be used to monitor over time outcomes of mental health care by primary care providers¹¹ are:

- I have at least one close mutual (give-and-take) relationship.
- I am involved in meaningful productive activities.

⁸ This question relates to not just disability accommodations, but whether the provider delivers services that address the life circumstances, preferences and goals of the member. The question goes beyond whether the provider listens to the member; it is about whether the provider takes action on what he or she hears from the member. Cambridge Health Alliance, which recognizes that a "mismatch between treatment and patient preferences worsens health outcomes via lower patient engagement, poorer adherence, and higher attrition," is embarking on a project to effectively elicit patient preferences . See, <http://www.pcori.org/research-results/2016/improving-methods-incorporating-racial-ethnic-minority-patients-treatment> (last accessed 4/29/16).

⁹ The questions in the CAHPs tend to look at the manner in which care was provided.

¹⁰ Research into patient experience of outcomes, including symptom control, is becoming recognized as a key indicator of quality of care. See, e.g., <http://www.pcori.org/research-results/2016/development-and-evaluation-patient-centered-approach-assess-quality-care> (last accessed 4/29/16).

¹¹ "Every member in an ACO will have a PCP with accountability for their total care."(22) A deterioration in the mental status of a member is a reflection on the PCP's performance in that role.¹² We are disturbed that benefits under the fee-for-service plan will be reduced prior to a comparison of patient-reported outcomes under fee-for-service and ACO models.

- My psychiatric symptoms are under control.
- I have enough income to meet my needs.
- I'm not working, but see myself working within 6 months.
- I like and respect myself.
- I have goals I'm working to achieve.
- I control the important decisions in my life.
- I contribute to my community.
- I have a sense of belonging.
- I feel alert and alive.
- I feel hopeful about my future.
- I believe I can make positive changes in my life.

The full set of DREEM recovery measures should be used to ascertain member experience and outcomes in mental health care settings.

CAHPS supplements include health information technology questions (e.g., HIT 18). Because privacy principles and best practices are indicative of quality of care, some basic survey questions should address ACO compliance with them. These include:

- Did you request your medical records?
- Did provider give you the records that you requested?
- Did provider respect your choices about with whom to share your behavioral health information?

Whatever outcome measurements are used, members should have a substantial role in their development.

Areas of concern

Under-service

Implicit in the restructuring plan is the presumption that ACOs will both improve outcomes and reduce costs.¹² Capitated rates, shared savings, and even

¹² We are disturbed that benefits under the fee-for-service plan will be reduced prior to a comparison of patient-reported outcomes under fee-for-service and ACO models.

performance bonuses (depending on the metrics used ¹³) risk the denial of needed services to obtain cost reductions. Therefore, MassHealth must closely monitor:

- Claims data and complaints, as well as member grievances and appeals to unearth signs of under-service.
- Claims and/or data on the use of capitated payments and DSRIP funds, all of which should be presented to MassHealth in a uniform fashion by ACOs and Community Partners of all types.¹⁴
- Quality measurements must not be process measurements (e.g., member appointment with PCP within X days of hospital discharge ¹⁵) or data that lends itself to manipulation by denial of referral to or authorization of necessary services (e.g., all-cause readmissions vs. preventable

¹³ Studies have shown that paying bonuses for performing processes can lead to the neglect of care that is not incentivized. Campbell et al., *Effects of Payfor Performance on the Quality of Primary Care in England*, 361 *New Eng. J. Med.* 368 (2009).

¹⁴ Massachusetts Behavioral Health Partnership (MBHP), for example, reports claims data to MassHealth for each individual service (not aggregated by categories such as "inpatient" and "outpatient") broken down by units utilized, cost, number of unduplicated recipients using the service, age of recipients, and total enrolled members. Other categories may be substituted or added for the ACOs and Community Partners. It is particularly important to track the use of flexible services and Community Partners, as each of these may be the keys to improving outcomes and the course of health care costs. Uniformity of claims and data presentation is essential for comparability of models of care and the ACOs themselves.

¹⁵ For example, "follow-up after hospitalization for mental illness." (53) This measure does not address the quality of the follow-up or its usefulness to the individual. Furthermore, hospitalization follow-up is already established as a basic standard of care and was an MBHP bonus criterion over a decade ago. Likewise, the performance of weight assessment (including adult BMI) and counseling for nutrition and physical activity for children/adolescents is also of questionable value as a quality measure, regardless of its obvious connection with wellness. Like follow-up after hospitalization, weight assessment and counseling are low bars to set for the receipt of shared savings. ACO initiatives to facilitate the provision of healthy and attractive school lunches in low-income schools, to organize or pay for opportunities to participate in physical activities, and to remove common barriers to exercise are more likely to produce better outcomes and are more worthy of warranting the award of shared savings than just performing what should be a basic part of care. (In any case, very few people eat better or exercise more merely because they are aware doing so improves their health. People tend to engage in healthy activities the easier it is to do. See, e.g., J. Sallis, et al., *Physical activity in relation to urban environments in 14 cities worldwide: a cross-sectional study*, *The Lancet* (April 1, 2016) <http://www.thelancet.com/pdfs/journals/lancet/PIISO140-6736%2815%2901284-2.pdf> (last accessed 4/29/16)(Study participants living in the most activity-friendly neighborhoods exercised from 68 to 89 minutes a week more than in the least activity-friendly neighborhoods, which represents 45-59% of the of the weekly recommended by guidelines for physical activity.); A. Eyler, *Environmental, Policy, and Cultural Factors Related to Physical Activity* at 88 (2002)(convenience promoted exercise; family priorities and financial considerations were barriers).)

readmissions ¹⁶ (53), but must be outcome measurements that include self-reported, recovery-based measurements. ¹⁷

- Cost reduction must be balanced by risk adjustment for the population and improvements in outcomes/quality. Cost reductions (9) may begin later than scheduled as some quality improvements require initial investment/contracting, working out the bugs in implementation, and time for wellness and recovery initiatives (e.g., diet/exercise, development of social relationships) to show results. Further, DSRIP funding doesn't start until FYI 8, and Community Partners are not launched until FY18.
- Under Model B payment provisions, ACOs will only receive shared savings if they manage costs to below the savings target. (25) Some portion of shared savings should be awarded to an ACO even if its costs are not kept below the savings target if its outcomes and quality metrics are good. Quality and outcome improvements merit reward and may lay the basis for best practices that return long-term savings.¹⁸

Community Partners and ACOs

Community Partners that are part of an ACO (32) be considered immune from interest conflicts. Self-referral is not the only conflict of interest. Internal financial incentives and administrative pressures, even if DSRIP streams are separate, may alter the independence of the Community Partner and its willingness to recommend necessary services that cut into ACO earnings.

¹⁶We suggest the removal of all-cause readmissions as a quality measure upon which shared savings are dependent. MassHealth should carefully define what is or is not preventable and should include readmissions caused by social determinants of health that the ACO had the ability to address but did not.

¹⁷See generally, Chiu et al., *Operationalization of the SAMHSA Model of Recovery: A Quality of Life Perspective*, 19 Qual. Life Res. 1 (Feb. 2010).

¹⁸Commercial insurance commonly seeks short-term returns to present its stockholders at its annual meeting. Commercial insurance has not been terrifically successful in holding down health care costs. MassHealth should have the foresight to focus on outcomes, which will provide savings over time.

Certification of Community Partners

Infrastructure and capacity should not per se disqualify (31) Community Partners from certification. Part of the purpose of DSRIP funds is to expand Community Partner infrastructure and capacity, and DSRIP doesn't start until after certification. (41)

Limited networks

- MassHealth network adequacy rules should include geographic, temporal ¹⁹, disability specific expertise, disability accommodations for all disabilities including psychiatric disabilities, and be part of Model A and C contracts.
- MCO/ACO networks should allow for continuity of care (single-case, out-of-network agreements).
- MassHealth should monitor the ability of individuals to obtain out-of-MCO/ACO referrals, the denial of which referral should be an appealable action.
- Attribution of members based on their choice of PCP is not appropriate for all members as some members' most important provider might be someone other than their PCP. This is particularly true for mental health care. The therapeutic alliance is the single most accurate predictor of successful outcomes. If the attribution of members is made on the basis of PCP, ACOs must enter into single-case agreements to maintain (or if the network is inadequate, to begin) treatment with a trusted provider.
- Preferred networks, if they do not limit member choice or result in care from a non-preferred provider being more expensive to the member or being delayed, are fine as indications of PCP preference. Limited networks aren't needed to coordinate care -coordination is a matter of communication, not contract or co-location.²⁰ In fact, limited networks are a barrier to necessary

¹⁹Temporal accessibility means that care is available when members need it. It includes the ability to obtain appointments in a timely manner and without long waits at a time appropriate to the member (e.g., after-hours care for uncomfortable conditions or if the member is reliant on relatives who work during business hours for transportation/support, and afternoon appointments if their disability or medication makes morning appointments difficult).

²⁰ Co-location requirements actually impede care. Several MHLAC clients have had trouble finding a psychiatrist because the clinics insist they switch therapists, with whom they had good relations, to therapists in the clinics if they wanted to see the clinics' psychiatrists.

care. For example, the American College of Emergency Physician found that limited networks contribute to emergency room boarding of persons with psychiatric crises and recommends the elimination of out-of-network insurance issues.²¹

Annual enrollment for MCO program (11)

MHLAC opposes enrollment lock-in. (See attached comments.) Members should not be locked in for a year when providers are not locked-in for the year and MCO internal policies, protocols and services may change. Further, the health needs of a member may change, affecting the desirability of the MCO for that member.

Proposals

MassHealth should structure the delivery system so that it relies more heavily on alternatives, LTSS, peer services, and meeting the social needs of persons with behavioral health challenges, by:

- Expanding the definition of social service providers;
- Educating providers with respect to the recovery model of mental health care and about alternative models of behavioral health care;
- Initiating a pilot program for a control group of non-ACO fee-for-service providers that allows reimbursement for flexible services and care coordination with community-based organizations/peer services. This will allow at least a rough look at whether it is the services offered or the payment mechanism that alters quality of care;
- Funding much-needed alternative service capacity. DSRIP money should go directly to invest in services that are in short supply and to develop the peer workforce -for example, peer-based respites of which there is only one in the Commonwealth²² -and to provide

²¹ American College of Emergency Physicians, Psychiatric Emergencies, <http://newsroom.acep.org/fact-sheets?item=30093> (last accessed 4/29/16). Limited networks directly work against MassHealth efforts to reduce the number of behavioral health members experiencing long stays in EDs.(39)

²² MassHealth notes that some of the DSRIP funding will be used for state priorities, including Emergency Department (ED) boarding. (27) While insurance blind placement of persons needing

funding for social needs and alternatives. The majority of DSRIP money should not be directed to ACOs (7, 38). While some ACOs may need financial assistance for infrastructure and startup,²³ DSRIP funding for infrastructure primarily should be directed to developing the capacity of alternative providers and community-based organizations to deliver services. The predilection of MCOs and most existing ACOs is to default to the medical model of care, resulting in ineffective and expensive care and a lack of investment in alternative means for improving wellness and achieving recovery. DSRIP should support the public interest in a change in what services are delivered, not just a change in the way in which existing modes of care are delivered;

- While we support ACO flexibility in funding social service needs, we do not support unlimited ACO discretion²⁴ in determining the composition of the care teams (32). If a member desires a particular provider, including a Community Health Worker/peer support on his or her care team, that person should be included. Likewise, if a member requests the exclusion of a provider from the care team, that request also should be honored;
- Transportation (8) should be part of the program from the start.

Privacy pilot

One intended use of DSRIP is for HIT investments. (29) MassHealth has heard from members and is aware of studies describing how the sharing of psychiatric information has resulted in unnecessary delays in treatment and unnecessary and

inpatient psychiatric care would greatly help, see [http://www.jointcommission.org/assets/1/23/Quick Safety Issue 19 Dec 20151.PDF](http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_19_Dec_20151.PDF) (last accessed 4/29/30) (noting estimated boarding times for Medicaid patients and the uninsured were longer than the average ED waiting time of six hours or more), peer respites also would be of huge benefit in reducing expensive ED use and in accommodating the preference of many persons in crisis to use peer respites rather than hospitals.

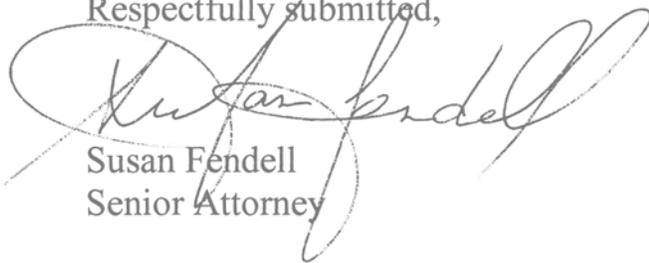
²³ We agree eligibility for that funding should be contingent on meeting MassHealth requirements on formalizing relationships with Community Partners.

²⁴ We wholeheartedly support the inclusion of the LTSS CP on the care team (48) if the member does not ask for the exclusion of the LTSS CP.

costly visits to both behavioral health providers and specialists. Given that one of the goals of DSRIP is a reduction in avoidable utilization and an increase in quality of care (28), it is therefore appropriate that a modest investment be made to pilot an electronic medical records system that does not disrupt work flow, respects member choice, and ultimately improves care and reduces costs to MassHealth. MassHealth should provide assistance to provider-led ACOs and small group providers associated with these ACOs to pilot software or other tools to facilitate technical implementation of member choice of sharing options.

MHLAC appreciates the time and effort that MassHealth has invested in the restructuring of the delivery system. Our comments and proposals are directed to making that restructuring a success for members, for MassHealth, and for all participants in the process. We look forward to working with you to promote wellness and recovery.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Susan Fendell", written over a large, light-colored circular scribble or watermark.

Susan Fendell
Senior Attorney

Attachments



NEW ENGLAND COLLEGE OF OPTOMETRY

Clifford Scott, OD, MPH

President

July 15, 2016

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Mr. Daniel Tsai, Assistant Secretary
Executive Office of Health and Human Services, Division of MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: MassHealth Section 1115 Demonstration Extension Request

Dear Secretary Sudders and Assistant Secretary Tsai,

On behalf of the New England College of Optometry ("NECO"), I am writing to submit comments relative to MassHealth's Proposed 1115 Waiver Demonstration Extension proposal. As you may know, NECO has been educating optometrists in Massachusetts for over a century and is acutely aware of the importance of vision screenings, comprehensive eye exams and corrective treatment in children, patients with behavioral health concerns and intellectual or physical disabilities. Optometrists can and will play a key role in ACOs by working to contain costs through the provision of high-value health services as part of a care coordination team. That said, and as MassHealth's Extension proposal recognizes through the establishment of a Student Loan Repayment Program, there are challenges in recruiting and retaining primary care providers to practice in underserved areas. This issue is also prevalent for primary eye care providers. As such, NECO respectfully recommends that the Student Loan Repayment Program be expanded to include eligible full-time optometrists employed at community health centers.

A recent analysis by the George Washington University School of Public Health and Health Services, entitled "Assessing the Need for On-Site Eye Care Professionals in Community Health Centers", found that while eye and vision problems are often associated with age; low income and racial and ethnic minorities also have elevated risk of eye problems. Federally-funded community health centers, which are mandated to provide comprehensive primary care in underserved communities, are often the only option to improve vision health for low-income residents. However, as the study also found, *seven out of ten* health centers do not staff on-site eye care professionals to provide comprehensive eye exams.

In the Commonwealth, there are approximately 1,000 practicing optometrists. Among optometrists alone, there is a national ratio of one optometrist to 7,820 individuals; in Massachusetts' rural areas this figure can exceed a ratio of one optometrist to 12,000 individuals and in some communities in Southern Worcester and Hampshire County, there are no optometrists. As recognized by the American Optometric Association, the American Academy of Ophthalmology and the American Public Health Association, rural and inner city communities have a tremendous need for trained eye care professionals. Chronic systemic conditions such as hypertension and diabetes among older adults have been linked to eye diseases like glaucoma and diabetic retinopathy. Macular degeneration and injuries to the eyes are also common in rural and inner city communities. Finally, childhood learning has been found to be directly and significantly impacted by eye and vision problems. Despite our knowledge about the advantages of treating eye and vision problems early, access to eye and vision care providers in these communities remains lacking.

The proposed Student Loan Repayment Program includes a range of primary care providers, including, but not limited to: physicians, advanced practice nurses, nurse midwives and physician assistants as well as a variety of behavioral health providers. NECO respectfully urges MassHealth and the Executive Office of Health and Human Services to extend this Student Loan Repayment Program to include full-time optometrists employed at community health centers, in exchange for a two-year commitment. Similar programs have proven to be effective at establishing providers in underserved areas even long after their commitment expires. Given that the goal is to ensure that a long-term plan is in place to drive access to care to all for *all* primary health services throughout the Commonwealth; optometrists can play a key role in this initiative.

In order to prevent greater future health costs, we must provide those living in underserved and rural areas with access to eye care today. Many eye and vision problems can be successfully treated if addressed early on; a lack of access to an eye care provider should not be the place at which our health care system breaks down. Trained eye care professionals living and working in rural and inner city communities are an important part of the health care team needed to keep residents of the Commonwealth healthy. We must remove the barriers to entry and create incentives for eye care providers to work in communities of need to ensure that the eye and vision care of all our residents is being met.

On behalf of the faculty, students and staff of the New England College of Optometry, I respectfully request that you expand the Student Loan Repayment Program proposed in MassHealth's Proposed 1115 Waiver Demonstration Extension to include optometrists. This program could go a long way to making sure that residents of the Commonwealth are able to access an eye care provider -regardless of the community they live in. Thank you for considering this recommendation. Please contact me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Clifford Scott', written over a white background.

Clifford Scott, OD, MPH
President



July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Comments on MassHealth 1115 Demonstration Project

Dear Assistant Secretary Tsai,

I'm writing on behalf of the On Solid Ground Coalition, a cross-sector group of more than 30 organizations committed to a research-based approach to increasing housing stability and economic mobility. We believe the best way to do that is to bring housing, workforce development, education and health and wellness policies together to build a proactive comprehensive system to support housing and income stability. In that vein we are pleased with the innovative steps this waiver takes to support a comprehensive understanding of the social determinants of health.

Of particular interest to the Coalition is section 5.3.2.3 (on page 42). We strongly approve of the dedication of funds to costs not normally reimbursable by MassHealth, but which address health-related service needs. We think spending by ACOs on issues like housing stabilization, domestic violence supports, and utility assistance, will go a long way to reducing negative health outcomes. We encourage you to continue with this focus on social needs, and the funding necessary to make it happen. We ask for further clarity on how Community Partners (CP) will be selected and an explicit additional focus on families. Further, AS ACOs allocate those funds, we strongly encourage them to work with community partners in the housing support, childcare, and antipoverty fields to distribute those funds through those existing CP pipelines rather than reinvent the wheel. This will allow those funds to support a growing infrastructure of supports rather than have to waste some on duplicative overhead.

Additionally we support the efforts on page 76 to include improvement in National Outcomes Measures, such as increased housing and increases in education and employment, in MassHealth's global measures of success. The evidence is clear that housing and economic instability being adverse health effects to people, so we're excited that MassHealth sees progress towards housing and economic stability as what it is: progress to good health. We ask that the waiver explicitly arrange for working with community partners to develop further shared measures dealing with social determinants of health.

Again, we appreciate the general thrust of MassHealth's efforts and especially endorse the role of housing stabilization and supports in your plan for better community health.

Andre Green
Senior Project Manager
On Solid Ground Coalition

COALITION MEMBERS:

Action for Boston Community Development	Father Bill's & Mainspring	Metropolitan Boston Housing Partnership
Advocacy Network to End Family Homelessness (ANEFH)	Friends of Families in Transition	One Family, Inc.
Bessie Tartt Wilson Initiative for Children	HAPHousing	Project Bread
B'nai B'rith Housing	Home Funders	Project Hope
Casa Myrna	Homes for Families	Project Place
Children's HealthWatch	Horizons for Homeless Children	Regional Housing Network of Massachusetts
Citizens for Affordable Housing in Newton Development Organization (CAN-DO)	Jane Doe Inc., the Massachusetts Coalition Against Sexual Assault and Domestic Violence	Somerville Homeless Coalition
Citizens' Housing and Planning Association	Jewish Community Relations Council	Square One
Crittenton Women's Union	Massachusetts Association for Community Action	Thrive In Five Initiative
Family Independence Initiative	Massachusetts Coalition for the Homeless	Tzedek Reflection
Family-to-Family Project	Massachusetts Law Reform Institute	Western Massachusetts Network to End Homelessness
	Massachusetts Public Health Association	Worcester Area Mission Society

RESEARCH PARTNERS:

Center for Social Policy, UMass Boston	Collins Center, UMass Boston
Massachusetts Budget & Policy Center	

Andre Green
On Solid Ground Coalition
617.201.9512

July 15th, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Section 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai,

On behalf of the members of the Oral Health Integration Project (OHIP), thank you for the opportunity to offer our comments on the proposed Section 1115 waiver request. OHIP is a new initiative of the Oral Health Advocacy Taskforce (OHAT), a longstanding coalition of diverse stakeholders dedicated to improving the oral health of the Commonwealth. The members of OHIP firmly believe that oral health has a critical role in improving overall health and wellbeing and seek to promote the integration of dental care into the rest of the health care system.

Although largely preventable, oral diseases continue to be among the most common chronic diseases in the U.S., resulting in millions of hours of missed school and work days annually.¹ Preventable dental visits to emergency departments (ED) also cost the Commonwealth millions each year,² and almost half of all ED visits are by MassHealth members.³ Nonetheless, there is mounting evidence to suggest that the provision of oral health care actually lowers overall health care costs.⁴

Aside from the economic toll, poor oral health severely impacts quality of life, particularly for the most vulnerable, including MassHealth enrollees. According to a recent survey by the American

¹ National Center for Chronic Disease Prevention and Health Promotion, (2002). *Fact Sheet: "Preventing Dental Cavities."* Centers for Disease Control and Prevention.

² Division of Health Care Finance and Policy. (2012). *Massachusetts' Emergency Departments and Preventable Adult Oral Health Conditions: Utilization, Impact and Missed Opportunities (2008-2011)*. Boston, MA: Center for Health Information and Analysis.

³ Massachusetts Health Policy Commission. (2016). *ED Utilization for Preventable Oral Health Conditions in MA* [Powerpoint slides]. Boston, MA. Retrieved from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/committee-meetings/20160401-public-presentation-dental-findings.pdf>

⁴ Jeffcoat, M.K., Jeffcoat, R.L., Gladkowski, P.A., Bramson, J.B., Blum, J.J. (2014). Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions, *American Journal of Preventive Medicine*, 47: 174-182.

Dental Association, the top oral health problem for low income adults in Massachusetts is difficulty biting and chewing, posing challenges to good nutrition; 36% of low income MA adults also report avoiding smiling and 20% reducing participation in social activities due to the condition of their mouth and teeth.⁵ Patients unable to adequately address their oral health needs often turn to opioids to address pain, which is especially concerning in light of the escalating opioid use disorder crisis.

The current dental care delivery and payment system does not focus on outcomes and fails a significant part of the population. The existing fee-for-service reimbursement model needs readjustment; it has not kept up with the development of the oral health evidence base, insufficiently prioritizes prevention by rewarding volume, not value, and perpetuates an ineffective surgical approach to infectious disease processes. Additionally, the arbitrary historical separation of dental services from the rest of health care means there is very little incentive for providers to communicate with each other, again posing risks in areas like pain medication management and chronic disease care coordination.

The new 1115 waiver is a tremendous opportunity to improve the way that oral health care is financed and delivered, and elevate oral health throughout health care more broadly. OHIP applauds the inclusion of oral health in its proposed ACO models as an important first step to oral health integration. All members should have access to patient-centered, integrated, and continuous quality oral health care. We encourage MassHealth to take additional steps beyond incorporating oral health incentives on the primary care side, including requirements for increased ACO accountability for dental services. MassHealth's primary goal of promoting truly integrated, coordinated, and accountable care cannot be achieved without an additional focus on oral health and dental services and sufficient resources allocated for oral health system transformation.

ACOs must have accountability for oral health and dental services

Oral health care is a vital part of overall health care. As such, ACOs must have accountability for dental services, which can help address unmet population need and help the overall system save money. To start, MassHealth should require ACOs to establish referral relationships and/or partnerships with dental providers and delineate accountable referral processes, with the goal of ultimately moving all dental services to risk-sharing arrangements and value-based reimbursement. This must involve an incremental phasing-in of dental services into ACO total cost of care, with safeguards to ensure the population's service needs can be adequately met. We propose MassHealth consider a similar process for oral health integration as is currently proposed in the waiver request for LTSS integration.

Dental providers should be explicitly allowed to join ACOs and/or establish relationships with ACOs and take part in risk-sharing arrangements that align financing with better outcomes. This can occur during Year 1 of ACO roll-out. In order to facilitate phasing in dental services, MassHealth

⁵ Health Policy Institute. (2016). *Massachusetts' Oral Health and Well-Being*. Retrieved from <http://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being/Massachusetts-facts>

should incentivize oral health providers to join or partner with ACOs at the start of Year 1. This will also support ACOs to be flexible in meeting the needs of its members while helping providers transition to a new culture of integrated, collaborative care. We ask that MassHealth be more specific about the timeline of implementation of ACO accountability for dental services.

Examples:

- Several states' Medicaid innovation models have already integrated oral health care. Oregon Medicaid's Coordinated Care Organizations (CCOs) have a global budget and are responsible for coordinating all care, including medical, behavioral, and dental. CCOs are specifically required to have formal contractual relationships with dental care organizations in their region.⁶
- A number of health insurance companies have piloted oral health integration, with remarkable results in cost savings and improved outcomes, particularly for those with chronic disease. United Concordia found annual medical cost savings ranging from \$1,090 annually for members with coronary heart disease to \$5,681 annually for stroke patients that underwent periodontal treatment and maintenance. Hospitalizations were also at least 21% lower among patients with chronic disease who underwent dental treatment versus patients with chronic disease without dental intervention.⁷
- Access to full oral health benefits can be a draw for members. For example, One Care members report the availability of dental care is a significant incentive for enrolling in the program, with 48% of voluntary enrollees describing getting better dental benefits as a primary reason for joining One Care.⁸

ACO payment methodologies for dental and oral health services should be value-based and not volume-based

To develop a patient-centered model in dentistry similar to that in medicine, there must be both upfront investments to help dental providers implement the model as well as sustaining reimbursement mechanisms that are aligned with value. Dental providers, like other health care providers, should be held accountable for quality metrics and reporting. This must involve changes to the existing fee-for-service reimbursement system, creating incentives for disease prevention and health maintenance rather than procedure-based care and the treatment of active disease. These modifications should involve the use of shared savings and risk models that reward patient outcomes. There should also be better alignment of payment periodicity with established evidence-based clinical guidelines, encouraging the use of treatment protocols that are based on an individual patient's risk for oral disease rather than third party payer frequency limits.

⁶ Vujicic, M and Nassch, K. (2013). *Accountable Care Organizations Present Key Opportunities for Dental Profession [research brief]*. American Dental Association and the Health Policy Resources Center. Retrieved from http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0413_2.ashx

⁷ Jeffcoat, M.K., Jeffcoat, R.L., Gladkowski, P.A., Bramson, J.B., Blum, J.J. (2014). Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions. *American Journal of Preventive Medicine*, 47: 174-182.

⁸ Henry, A., Fishman, J., Gettens, J., Goody, M. and Alsentzer, D. (2015). *Findings from One Care Member Experience Survey: The One Care Early Indicators Project*. Retrieved from <http://www.mass.gov/eohhs/docs/masshealth/onecare/eip-survey-2-report.pdf>

Additionally, there is an important opportunity to help push dentistry toward using diagnostic coding, which creates greater accountability in treatment by establishing medical necessity for procedures billed. Not only would this more closely align dental services delivery with the rest of health care, but it would also enable better tracking of care quality and patient health outcomes.

Because dental visits are typically longer than medical visits, there is also great potential in dentistry to offer some services and procedures typically done in the primary care setting – for example, certain screenings, vaccinations, and patient education. Adequate risk-sharing in dentistry can support quality care and spur innovations in care delivery. ACOs that incorporate dental services may be better poised to implement such innovative models, provided that appropriate initial investments and sustaining payment models are also applied in areas such as workforce training and infrastructure development, including in health information technology.

There similarly should be sufficient investments and incentives for oral health services to be done in primary care settings, including oral health risk assessments and screening questions, fluoride varnish application, and oral health patient education. Contemplation of value in oral health and dental care must also consider incentives for greater coordination of primary medical and dental care, and special attention should be brought to establishing processes and systems for closed-loop, bi-directional referrals.

Examples:

- Hennepin Health in Minnesota is a county-based Medicaid ACO with advanced integration of dental care, including shared risk and incentives based on performance and outcomes. Recognizing potential cost savings by reducing hospital admissions for dental emergencies, Hennepin Health also created an ED diversion program that connects patients to local dentists.⁹
- Boston Children’s Hospital Early Childhood Caries program uses an evidence-based disease management clinical protocol that treats patients based on disease risk. It has been highly effective in reducing caries rates in children, with significant reductions in operating room utilization, new cavities, and pain compared to a historical control group.¹⁰
- The total cost of care approach in Oregon Medicaid is currently allowing Advantage Dental to pilot an innovative care delivery system that uses community-based services for prevention and stabilization. The PREDICT program identifies high-risk patients and through case management, facilitates seamless transitions to dental services by removing barriers to accessing in-office care. The program is being evaluated by the University of Washington and early indicators are very positive.¹¹

⁹ Edwards, J.N. (2013). Health Care Payment and Delivery Reform in Minnesota Medicaid. *The Commonwealth Fund*. 12:1667.

¹⁰ Ng, M. W., Ramos-Gomez, F., Lieberman, M., Lee, J. Y., Scoville, R., Hannon, C., & Maramaldi, P. (2014). Disease Management of Early Childhood Caries: ECC Collaborative Project. *International Journal of Dentistry*, 2014, 327801. <http://doi.org/10.1155/2014/327801>

¹¹ Ludwig, S. (2016). *PREDICT: Delivery System Design & Science to Reduce Oral Health Disparities in Rural Oregon* [Powerpoint slides]. Retrieved from <http://www.nationaloralhealthconference.com/docs/presentations/2016/04->

Use DSRIP funds to transition delivery system to adequately address oral health

State and federal investments in ACO development and infrastructure should consider oral health. Because of the longstanding separation between dental and medical services, thoughtful investments in network development, health information technology, and workforce development and training are particularly critical for successful integration of oral health services and necessary to encourage providers, including oral health providers, to enter into ACOs.

Much like the proposed certifications for Community Partners in Behavioral Health and LTSS integration, MassHealth should establish a similar stream for investments in oral health. Oral health should be one of the ten high priority initiatives in alignment with overall DSRIP goals. Health care workforce development and training programs should include eligibility for dental providers. One out of ten Massachusetts residents lives in a dental health professional shortage area (DHPSA)¹²; meanwhile, a significant number of dentists are approaching retirement, threatening access to dental services. MassHealth has the opportunity to help ameliorate this shortage and maldistribution with DSRIP funds.

Technical assistance offered to providers should include solutions for oral health integration into primary care practice and promote integration models already developed for safety net providers.¹³ According to recent findings from the Health Policy Commission, almost half of all preventable emergency department visits for oral health were paid for by MassHealth.¹⁴ Accordingly, MassHealth should also consider oral health when investing in new care delivery model innovations, especially when examining interventions that may result in the highest return on investment. These innovations must be flexible and meet people where they are; these might include emergency department diversion programs for oral health-related problems and/or tele-dentistry (notably, Paul Glassman's Virtual Dental Home model), among others. Tele-dentistry extends dental service access to members who may otherwise have difficulty accessing care and would utilize existing public health dental hygienists and other allied health providers to the full scope of licensure. MassHealth should enable reimbursements for off-site screening and service delivery, which would facilitate the use of telemedicine and tele-dentistry in ACOs.

20/Sharity%20Ludwig-Delivery%20and%20Payment%20Systems%20Innovations%20in%20Dentistry-PREDICT-Population-centered%20Risk%20and%20Evidence-based%20Dental%20Interprofessional%20Care%20Team.pdf

¹² Massachusetts Health Policy Commission. (2016). *ED Utilization for Preventable Oral Health Conditions in MA* [Powerpoint slides]. Boston, MA. Retrieved from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/committee-meetings/20160401-public-presentation-dental-findings.pdf>

¹³ Hummel, J., Phillips, K.E., Holt, B., Hayes, C. (2015). *Oral Health: An Essential Component of Primary Care*. Seattle, WA: Qualis Health. Retrieved from <http://www.safetynetmedicalhome.org/resources-tools/white-papers>.

¹⁴ Massachusetts Health Policy Commission. (2016). *ED Utilization for Preventable Oral Health Conditions in MA* [Powerpoint slides]. Boston, MA. Retrieved from <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/committee-meetings/20160401-public-presentation-dental-findings.pdf>

Investments in health information technology are particularly crucial for oral health integration. Currently, electronic medical and dental health records are largely incompatible; for effective care coordination, particularly for complex and high-risk patients, bidirectional data sharing and structured referrals between primary care and dental care providers is absolutely necessary. ACOs should set standards for health information technologies that enable greater inter-professional communication.

Presently, the vast majority of Massachusetts dentists do not accept MassHealth. Incentives to help transition dental practices to adopt flexible HIT systems may have the added benefit of recruiting more dental providers to serve MassHealth patients. This is particularly opportune considering the impending requirement in Chapter 224 of the Acts of 2012 for all providers, including dental providers, to adopt electronic health records systems by next year.

Additionally, the Safety Net Care Pool redesign must ensure that dental services will continue to be covered.

Oral Health Quality Metrics can help tie oral health into overall health in ACOs

We are pleased to see the inclusion of an oral health quality metric within the ACO prevention and wellness quality measure slate. We encourage MassHealth to establish this measure in accordance with national efforts to develop oral health quality metrics – e.g. the HEDIS dental measure and those from the American Dental Association’s Dental Quality Alliance – and also ensure that the measure adequately captures the incentive for primary care providers to address oral health in a comprehensive manner. For example, the U.S. Preventive Services Task Force recommends that children from birth through age five years receive fluoride varnish application, a reimbursed procedure readily done in the primary care setting and one that is easily measured. Moreover, we see the proposed metrics on avoidable utilization as another important opportunity to evaluate progress in oral health prevention in both primary care and dental settings, and ask that the final metric on potentially preventable admissions captures not only admissions but also preventable ED usage for oral health.

As dental services are phased in to ACOs, we ask that MassHealth expand oral health quality measures to include metrics evaluating dental provider quality and access to care. These metrics should capture the needed shift toward prevention and risk-based chronic oral disease management in care delivery – which may be facilitated by eventual use of dental diagnostic codes – as well as patient experience and outcomes in dental settings. As an essential part of value-based care, oral health-related measures need to be tied eventually to shared risk and savings.

MassHealth should ensure that oral health metric development involve oral health providers and receives substantial input from the oral health and medical provider communities, including those practicing in diverse settings serving various populations. Measures established should also allow the

monitoring and evaluation of care for unique populations, including children, the elderly, and individuals with special needs.

Aside from tying metrics to payment, transparency of data collected is critical for ACO oversight. Just as CHIA publishes annual, public data on the performance of the state's health care system, MassHealth and any bodies responsible for oversight must continuously monitor and evaluate program implementation, including roll-out of dental pilot programs. This will also require publicly setting and reporting on system-wide, measurable goals such as reduced ED utilization and improved health outcomes. Any baseline data collection should be disaggregated and also include oral health data. We respectfully direct you to Health Care For All's comments describing recommendations for increased ACO transparency and oversight.

Examples:

- In the recently released quality metrics final report for Oregon's CCOs, the sole dental metric – the rate of dental sealants on permanent molars for children – increased by a staggering 65% in one year. This demonstrates the efficacy of tying reimbursement to a dental quality metric. Dental services are included in total cost of care and CCOs are eligible for incentive payments if they meet the benchmark.¹⁵
- New Jersey ACO gainsharing plans submitted to the Department of Human Services will be evaluated in part on whether a gainsharing plan provides funding for improved access to dental services for high-risk individuals likely to inappropriately access an emergency department and general hospital for untreated dental conditions.¹⁶
- The Massachusetts League of Community Health Centers conducted two medical-dental integration pilots programs across multiple community health centers (CHCs). Using a quality improvement approach, CHCs monitored metrics ranging from the percentage of pediatric patients asked about oral health to tracking diabetic patients' referrals to dental care.¹⁷

Oral health should be integrated into all aspects of care coordination

Case managers, community health workers, and other health care workers that coordinate care both within the ACO and with community partners should all consider oral health. These health care workers are key members of the patient care team who can and should have responsibility in supporting members to identify oral health concerns and facilitating connections with oral health providers.

Oral health should be a standard part of any baseline patient assessment or care plan developed by the ACO, MCO, or other provider. Simple screening questions asking about oral health status, oral health self-management, and dental service utilization can identify the need for oral health care. All

¹⁵ Office of Health Analytics. (2016). Oregon's Health System Transformation: CCO Metrics 2015 Final Report. *Oregon Health Authority*. Retrieved from http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf

¹⁶ N.J.A.C. 10:79A-1.6(a)(1)(v).

¹⁷ Wells, S. (2016). *The Power of Integrated Care Teams in Improving Oral Health Outcomes: Lessons Learned from Community Health Center Integration Pilots* [Powerpoint presentation]. Massachusetts League of Community Health Centers.

health care team members must be incentivized to guarantee continuous quality oral health care for each patient. Oral health and dental care providers should also be considered part of the extended patient care team, and adequate, ongoing communications with dental providers must be ensured. This is especially important in light of the ongoing opioid crisis.

These aims will require ACOs to invest not only in oral health training for various team members, but also require providers to establish formal relationships with dental providers. In addition, investments will need to be made to ensure that patient assessments include questions to assess patient oral health, and care plan formats will need to include sections that trigger the inclusion of oral health care needs.

There is also an opportunity to address oral health in community-based settings. ACOs should establish partnerships with community programs and social and support services that address social determinants of health as well as oral health; these partner organizations should include existing community-based oral health services such as school-based oral health programs.

Roll-out of dental services inclusion in ACOs should consider piloting

MassHealth should directly contract with dental care organizations (DCOs) similar to Oregon's Medicaid model or assist ACOs in launching pioneering dental-focused integration pilots for each proposed ACO model. To promote cost-effectiveness and efficiency, MassHealth should adjust the free choice of provider clause that has appeared in previous 1115 waiver agreements to best allow for optimally-structured dental pilots. All pilots should be introduced in advance of the full inclusion of dental services in ACO total cost of care and should also consider leveraging the expertise of third party dental benefits administrators and their knowledge in working with dental providers to ensure the adequacy of the dental provider network. Additionally, pilot programs need to be implemented and tested with significant and meaningful input from the dental and medical provider communities as well as consumers. This should include benchmarks for each pilot that are consistent across the board, and clearly defined risks that providers are assuming. MassHealth should facilitate the sharing of best practices and data collected through and at the end of the dental pilot phase in order to assist with the next stage of oral health integration roll-out.

A successful pilot that rewards providers for achieving greater patient health may have the added benefit of convincing more providers to accept MassHealth. Piloting should be conducted with diverse practices and in varied geographical settings to demonstrate efficacy of dental integration in ACOs, including with solo-practitioner private practices, and in rural and health professional shortage areas.

ACO governance, quality, and clinical committees should have representation from oral health clinicians

Dental providers, including dental specialty providers and those serving diverse populations, should be represented in ACO governance, quality, and clinical committees. Oral health practitioners,

particularly those who serve vulnerable populations, represent an important voice to help ACOs ensure adequate resource allocation to populations commonly left out of the dental care system. Additionally, representation from primary care providers and pediatricians knowledgeable in oral health integration may also be helpful in ensuring sufficient consideration of oral health in ACO decision-making.

Ensure adequate consumer protections through representation and input in ACO governance bodies and advisory councils

We are heartened to see strong consumer protections outlined in the waiver proposal, particularly around meaningful patient engagement in ACO governance structures. We appreciate the preservation of robust member appeals and grievance procedures as well as the establishment of a new ombudsman role to help MassHealth members who may need assistance. Member choice of providers, including dental providers, should be protected. If MassHealth rolls in dental services, members should still have access to the full network of MassHealth dental providers.

Risk adjustment methodology should consider oral health and social determinants of health. Due to geographical differences in the availability of dental health professionals, certain populations are at exceptionally high risk. Providers serving high-risk populations, including oral health providers, should not be penalized for serving sicker patients. By the same token, there must be rigorous monitoring and tracking of underutilization where providers may be potentially stinting on care. There should be internal ACO monitoring mechanisms as well as broader MassHealth oversight, particularly for vulnerable and high-risk populations, and all public reporting required of ACOs should also include dental.

We appreciate the chance to offer our thoughts on the 1115 waiver proposal and ask that oral health be more prominently featured in the final version of the proposal. Fully integrated and coordinated care cannot exclude oral health, and MassHealth has the significant opportunity to lead the dental delivery system to be more patient-centered, accountable, and value-driven. We certainly understand that the integration of oral health into the rest of health care is a daunting task – one that will require much thoughtfulness in both planning and implementation. We thank you for your consideration and your leadership and are eager to collaborate with MassHealth to ensure members have access to truly whole-person care. If you have questions or would like more information, please contact Helen Hendrickson, Oral Health Project Manager at Health Care For All, at 617-275-2926 or hhendrickson@hcfama.org.

Sincerely,

Hugh Silk, MD MPH, FAAFP, Professor, Department of Family Medicine and Community Health,
University of Massachusetts Medical School

Lisa Simon, DMD, Fellow in Oral Health and Medical Integration, Department of Oral Health
Policy and Epidemiology, Harvard School of Dental Medicine

Michelle Dalal, Chair, Oral Health Committee, Massachusetts Chapter of the American Academy of
Pediatrics

Robyn Olson, Chair, Oral Health Advocacy Taskforce Steering Committee

Samantha Jordan, DMD MPH, Dental Director, Federally-Qualified Health Center

1199SEIU- United Healthcare Workers East

Action for Boston Community Development, Inc.

AIDS Action Committee

Better Oral Health for Massachusetts Coalition

Boston Center for Independent Living

Boston Health Care for the Homeless Program

Boston Public Health Commission

Children's Dental Health Project

Community Health Center of Franklin County

Community Servings

DentaQuest

Disability Policy Consortium

Forsyth Institute

Forsyth School of Dental Hygiene

Harbor Health Services, Inc.

Harvard School of Dental Medicine

Health Care For All

Massachusetts Dental Hygiene Association

Massachusetts League of Community Health Centers

MCPHS University

Partners for a Healthier Community, Inc.

Tufts University School of Dental Medicine



FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

July 16, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: Comments on Section 1115 Demonstration Project Amendment and Extension Request

Dear Assistant Secretary Tsai:

Thank you for the opportunity to submit comments regarding the Executive Office of Health and Human Service's Section 1115 Demonstration Project Amendment and Extension Request to amend the state's Medicaid waiver. We have appreciated the opportunities to supply comments and feedback to you in a variety of formats and settings and acknowledge that many of our formal comments in this letter are concerns that we have previously raised. We greatly value these opportunities and our collaborative relationship with MassHealth.

We respectfully submit the following comments to EOHHS on the Section 1115 Demonstration Project Amendment and Extension Request and we look forward to our ongoing discussion and collaboration on new models of care for low-income patients.

ACO financing and payment methodologies:

As you are well aware, MassHealth members represent a highly complex, heterogeneous group of patients, many of whom experience significant medical and behavioral health complexity. Moreover, given the fluid nature of coverage and eligibility, patients frequently move from MassHealth to other coverage, adding further challenge to risk-based payment, particularly downside risk.

Currently, MassHealth reimburses care at a lower rate than cost, which accounted for over \$383 million in losses to our delivery system last year for the care we provided to low-income individuals and families on MassHealth. We urge the state to consider flexibility on the downside risk for this population, particularly as it works to review data, payment, and risk methodologies for this new care delivery model. We are concerned that we have insufficient information on DSRIP PMPY amounts in order to plan and evaluate the feasibility of our potential ACO programs and expect that this information will be available to us very soon. We are also concerned that MassHealth has not been able to provide comprehensive data for our PCC plan patients and what this signals for MassHealth capabilities to support the ACO program.

We would ask for MassHealth's commitment to work closely with ACOs to ensure that DSRIP funds are distributed in proportion to the patients whom the money is intended to serve, and in ways that support the work and investments of the ACOs.

PCP participation in ACOs:

The waiver specifies that PCPs will be limited to serving only those patients who have selected their ACO from day one. While we understand why a PCP would not be allowed to participate as providers in multiple ACOs, we are concerned about what this means for longstanding patients who have not yet selected the ACO, or for new patients who are not yet able to be attributed to that PCP via the ACO attribution methodology, or for patients who may continue to be in an MCO outside of an ACO. Unless a PCP's entire panel can be converted over to the ACO on day one and any new patients automatically attributed, we would ask MassHealth to consider flexibility in the timeline for program implementation and launch to address these concerns.

Member experience:

While we recognize the need to incentivize MassHealth members to select ACOs, we are worried about the reliance on measures that reduce benefits and increase cost sharing for members. The addition of these elements will create confusion for members who are already navigating a complex system of coverage, and adding copays for Medicaid members more often simply results in bad debt for providers. These elements will also contribute to adverse selection between MCO and PCC Plan programs whereby only members with greater service needs will migrate to MCO/ACO program and it is not clear that risk adjustment will compensate for these shifts. We would ask that the state work with the ACOs to devise positive and effective ways to promote the advantages of ACOs, before resorting to these more punitive means of encouragement.

Safety Net Care Pool:

We commend the financial support to providers in general, and safety net hospitals in particular, proposed in the SNCP restructuring. This support is critical to safety net hospitals as they do not have strong private sector revenue bases to cross-subsidize public payer losses. We further commend MassHealth for its proposal to increase the number of qualifying hospitals from the current 7 to 11, demonstrating its willingness to continue to recognize the extraordinary commitment of this subset of hospitals to care for the Commonwealth's most vulnerable citizens.

We welcome the proposed establishment of a "UCC Pool" to provide additional payments to hospitals, community health centers, DPH/DMH hospitals and IMDs for uninsured uncompensated care. We trust these additional payments will ameliorate the significant shortfall – with estimates approaching \$100 million for FY 2016 - in the Health Safety Net.

Finally, we note that the absence of detailed information regarding the Safety Net Financing in the waiver proposal prevents us from further comment. As stakeholders, it is important that we have a full understanding of the proposed financing and urge MassHealth to provide this information as soon as possible.

Community partnerships - behavioral health:

We are supportive of the oversight role that the state proposes to play with respect to certified behavioral health providers. Establishing quality and/or process metrics would optimally be a collaborative process among MassHealth, the ACOs, and the community organizations, rather than a top down approach. We would also note that community support services that are already incorporated within potential ACO organizations should not be considered less of a resource than those of an independent entity. As in most aspects of defining the model approach, flexibility is key in defining the roles of care coordination and management for the ACOs and their community partners.

Substance use disorders:

We applaud the state for its thoughtful and comprehensive approach to enhancing services for people with substance use disorders. We request that the state consider the explicit mention of the need and requirement of pharmacotherapy for patients within transitional support services as well as in residential rehabilitation services. It is also critically important that we have residential settings that can handle medically co-morbid patients, such as those who need IV antibiotics. We urge the state to consider adding a similar model for those with medical need to its noted accommodation for higher intensity services for those with co-occurring psychological illness.

Pediatrics:

Many of the key components of the waiver offer real opportunities to address important items in care for children and youth. Yet, it is critical to recognize that children and youth – who comprise almost 40% of MassHealth enrollees – have substantially different health care needs, life course health trajectories, and social determinants that affect their health and well-being. We urge the state to take this into consideration when developing plans for children with chronic conditions, network adequacy, timely data sharing, support for the social determinants of care, and appropriate methods for patient attribution for children. On all of these fronts, we encourage the state to reach out to the pediatric community to help determine best care practices for low-income children and youth.

Thank you again for this opportunity to continue to take part in the ongoing dialogue about this important and ambitious work. We look forward to our continued discussion and engagement through the waiver and MassHealth ACO implementation processes.

Sincerely,



Timothy G. Ferris, MD
Senior Vice President
Population Health Management
Partners HealthCare



Matthew Fishman
Vice President
Community Health
Partners HealthCare

I am the CFO at Pediatric Associates of Greater Salem with locations in Salem and Beverly. Dr. Ayres D'Souza started the practice in 1977, and one year later, added an additional physician. Almost forty years later, we have fourteen providers and a panel of over 24,000 patients however approximately 16,000+ are considered active. Since our inception, we have been providing quality, comprehensive pediatric services, and we are committed to serving all of our patients and their families with both compassion and first-rate medical care. Using the most current medical information available, it has always been our mission to assure that our patients grow up in a healthy environment so that they can achieve their greatest potential. With this commitment in mind, our patients have unfettered access, as we are open seven days a week, 365 days a year, and have staff on call 24 hours a day.

Beginning in February of 2010, we became one of thirteen pediatric practices in the state to join the CHIPRA Massachusetts Medical Home Initiative. Through a learning collaborative lead by the National Institute for Children's Health Quality (NICHQ), and with the help of world-class medical home and quality improvement experts, we have worked towards successfully implementing a patient-centered, medical home model of care. Over the past four years, we have made multiple changes to our practice, both in terms of the quality of care we provide and the process by which we provide it. This has come at quite a cost. These changes have necessitated that we make structural alterations to our building. Furthermore, we have undergone substantial re-training of staff to improve flow, and we have hired additional staff to ensure that these quality improvements are maintained. All of this has been done with one, primary goal in mind – to provide each and every one of our patients with the best care possible. We have achieved NCQA Level 3 Recognition as a result of this continuous focus on the quality care we provide.

We are now providing the type of quality care that the government, the insurance companies, and society at large want from their healthcare providers, as you know, it comes at a tremendous cost. The cost to our physicians and other staff is significant. The paperwork, electronic and non-electronic, associated with all this “other” non- patient face time has greatly extended the day of all staff. Much of this could be handled by a better EHR systems and/or less restrictions as ICD-10 debacle. Plus we are expected to use the exact same criteria for Patient Centered Medical Home for adults. Based on the current system, the level of care provided to pediatrics patients is threatened by the reimbursement models.

I applaud the state's efforts to reduce overall costs and I have read through the 1115 Waiver proposal. In the end, I expect it will only continue to drive up costs and it will not fix the current issues with the system causing the primary care physician to pay the price. My suggestion for what needs to happen would be to address the current major issues first then implement a new ACO model.

- Fix the qualifications for Medicaid
- Create some deterrents for urgent care and specialty care; the provider is held accountable when the patient has no accountability
- Break down the barriers for the process of integration of behavioral health and other specialties in a practice with contracts credentialing
- Medicare / Medicaid disparity
- Get rid of facility fees

Reimbursements have decreased despite health care costs rising dramatically and it's not going to primary care or at least private practices. The number of patients with commercial insurance has decreased by approximately the same amount that our Medicaid population has increased, yet we

are reimbursed \$100 less per visit. The table below shows Medicaid rates from 1998 to 2016 for 2 common sick visit codes as an example, however, all codes had similar disparity in reimbursements. In 2013 & 2014 reimbursements were increased to Medicare levels if a provider was aware that they needed to signed up for it. Staffing costs have increased about 3%-7% per year due to inflation and other outside influences still reimbursements decreased 7.5% 2007 to 2016. Where is the money going? Staffing costs have only increased in this time frame and we had increased cost due to meaningful use and NCQA certification.

Medicaid Rates

	1998	2001	2004	2007	2010	2014	2015	2016
99213	33.54	43.99	38.24	58.67	48.67	76.38	76.38	52.37
99214	50.49	62.09	59.86	83.71	73.71	112.57	112.57	77.46

Fix who should qualify for Medicaid

- When the ACA started 1/1/2013, our practice mostly saw a switch from a commercial insurance plan to some Medicaid plan and not an increase in patients as expected.
- People travel to the United States to deliver their baby so it is born a U.S. citizen. This population tends to pay cash prior to the babies delivery but once the baby is born he/she qualifies for Mass Health immediately. Why should tax payers be pay for a baby's health care when the family obviously has the capacity to pay since they are paying for housing etc. for 9+ months.
- A personal experience of how I have seen the system fail as currently run is: I have a friend who received a golden parachute from a company. He had a lengthy argument with the employee from the health connector because he wanted to pay for a reasonable plan. The employee at the health connector tried to convince him that his children qualified for Medicaid because he was "unemployed" when he has millions of dollars in his bank account.
- Tighten up the criteria and come up with a better qualification for Medicaid because we have plenty of patients parents that have very expensive homes and some pay more in real-estate taxes than what most people make in year.

Creation of deterrents

- Our office is open 365 days per year but yet we have patients that will go to the ER instead because there is no deterrent. We always see the patient the same day that they call our office for sick calls. We also do regular follow up calls to ask why they went to the ER vs calling our office and there never is a good explanation
- We are available 24/7 by phone but yet some patients will not call us for help over the phone and will automatically go to the ER if its outside 7am to 7pm again because there is no deterrent like a copay.
- A great example of the abuse to the system is from a Medicaid patient that was seen in our office for constipation on 7/6/16 then again on 7/14/16
 - o 7/6 – PAGES- Constipation
 - o 7/7 - NSMC ED
 - o 7/8 - NSMC ED

- 7/9 - BCH ED
- 7/12 - NSMC ED
- 7/14 - MGH Urgent Care
- 7/14 – PAGES

Because the patient didn't agree with our diagnosis the patient then went to 4 Emergency Rooms and one urgent care over the course of 8 days before coming back to our office. Granted constipation is not fun but I am guessing this one patient will cost the system well over \$8,000 for 9 days. How can you hold a provider accountable for the total cost of care when the patient has no deterrents.

Break down barriers for implementing behavioral health

- To bring in a provider to our practice that is already licensed in Massachusetts ~~is~~ takes 3+ months.
 - Private practice needs to fill out new separate contracts with each insurance company for each of the additional services that you looking at bringing in house for better coordination.
 - The credentialing piece alone takes 3+ months which is absurd when they are a practicing MD in Massachusetts and most times already credentialed with a different contract
(It' expected that we do a better coordination of care but there are barriers that don't allow this to happen easily)

Medicare / Medicaid disparity

- Over the years someone decided that those who care for children should be reimbursed less.
 - Children's office visits often need more time
 - Hearing, Vision, and general growth assessments add to the length of time of an appointment
 - Children cannot accurately communicate their symptoms; ~~and~~ the physician therefore faces greater diagnostic challenges than with adult care.
 - During the visit, Pediatricians manage the parent as well, questions about growth and development etc. also make the visit longer.
 - Pediatricians have the same amount of schooling and expenses as a Family practitioners and other providers.
- Part of the ACA for 2013 & 2014 increased reimbursements to Medicare levels (45% Increase) if you signed up for it.
 - This dramatically helped with the transition which was mostly a change from commercial insurance to Medicaid in our office.
 - In 2015 we saw a decrease in reimbursements of \$700,000+ due to the section 1202 rates going away.
 - All physicians who service adults complain about Medicare reimbursements however Medicaid is approximately 31% less in Massachusetts.
 - Several states maintained reimbursements at the Medicare levels when the section 1202 rates ended 12/31/2014. Why has Massachusetts not supported their practitioners in the same way?
 - There have been a number of House and Senate bills proposed to maintain the reimbursements at Medicare levels, however nothing has happened except at a state level (in other states).

Facility Fees

- Facility fees are a way for hospitals and hospital off-site hospital owned clinics etc. to charge extra fees on top of the higher reimbursements they are already receiving
 - o Removing the facility fee will level the playing field and reduce costs
 - It will potentially slow down the acquisition of smaller practices. AMA released a statement on 7/7/16 regarding this - <http://www.ama-assn.org/ama/pub/news/news/2016/2016-07-07-preserve-independent-medical-practices.page>
 - ER's may steer patients back to the clinics as it won't be profitable to see that patient

As a practice, we have always taken pride in the fact that we provide the same level of service to each and every patient, regardless of their ability to pay or the differing levels of reimbursements. Many primary practices have had to sell out to hospital systems in order to survive which in turn has been a factor in driving up health care costs. The remaining practices are in a similar situation as we, although may not have as many Medicaid patients. We only have a few options that are available to us at this point:

- Sell out to Partners or another hospital system (which will only increase health care costs)
- Providers will need to see 5-6 patients per hour and reduce the quality of care (which is really not an option for our practice)
- Stop taking Medicaid which will displace over 5,300+ children in the North Shore in an already crowded system (it will increase ER & Urgent care visits)
If we stop accepting new Medicaid patients to our existing panel we will still be struggling to survive.
- Push to encourage the state or federal government to increase reimbursements to Medicare levels like we saw in 2014 & 2015. Reimbursement should be equal for adults and children.

How can primary care providers be held accountable for a population who tend to have more health care issues, are non-compliant with their care, or the system itself has no incentive to keep these patients from inappropriate and over use of the system? I urge you to take another look at what is proposed; this model will ultimately force private practices out of business, ultimately causing additional increase health care costs.

Respectfully submitted,

Mark McKenna

Mark W. McKenna

Chief Financial Officer

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Pine Street Inn

Ending Homelessness

Comments: MassHealth Public Stakeholder Listening Sessions
Section 1115 Demonstration Project Amendment and Extension Request
June 24, 2016

I am here today to speak to the needs of homeless individuals and how the systems that currently serve and support them can be integrated into the delivery system reform model you are proposing.

At Pine Street Inn, we have 10,000 homeless men and women coming to us each year. We estimate about 70% them are MassHealth members and the remaining are uninsured and users of the safety net at hospitals and community centers. We know who they are. We know how long they have been homeless (see attached chart). Many of the people we see struggle with mental health and substance abuse issues (60% - 70% self-reported) as well as challenging medical issues. They are often frequent users of public systems and if we do nothing they will continue to cycle through these systems. As this group ages, they will become even more costly to insure. We triage each of these individuals into existing systems of care, however these systems are complex and fragmented and as such coordination and navigation through these systems remains an enormous challenge for our guests. We have learned how to help homeless men and women with this navigation and most importantly we have tripled our permanent supportive housing (we have just under 1,000 units), in the past 5 years because we understand that people cannot get healthy if they live on the streets. They need a stable place to live. In addition to our housing, we offer job training, mental health and substance abuse counseling, healthcare, outreach, housing search and integrated care coordination. And we know that when our system works, your costs go down. Let me give you an example.

We did a study of 16 sheltered and unsheltered homeless individual ED visits from one local hospital. We found that in a 28 month period collectively they had 1,335 emergency department (ED) visits. Based on an average cost for an ED visit of \$1,233, the cost of these visits was \$1.6 million. This does not include any hospitalizations, specialists, medications, additional testing or visits to other hospital ERs. On average the expense, per year, per homeless individual, for this cohort is of 16 is approximately \$44K - for ED visits only.

Remember that even after all this these people are still homeless. Because we have had good success in housing chronically homeless individuals, we know that we could have housed this cohort with permanent supportive housing over the same 2+ year period for \$933K; instead MassHealth paid \$1.6M for just their ED costs. That's almost a million dollar difference.

I would like to also point out another study from Los Angeles - The Cost Effectiveness of the Permanent Supportive Housing Model in the Skid Row Section of Los Angeles that showed a 68% decline in medical costs for a group that was housed versus a group that received usual care (not housed).

These 2 examples illustrate our excitement at your inclusion of CSPECH (Community Support Services for those Experiencing Chronic Homelessness) into the community partners model. This proven model of care provides support services to chronically homeless individuals in housing. And it works because MassHealth/Medicaid pays for the support services that keep these high end utilizers of expensive systems of care out of those hospital EDs and inpatient beds. Pine Street has created 40 permanent supportive housing programs with a 93% retention rate across Boston and while we can secure the capital dollars needed to create housing for this group we are enormously challenged to find the support dollars. Expansion of CSPECH will not only bring down costs but it will facilitate a system of care that is integrated, efficient, simple, not overly administrative and direct. As it is currently structured it works very well.

Meeting the behavioral health and medical needs of homeless individuals is complicated. The recognition of social determinants as a response is smart and housing must be the primary focus. We are encouraged at the proposal's intent to bring community partners into the delivery system and we are ready to bring to the table our experience and outcomes. We have the capacity 24 hours a day for boots on the ground in the community managing the total care of your most expensive utilizers of tertiary medical care and the chronically ill.

Within the S goals outlined in this plan, we saw embedded the values behind and the alignment with the work we do with and for homeless individuals every day. Integrated coordinated care reflects a concept we have embraced and have many years of successful experience to bring to the table. From driving someone to an appointment, to assisting with AD Ls, providing food, dispensing medication and connecting people to community supports and resources - it has been our work for decades. Additionally, we are working closely with the city of Boston to align coordinated access for homeless individuals ensuring they get the right housing and services in the right place at the right time. And like many providers, we find ourselves reacting to those with substance addictions, particularly opioids. Expanding the access to a broad spectrum of recovery and substance use disorder treatment is welcome but less costly and equally effective for the homeless population is offering housing - using housing first as a best practice model.

In summary, please understand our excitement for your recognition of the role we hope to play as community partners and the inclusion of CSPECH in your model. We think you're on the right path towards making the necessary connections with the right providers to ensure integrated care for homeless individuals.

Respectfully submitted,

Aimee Coolidge
Director of Community and Government Relations
Pine Street Inn
444 Harrison Ave.
Boston, MA 02118
Tel: (617) 892-9107
Email: aimee.coolidge@pinestreetinn.org
Website: www.pinestreetinn.org

Shift to Older, Higher Acuity Chronics in Housing

Age of Tenants in Housing	2003	2016
18-30years	4%	2%
31-50 years	50%	24%
51-61 years	31%	48%
62+ years of age	15%	26%
Total	100%	100%

% of Tenants with MH Dx or Substance Abuse	2003	2016
Mental Health Diagnosis	27%	77%
Substance Abuse	31%	62%

High Utilizers of Emergency Department

Guest Name	PSI	Hospital ED Visits	COST based on an average daily rate of	CSPECH
[Redacted] PSI Shattuck, WI Anchor Inn ,Men's Inn, Post	PSI History	2.4 yrs./28 mos.	\$1233	\$6,314.5 > p.er person
Person #1	Detox Outreach	190	\$ 234,270.00	
Person #2	Men's Inn Outreach	171	\$ 210,843.00	
Person #3	Men's Inn ,Shattuck Outreach	137	\$ 168,921.00	
Person #4	Men's Inn Outreach	114	\$ 140,562.00	
Person #5	Shattuck, Women's Inn Outreach	105	\$ 129,465.00	
Person #6	Shattuck, Men's Inn Outreach	73	\$ 90,009.00	
Person #7	Women's Inn Outreach	71	\$ 87,543.00	
Person #8	Men's Inn, Shattuck Outreach	70	\$ 86,310.00	
Person #9	Men's Inn, Shattuck Outreach	67	\$ 82,611.00	
Person #10	Men's Inn Outreach	57	\$ 70,281.00	
Person #11	Shattuck, Men's Inn Outreach	53	\$ 65,349.00	
Person #12	Women's Inn Outreach	49	\$ 60,417.00	
Person #13	Shattuck ,Men' Inn Outreach	48	\$ 59,184.00	
Person #14	Men's Inn Outreach	45	\$ 55,485.00	
Person #15	Men's Inn Outreach	44	\$ 54,252.00	
Person #16	Men's Inn Outreach	41	\$ 50,553.00	
Total for 28 months/ 16 guests			\$ 1,646,055.00	\$176,800

Potential Savings

\$1,469,255

Pine Street Inn

Ending -f romelessness

tlfl

I&.QP

Housing First Evidence-Based Practice

County of Los Angeles Project SO:
The Cost Effectiveness of the Permanent Supportive Housing Model in the Skid Row Section of Los Angeles June 2012



SO chronically homeless participants;
50 usual care (non-housed Group)

<http://www.latimes.com/local/la-me-homeless-project50-htm1story.html>

- \$4,474 in savings per occupied unit
- Medical costs declined by 68% for housed group; 37% for non-housed group
- Incarceration costs for non-housed group increased by 42%
42% from \$17,733 to \$25,229



Planned Parenthood League of Massachusetts

15 July 2016

Secretary Mary Lou Sudders
Assistant Secretary Dan Tsai
Executive Office of Health & Human Services
Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Secretary Sudders and Assistant Secretary Tsai:

Thank you for the opportunity to comment on the MassHealth Section 1115 Waiver proposal. Planned Parenthood League of Massachusetts (PPLM) recognizes the considerable time and energy that has been spent developing this proposal. We hope you will consider the following comments before filing with the Centers for Medicare and Medicaid Services (CMS).

Background

PPLM plays an important role in the Commonwealth's health care delivery system, serving as the largest freestanding reproductive health care provider in the state. We provide a wide range of preventive health care services, including lifesaving cancer screenings, birth control, testing and treatment for sexually transmitted infections (STIs), as well as abortion services. Additionally, PPLM provides general behavioral health and addiction screening and makes referrals for behavioral health services. Each year, PPLM provides sexual and reproductive health care to more than 30,000 patients – 40% percent of these patients are insured through MassHealth.

PPLM's Role in Accountable Care Organizations (ACOs)

PPLM is eager to play a partnership role as a referral provider in multiple ACO networks. A cost effective option for ACOs, PPLM serves not just as a subcontractor of care, but as an active participant in quality and service metrics, as well as alternative payment models. For example, our on-site lab provides lower cost, faster turnaround for STI and other tests. In spite of this, we recognize that entering into these partnerships may be challenging given PPLM's the relatively narrower scope of services provided compared to many primary care providers. As such, MassHealth's work to encourage ACOs to buy/partner for services rather than building them is critical.

Recommendations:

1. **Additional consideration for small providers is necessary to meet ACO goals:** We appreciate that the Commonwealth has stated its intention “to balance the needs of large health systems with those of small community providers.” However, the waiver proposal does not provide sufficient attention to this important issue. It is our hope and recommendation that small providers will be able to actively participate in shared savings models and that MassHealth will develop incentives for ACOs to create partnership models with smaller providers. As such, we are pleased that the Commonwealth has proposed the Alternative Payment Methodology (APM) Preparation Fund. This grant program will help increase ACO participation by supporting smaller providers like PPLM in efforts to join ACOs. However, we are concerned that by the time the fund is established and investments are made, many large and mid-size providers will have already made decisions about ACO participation. We urge the Commonwealth to consider fast-tracking this APM Preparation Fund so that smaller providers and their patients are not left behind. Such fast-tracking will also be critical for MassHealth to achieve its goal of enrolling at least 60% of eligible MassHealth lives in ACOs by Year 5. In addition, MCOs should be expected to support all providers “in making the shift to accountable care through provisions of analytics and reports for population management.”
2. **Expand the definition of Community Partner (CP):** PPLM appreciates the importance of Behavioral Health (BH) and Long Term Services and Supports (LTSS) providers. We continue to believe that the CP definition should be expanded to include partners that address other key social determinants of health – including appropriate family planning. To this end, we urge MassHealth to create an additional CP category: Complementary Providers. Creation of this additional category will encourage ACOs to “buy” rather than “build” duplicative clinical services already offered by smaller, expert providers. PPLM provides lower-cost clinical services, better access, and equivalent quality & patient satisfaction which will ultimately contribute to the success of an ACO. Notably, HHS recently finalized the 2017 Notice of Benefits and Payment Parameters rule and reaffirmed that family planning providers shall qualify as a unique category of Essential Community Providers. In so doing, HHS recognized the important role family planning providers play in ensuring reasonable and timely access to a broad range of health care services for low-income, medically-underserved individuals.
3. **Avoid future costs by including family planning in the Substance Use Disorder (SUD) Program:** PPLM applauds MassHealth for its efforts to address the opioid crisis and establish the SUD program. However, we are concerned that family planning is not mentioned in the necessary intervention strategies and request that it be explicitly included. Contraceptive options should be easily accessible to women with substance use challenges,

including those in treatment. In addition to avoiding costs of unintended pregnancies, improved access to contraception and other preventive services can support recovery goals. In 2010, there were 25,700 MassHealth births; 13,200 of these pregnancies were unintended. Lowering the number of MassHealth unintended pregnancies by just 1% would save approximately \$3.5 million annually.

4. **Permit non-ACOs and non-CPs to access Technical Assistance:** It is unclear in the proposal whether technical assistance is available only to ACOs. PPLM urges the Commonwealth to earmark a portion of the funds given to ACOs for technical assistance for small providers, or to dedicate adequate funds allowing all, but especially small providers, to apply for technical assistance.
5. **Workforce Development Program:** PPLM appreciates the inclusion of the new Workforce Development Program, recognizing that the shift to ACOs may require new hiring, training, and redeployment plans for existing staff. This workforce development will be particularly important to small providers in two key ways: 1) training staff to provide clinical services in collaboration with ACO providers; and 2) providing training which allows healthcare administrators to gain the expertise to shift to APMs.
6. **Add non-claims-based quality metrics:** PPLM recommends the Commonwealth consider inclusion of non-claims based quality metrics for ACO performance. Such action would enable the Commonwealth to capture patient data in confidential cases where a patient chooses to pay-out-of-pocket (e.g. for behavioral health services or family planning counseling). When data is not accessed from these patient visits, the Commonwealth also misses data on additional clinical services provided including prenatal care, tobacco use, adult BMI, etc. The ability to capture data from these non-claims-based quality metrics is essential where the collaboration between primary care providers and small, specialty providers drives outcomes and is necessary to enhance population management and quality of care.
7. **Maintain the ability of specialty providers to participate in more than one ACO:** We are pleased to see that specialty providers are authorized to join or participate in more than one ACO, which will also help increase participation of smaller, value-based providers in ACO models.
8. **APMs for Small Providers:** It is unclear how the Model C ACO Option differs from executing alternative payment directly with MCOs. We are concerned that there is no clear risk-based payment model for small providers proposed to date. If a risk-based payment model for small providers is not developed within the scope of work under the APM Preparation Fund, the ability of smaller, specialty providers to participate in Model C ACOs is limited. This concern applies similarly to Model A and Model B participation. We

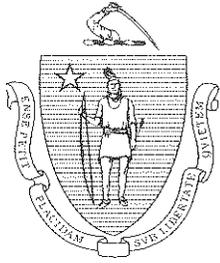
welcome an opportunity to collaborate with MassHealth to develop an APM model to address this concern.

As EOHHS works to achieve the Triple Aim, it is imperative that the state intentionally designs an enhanced health care system that considers and incorporates the participation of small providers who offer high quality service, often at a lower cost. History has shown that patients want choice and options for care. Including smaller, specialty providers like PPLM as full participants in MassHealth ACOs will enhance care coordination, facilitate cost control, and ultimately will ensure patients access to choice. PPLM looks forward to continuing to be a partner to the Commonwealth on this important work.

Should you have any questions or want to discuss these comments further, please contact our Government Relations Manager, Leda Anderson, at landerson@pplm.org.

Sincerely,

Jennifer Childs-Roshak, M.D., M.B.A.
Chief Executive Officer



The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES
STATE HOUSE, BOSTON 02133-1054

REPRESENTATIVE
LIZ MALIA
111H SUFFOLK DISTRICT

CHAIR
Committee on **Mental Health & Substance Abuse**

ROOM 33, STATE HOUSE
TEL: (617) 722-2060
FAX: (617) 722-2849
Liz.Malia@mahouse.gov

Daniel Tsai, Assistant Secretary for MassHealth
EOHHS Office of Medicaid
One Asbnrton Place, 11th Floor
Boston, MA 02108

July 15, 2016

Re: Comments on Demonstration Extension Request

Dear Secretary Tsai,

I thank you for the opportunity to comment on the request to amend and extend the MassHealth 1115 Demonstration. It is clear that the transition to the ACO model of integrated healthcare is complex. I commend the efforts of all those involved and support many of the features of the proposed 1115 amendments, particularly the strong focus on behavioral health. With that said, I write to express my concern on two matters:

- **Cultural and Linguistic Competence:** I am very pleased to see attention to cultural and linguistic behavioral healthcare. It will be essential for ACOs to meet the needs of the people they serve, and have adequate culturally and linguistically appropriate providers. Community providers are best equipped to address the individual needs of people within the community, particularly with respect to behavioral health. Those struggling with substance use disorder or mental illness face a unique set of issues. Additionally in my district in Boston, for a significant portion of my constituents, English is not their first language. The community providers are uniquely situated to address the types of cultural and linguistic barriers that many people face when trying to find a good provider. As such, I write to strongly encourage the inclusion of language that would ensure ACOs are held to a high standard in providing culturally competent care, and are required to partner with community providers to best serve the needs of the community,
- **Access to Peer Support for Mental Health:** I am very encouraged to see such a strong support for the use of peer recovery for substance use disorders. As Chair of the Committee on Mental Health and Substance Abuse, I know how important peer recovery is for individuals struggling with the disease of addiction. However, peer support is also essential for those with mental health issues. Individuals with lived experience are in a position to offer those who are struggling with mental illness support, inspiration, and resources, by which they are able to thrive. As such, I also strongly encourage the inclusion of language relating to supporting peer specialists for the treatment of mental illness.

Again, I thank you for all of your hard work in completing a truly comprehensive piece around behavioral health. Please feel free to contact my office with any questions at 617-722-2060,

Sincerely,

Representative Elizabeth A Malia
Chair, Joint Committee on Mental Health and Substance Abuse





July 17, 2016

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to: masshealth.innovations@state.ma.us

Re: Comments on MassHealth 1115 Demonstration Extension Request

Dear Assistant Secretary Tsai:

Thank you for the opportunity to continue to contribute to the development of the MassHealth Innovations initiative and, specifically, the pending 1115 Waiver request. We appreciate the commitment that MassHealth has made to engaging and informing stakeholders throughout the development process.

We would like to briefly highlight a couple of issues prompted by our review of the draft 1115 Waiver and to ask that EOHHS address these issues more thoroughly in the RFRs that will be issued to procure Accountable Care Organizations, Managed Care Organizations and Certified Community Partners as well as in other related implementation activities. We would be pleased to participate in future stakeholder discussions to support the progression of MassHealth's thinking about these matters in advance of the release of the required procurements.

Community First and Long-Term Services and Supports

We appreciate and applaud the explicit acknowledgement that EOHHS intends to ensure that the 1115 Demonstration will continue the Commonwealth's long-standing commitment to Community First, enabling MassHealth members to access community services and live and be supported in settings of their choice. It is clear that the Community First policy has contributed substantially to a reduction in the utilization of institutional settings and a rebalancing of the Commonwealth's spending on LTSS. What is less well studied and documented is how the increased utilization of community services has contributed to the more appropriate use of primary and acute services, to the total cost of members' care, or to improved health outcomes for MassHealth members. We are hopeful that EOHHS will ensure that the evaluation of new accountable care models will address this limitation in our collective understanding.

1115 Waiver discussions regarding members with complex needs who use community-based LTSS have focused extensively on the mechanism by which the Commonwealth will ensure care coordination and comprehensive care management for these members. There has been, however, limited public discussion, led by MassHealth, regarding the infrastructure

improvements necessary to ensure that LTSS providers are fully prepared to participate in MassHealth's reform efforts.

Neither the One Care model that MassHealth has indicated will be the model for future LTSS integration and accountability, nor other integrated managed care models that have operated in Massachusetts for a number of years, have substantially evolved the capacity of LTSS providers or introduced significant flexibility or innovation in the delivery of such services. There is little evidence that future accountable care models will be positioned to support such an evolution in the near term and it is unclear whether MassHealth intends for the Third Party Administrator for LTSS, to be selected later this year, to contribute substantially to such development.

It is imperative, therefore, that accountable care-related procurements not only feature payment and financial models that are consistent with broad Community First goals, but also specifically incentivize the network development, delivery system and payment reforms that will enhance the capacity of LTSS providers. We believe that, with nominal infrastructure investments in platforms that allow LTSS providers to communicate and collaborate across community services and with health care providers, MassHealth can encourage long-overdue development of LTSS organizations and enable such organizations to provide substantial insight on MassHealth members, contributing meaningfully to the Commonwealth's goals for reform.

In advance of the release of the necessary procurements, we urge MassHealth to convene relevant stakeholders for a focused discussion about the requirements that should be included in those procurements to ensure that selected contractors have a clear understanding of EOHHS' specific goals for the integration and management of LTSS.

Family Caregivers

The 1115 Waiver acknowledges the need to make statewide investments in programs that will support the formal workforce, as the retention and development of that workforce is critical to the Commonwealth's goals for the delivery of quality care. Unfortunately, despite the relative importance indicated during MassHealth Payment and Care Delivery Workgroup meetings in 2015 and as highlighted in the recent MassHealth LTSS Vision report from the Blue Cross Blue Shield Foundation/MMPI which specifically identified the importance of caregivers, there is no substantive mention or implied initiative around informal supports in the 1115 Waiver. There is abundant evidence that family caregivers contribute as substantially as formal caregivers to the delivery of care and supports in Massachusetts and across the country and, absent their continued commitment, our public resources would be appreciably more strained.

We urge EOHHS to more explicitly acknowledge the important role that family caregivers play in the delivery of care, particularly with children and adults with disabilities. Accountable care reform must ensure that ACOs, MCOs, and CPs fully engage family caregivers, with members' consent, where possible, in person-centered care planning, care transitions and ongoing care coordination activities, at a minimum. Procurements issued by EOHHS should explicitly encourage contracted entities to explore innovations that include family caregivers more expansively in the entities' models of care. Finally, we recommend that EOHHS' evaluation of the

accountable care initiative include a specific assessment of such innovations, where implemented, and that EOHHS publish best practices and associated results.

LTSS Community Partners

We support EOHHS's proposal to connect ACOs with community-based behavioral health and LTSS organizations and the selection and certification of such organizations as Community Partners through a procurement mechanism that will ensure CPs meet appropriately high performance standards for the delivery of consistent, culturally-competent supports to MassHealth members across the Commonwealth.

EOHHS has acknowledged that permitting organizations that will be CPs to also deliver direct services and to self-refer obligates MassHealth to establish checks and balances that will mitigate potential conflicts. While there is limited experience across the country that suggests best practices for conflict mitigation in systems comparable to Massachusetts, it is clear that such strategies must include, at a minimum:

- the establishment of specific performance standards to ensure that care planning processes and activities are focused on the choices, goals and preferences of members and free from agency bias; and,
- a commitment to the resourcing and implementation of a robust monitoring and oversight process by the State.

EOHHS must use future procurements to articulate goals and establish requirements that will provide appropriate safeguards to reduce the potential for conflict and ensure appropriate member protections. Informed by practices in other States, these requirements may include features such as those listed below.

- The obligation for CPs to include in their RFR responses:
 - the identification of all programs from which the organizations derive financial interest;
 - the organization's policies and procedures that will ensure that employees act in the best interest of members;
 - a description of the practices the organization will use to ensure that members are informed of all options available to meet their needs, including when members present requesting a specific service or a specific LTSS provider.
- An express prohibition on CPs promoting their own direct service provider organization, if any.
- The obligation for CPs to provide members with a clear notice that: discloses potential conflicts, if any; informs members that they may select a different CP; advises members that they will receive information about the full range of services for which they are eligible; informs members that they have the right to choose their providers and the right to appeal plans of care.
- A requirement that selected CPs provide MassHealth, for MassHealth's review and approval, the member notices that the CP will use.
- A signed assurance from each member that s/he received and understood such notices.

- The obligation for the CP to document that a member was provided with choices and the systematic storage of such documentation in a manner that enables to State to easily and systematically retrieve the information necessary to monitor such activity.
- Regular reporting by CPs on the number of instances in which members chose to receive services from the CP's LTSS provider organization and from unrelated provider organizations.

Thank you again for the opportunity to provide these comments. We hope that our feedback is helpful and look forward to continuing our support of EOHHS' goals for MassHealth reform.

Sincerely,

A handwritten signature in black ink, appearing to read 'TRiley', with a stylized flourish at the end.

Thomas P. Riley
Chief Executive Officer and President



Zlrbe QCommontuealtb of ;ffmassachusetts

;ffmtbblesex bertff's fftce

Peter J. Koutoujian

Sheriff

400 Mystic Avenue
Medford, Massachusetts

Phone (781) 960-2800
Fax (781) 960-2902

July 14,2016

Secretary Marylou Sudders
Executive Office of Health & Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders:

As you continue your negotiations with the Centers for Medicare and Medicaid Services (CMS) regarding the MassHealth 1115 Demonstration Extension, I am writing to express my support for the expansion of treatment for individuals with a substance use disorder outlined in the waiver. In addition, I would like to commend your strong commitment to improving the integration and delivery of care for individuals with behavioral health needs and those with co-occurring disorders.

The Middlesex Sheriff's Office is on the front lines in this effort and shares the urgency to focus more resources in this area. Often times individuals involved in the criminal justice system are in great need of treatment for mental health and/or substance use issues that in many cases have gone untreated or undiagnosed. For example, on average 35% of the individuals in the custody of the Middlesex Sheriff's Office have open mental health cases and over 80% have a substance use issue.

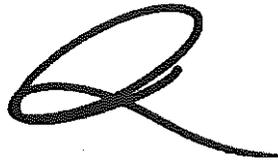
With 99% of the justice-involved individuals at the Middlesex House of Correction & Jail returning to the community, transitional assistance plays a critical role in a successful re-entry. To that end, I appreciate the expansion of recovery support services being included in the request as it will help address the needs of justice-involved individuals suffering from addiction. We have incorporated these services into our medication assisted treatment (MAT) program, and our recovery coach has been vital with assisting individuals in accessing the treatment and health care they need after leaving our custody.

An additional key component of transitional assistance provided for individuals re-entering the community is MassHealth enrollment. As you know, over the last two years we have been working with the Legislature and the Office of Medicaid on the full implementation of Section 227 of Chapter 165 of the Acts of 2014 which temporarily "suspends" rather than terminates MassHealth benefits for incarcerated individuals. A suspension of MassHealth during incarceration and reactivation of benefits after an inmate's release would eliminate the need to re-enroll upon release, providing them with immediate access to the medical care necessary to often times address the factors that led to their incarceration.

I was extremely pleased to see the Centers for Medicare and Medicaid Services (CMS) address this issue in their April guidance letter to state health officials regarding the facilitation of successful re-entry for individuals transitioning from incarceration to the community (attachment enclosed). As EOHHS finalizes negotiations, I respectfully request the Commonwealth explore the possibility of federal funding investment for improving eligibility systems to include the suspension function as outlined in question and answer number thirteen of the attached CMS letter. While the suspension of benefits may seem like a mundane technical change, several states across the country have embraced it as a tool to improve continuity of care, save tax payer dollars, increase the public safety and reduce recidivism.

Thank you for the opportunity to provide feedback in advance of the Commonwealth's MassHealth 1115 Demonstration Extension submission. I look forward to continuing to work with you to utilize health insurance as a tool to break the cycle of addiction and address the critical mental health needs of justice involved populations. If you have any questions or concerns, please contact David Ryan, Policy Director at (781)960-2833 if you have any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'P. Koutoujian', with a large, stylized initial 'P'.

PETER J. KOUTOUJIAN

SHO # 16-007

**RE: To Facilitate successful re-entry for
individuals transitioning from incarceration to
their communities**

April 28, 2016

Dear State Health Official:

The purpose of this letter and its attachment is to provide guidance on facilitating access to covered Medicaid services for eligible individuals prior to and after a stay in a correctional institution. This State Health Official Letter with attached Questions and Answers (Qs & As) describes how states can better facilitate access to Medicaid services for individuals transitioning from incarceration to their communities.

As a result of changes states are adopting in their Medicaid programs, individuals in many states who were previously uninsured now are eligible for Medicaid coverage, including a significant numbers of justice-involved individuals. While the Medicaid statute limits payment for services for individuals while residing in correctional institutions, Medicaid coverage can be crucial to ensuring a successful transition following incarceration. Many individuals in the justice-involved population have a high prevalence of long-untreated, chronic health care conditions as well as a high incidence of substance use and mental health disorders. Facilitating enrollment in Medicaid and supporting access to services following incarceration has the potential to make a significant difference in the health of this population and in eligible individuals' ability to obtain health services that can promote their well-being. Such enrollment will also help individuals with disabilities obtain critical community services to avoid crises and unnecessary institutionalization.

As states consider eligibility and coverage issues, many have asked questions about the longstanding provision of the Medicaid statute that excludes Medicaid payment for services provided to inmates of public institutions, including correctional institutions, except for services provided as "a patient in a medical institution". We address them in the following Qs & As. The Centers for Medicare & Medicaid Services (CMS) Center for Medicaid and CHIP Services (CMCS) welcomes the opportunity to work closely with states to identify ways to improve access to needed health care for individuals returning to the community following incarceration.

If you have any questions regarding the information in the Qs & As, please send questions to CMCSMedicaidQAinmates@cms.hhs.gov.

Sincerely,

Isl

Vikki Wachino
Director

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

Enclosure:

Questions & Answers

Section 1: Inmate Definition

Inmates of a public institution who are held involuntarily may be enrolled in Medicaid, but may not receive Medicaid covered services. The inmate coverage exclusion applies to Medicaid services to inmates, except as inpatients in a medical institution as provided in statute and described in Section 3 of this document.

Q1. Inmate Defined: *Who is an inmate of a public institution?*

Al. . Medicaid regulations at 42 Code of Federal Regulations (CFR) 435.1010 define an inmate of a public institution as "a person living in a public institution" and define a public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." A public institution includes a correctional institution. There are separate definitions for "child care institutions" and "publicly operated community residences," and we interpret such institutions to be in a separate category and therefore not included as public institutions for the purposes of identifying who is in an inmate in this guidance.

CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution, other than a child care institution, publicly operated community residence that serves no more than 16 residents, or a public educational or vocational training institution for purposes of securing educational or vocational training. Correctional institutions include facilities operated by, or under contract with, the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held involuntarily in lawful custody through operation of law enforcement authorities. Correctional institutions include state or federal prisons, local jails, detention facilities, or other penal settings (e.g., boot camps, wilderness camps). While correctional institutions may provide medical and related services, they are organized for the primary purpose of involuntary confinement. Thus, correctional institutions are never considered to be medical institutions (which are defined in 42 CFR 435.1010 to be organized to provide medical care).

We recognize that federal, state, local, and tribal authorities attach different names, conditions, and requirements to individuals in various custody arrangements. Regardless of the label attached to any particular custody status, an important consideration of whether an individual is an "inmate" is his or her legal ability to exercise personal freedom.

Q2. Individuals on Parole or Probation: *Is Federal Financial Participation (FFP) available for eligible individuals who are in the community on parole or probation, or have been released to the community pending trial (including those under pre-trial supervision)?*

A2. Yes. Individuals who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision) are not considered inmates, and thus are not subject to the prohibition on providing Medicaid covered services to inmates. If they are otherwise eligible for Medicaid, FFP is available for covered services provided to such individuals.

Q3. Residence in a Halfway House: *When is FFP available for Medicaid-covered services to individuals residing in state or local private or publicly operated corrections-related "supervised community residential facilities"?*

A3. FFP is available for covered services for Medicaid-eligible individuals living in state or local corrections-related supervised community residential facilities (whether operated by a governmental entity or a private entity) unless the individual does not have freedom of movement and association while residing at the facility. In order for FFP to be available for covered services for Medicaid-eligible individuals living in such a facility, the facility would have to operate in such a way as to ensure that individuals living there have freedom of movement and association according to the following tenets: (1) residents are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision; (2) residents can use community resources (libraries, grocery stores, recreation, education, etc.) at will; and (3) residents can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state. For this purpose, "at will" includes and is consistent with requirements related to operational "house rules" where, for example, the residence may be closed or locked during certain hours or where residents are required to report during certain times and sign in and out. Similarly, an individual's supervisory requirements may restrict travelling to or frequenting certain locations that may be associated with high criminal activity. To claim FFP for Medicaid-covered services furnished to Medicaid-eligible individuals while they are living in a supervised community residential facility, the state Medicaid agency must ensure that the facility meets the requirements described above.

Q4. Residential Reentry Centers: *Is FFP available for Medicaid-covered services to individuals residing in federal "Residential Reentry Centers"?*

A4. No. The Department of Justice, Bureau of Prisons (BOP) retains responsibility for payment of health care services rendered to individuals in Residential Re-entry Centers (RRCs). RRC residents previously enrolled in their state Medicaid program would have benefits suspended while serving a duly adjudicated term of incarceration in a federal facility or RRC.

RRC residents not previously enrolled in their state Medicaid program would be able to apply to their intended release state of residency for eligibility determination while incarcerated, but would not be eligible to receive Medicaid benefits until their status changed to home confinement, parole, probation, or full-term release.

QS. Free Choice of Provider: *Must individuals in transitional or supervisory arrangements have the ability to freely choose their Medicaid providers, as required in Federal law at Section 1902 (a)(23) of the Act?*

AS. Yes. Eligible individuals who are not inmates but rather who are in transitional or supervisory arrangements, as beneficiaries of the Medicaid program, have the same ability to choose their providers of health care services as afforded to other Medicaid beneficiaries in their states.

Q6. Individuals on Home Confinement: *Is FFP available if an individual is on home confinement?*

A6. Yes. An individual's private place of residence generally would not meet the definition of a "public institution", which is a component of the coverage exclusion, despite the involuntary nature of the home confinement scenario. FFP is available for expenditures under the approved state plan for covered Medicaid benefits furnished to eligible individuals living at home under home confinement.

Q7. Voluntary and Temporary Residence in a Public Institution: *Is an individual considered an inmate of a public institution if residing there voluntarily for a temporary period?*

A7. No. An individual is not considered an inmate when residing in a public institution voluntarily and the coverage exclusion does not apply. For example, FFP is available for services when an individual (if eligible and enrolled in Medicaid) is living voluntarily in a detention center for a temporary period of time after his case has been adjudicated and arrangements are being made for his transfer to a community residence. The voluntary nature of the residence is critical; an individual would be considered an inmate during temporary involuntary residence in a public institution imposed by the justice system (for example when confined pending trial) but not when the individual is free to leave, but is "residing in a public institution for a temporary period pending other arrangements appropriate to his needs" consistent with 42 CFR 435.1010.

Q8. Residence in Facilities for Treating Mental Health and Substance Use Disorders: *Is FFP available for mental health or substance use disorder services, furnished exclusively to inmates, in a residential treatment facility?*

AS. No. FFP is not available for services in a residential treatment facility for inmates who are involuntarily residing in the facility by operation of law enforcement authorities, since this facility would be a correctional institution (even if it were operated by a private entity under contract).

In addition to the inmate exclusion, the Medicaid statute also includes a coverage exclusion related to services for patients in Institutions for Mental Diseases (IMDs), which include residential treatment facilities of over sixteen beds that are primarily engaged in the diagnosis, treatment, or care of persons with mental diseases.¹

Q9. Applicability of other Medicaid Requirements: *Will services provided to individuals who have been released to the community be subject to any other requirements before being qualified for Medicaid reimbursement?*

A9. Yes. All Medicaid rules apply in determining the circumstances in which reimbursement is available, including the coverage exclusion for services provided to individuals who are in an MD and the Home and Community Based Services (HCBS) requirements relating to the provision of services authorized under 1915(c) HCBS waivers, 1915(i) HCBS state plan options, and 1915(k) Community First Choice programs.²

Section 2: Eligibility and Enrollment

Q10. Medicaid Eligibility While Incarcerated: *Does being incarcerated prevent an inmate from being determined eligible for or maintaining eligibility for Medicaid?*

A10. No. The inmate exclusion is a general coverage exclusion; it is not an eligibility exclusion. Incarceration does not preclude an inmate from being determined Medicaid-eligible. The state Medicaid agency must accept applications from inmates to enroll in Medicaid or renew Medicaid enrollment during the time of their incarceration. If the individual meets all applicable Medicaid eligibility requirements, the state must enroll or renew the enrollment of the individual effective before, during, and after the period of time spent in the correctional facility. Once enrolled, however, the state may place the inmate in a suspended eligibility status during the period of incarceration, or it may suspend coverage by establishing markers and edits in the claims processing system to deny claims for excluded services, as discussed below.

It should be noted that, due to Medicaid retroactive eligibility provisions at section 1902(a)(34) of the Social Security Act, FFP is available for Medicaid-covered inpatient services provided in

¹The exclusion for services provided to individuals who are in an Institution for Mental Disease can be found at section 1905(a)(29)(B) of the Act.

²The exclusion for services provided to individuals who are in an Institution for Mental Disease can be found at section 1905(a)(29)(B) of the Act; qualities of a home and community based setting are outlined in 42 CFR 441.301 (c)(4).

a medical institution to an inmate in the 3-month period prior to application, if the individual would have been Medicaid-eligible.

We strongly encourage correctional institutions and other state, local, or tribal agencies to take an active role in preparing inmates for release by assisting or facilitating the application process prior to release. Individuals can apply for Medicaid online at www.HealthCare.gov or through their state Medicaid agency or state-based Marketplace. If restrictions on internet access make it impossible or impractical for an inmate to file an online application, then a paper application may be used. A telephone application is another option; individuals may call the Marketplace call center at 1-800-318-2596 to apply 24 hours a day, 7 days a week. Correctional institutions and other entities should coordinate with their state Medicaid agencies in order to receive paper copies of forms. In accordance with federal regulations governing Medicaid applications at 42 CFR 435.907, state Medicaid agencies must accept applications that are submitted online, through the mail, or by phone.

We also support correctional institutions' efforts to transfer medical records to new primary care, mental health providers, substance use treatment providers, other specialists, and other providers to ensure continuity of care, including electronic means of maintaining and transferring such records. Various types of financial match are available for states to support these activities. In addition, federal Medicaid matching funds are available for application assistance and eligibility determination, assuming all other qualifications are met.

Q11. Financial Eligibility: *How does incarceration affect a Medicaid-enrolled individual's household income?*

A11. The effect of incarceration on an individual's financial eligibility for Medicaid depends on the individual's circumstances. For most individuals, financial eligibility is determined using modified adjusted gross income (MAGI), which is generally based on tax filing relationships and taxable income. There are no special rules or exceptions for incarcerated individuals. If the incarcerated individual does not expect to file taxes, then Medicaid financial eligibility would be based solely on the income of the individual.

Q12. Suspended Status: *How should states handle the situation when a Medicaid-enrolled individual is or becomes incarcerated?*

A12. To ensure that FFP is only claimed for Medicaid-covered inpatient services delivered to inmates in a medical institution, states should consider placing the eligibility of a Medicaid-enrolled inmate in a suspended status upon incarceration and/or setting up claims processing markers and edits to ensure that services are limited to only inpatient services. Other methods may also be used to accomplish the same result (suspending coverage instead of eligibility). A temporary suspension process maintains the individual's eligibility for Medicaid and provides for continuity of care so that the individual can immediately access Medicaid-covered services

upon release from the facility. Whatever approach is used, the suspension must be promptly lifted when the inmate exclusion no longer applies (e.g., upon release, or when the individual is admitted as a patient for inpatient treatment in a medical institution). Establishing proactive communication processes between the state Medicaid agency and state and local correctional facilities can help to ensure prompt notification of release and timely access to coverage.

Q13. *Feasibility of Suspended Status: Is it feasible for states' eligibility determination systems to accommodate a suspension process when a Medicaid-eligible individual is incarcerated? Are there resources available to support modernizing states' eligibility systems, to allow for suspended enrollment status?*

A13. Yes for both. While some states have a history of suspending eligibility for incarcerated individuals, others have faced challenges with their legacy eligibility and enrollment systems when placing Medicaid-eligible inmates in a suspended status. Addressing these challenges should be possible with the availability of enhanced federal funding for new or improved eligibility systems, as specified in the final rule, codified at 42 CFR 433.112, "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities, FR 2011-09340," published in April 2011 .

Q14. *Promoting Enrollment to Ensure Continuity of Care: What can states do in order to promote enrollment for Medicaid-eligible individuals who are incarcerated?*

A14. State Medicaid agencies can work with their local departments of corrections, prisons, and jails to assist incarcerated individuals, who may not have been enrolled in Medicaid at the time of their incarceration, to apply and receive an eligibility determination for Medicaid. Once enrolled, states may employ various approaches to suspend eligibility, such as implementing a claims processing edit, instead of terminating the Medicaid eligibility of an incarcerated individual. Suspension of eligibility or claims processing edits allow for individuals to retain eligibility for Medicaid-covered inpatient services provided in a medical institution while incarcerated. States and local jurisdictions, or their contractors, need to be proactive in notifying the state Medicaid agency of an inmate's release, to ensure timely removal of suspension or claims processing edits. This will ensure active Medicaid coverage at re-entry and timely access to the full array of Medicaid-covered services upon release. To further assist individuals exiting incarceration, states can encourage or require their Medicaid managed care entities to work with state and local correctional agencies to connect such individuals to needed health services upon release.

Q15. Eligibility and Transfers to Another State: *When an inmate is involuntarily transferred to a correctional institution out of the individual's home state, how does that affect the individual's eligibility for Medicaid and a state's ability to maintain, suspend, or terminate existing coverage?*

A15. If the inmate was incarcerated by a home state but sent to an out-of-state institution meeting the definition of "a public institution" under 42 CFR 435.1010, for any reason, including the home state not having capacity to house the individual, the home state remains the state of residence (see 42 CFR 435.403(b) and(e)). Therefore, in this scenario, the inmate would retain residency for purposes of Medicaid eligibility in the home state. The inmate would have Medicaid coverage from the home state for incurred costs for inpatient services provided within the exception to the inmate exclusion, even if such services were provided outside the home state.

Individuals who have committed a crime outside of their home state and are placed in a correctional institution in and by the state in which the crime was committed would be considered to be residents of that state while incarcerated, as provided at 42 CFR 435.403(h)(5). In these circumstances, it is, therefore, the responsibility of the state in which the individual is incarcerated to determine how eligibility is established and how inpatient costs incurred for the inmate would be reimbursed (e.g., claimed by the Medicaid agency under the exception to the coverage exclusion, if the individual is eligible for Medicaid in that state, or borne by the Department of Corrections in that state).

Q16. Home Addresses: *Can an individual incarcerated in a correctional institution be determined eligible for Medicaid in the state of incarceration using the correctional institution as the home address?*

A16. Yes. The correctional institution could be used as the home address for establishing residency for purposes of Medicaid eligibility, except in the scenario described in the preceding question, when the individual is placed in an out-of-state facility by their home state.

Q17. Avoiding Simultaneous Eligibility: *If an inmate is enrolled in Medicaid in the state in which he/she is incarcerated, does that Medicaid coverage need to be determined before he/she can begin the process of enrolling in Medicaid in the home state to which he/she will be returning upon release from the correctional institution?*

A17. There should not be simultaneous Medicaid coverage in multiple states. However, it would be possible to initiate an application for benefits in a second state prior to termination in the first state. In this situation, there should be communication between the respective state agencies to ensure there are no overlapping coverage periods.

Q18. Applying for Medicaid in a Different State: *Prior to release, can an individual incarcerated in a correctional institution apply for Medicaid in a different state in which the individual intends to reside upon release?*

A18. Yes. States can process applications of incarcerated individuals prior to the individual's release, regardless of whether the individual intends to reside in the same state or a different

state upon release. In the case of individuals who intend to reside in a different state, the address where the individual being released intends to live or the address of a probation or parole office or community residential facility may be used. We note that, in accordance with 1902(b)(2) of the Act and 42 CFR 435.403(h) and (i), Medicaid does not require an individual to have a fixed or home address in the state, but in that situation an address through which the state can contact the individual after release is needed. The effective date of eligibility would be the date the individual arrives in their new state of residence. Alternatively, if, for operational reasons, a state preferred to make eligibility effective prior to the date of release or arrival, the state could cover these individuals as non-residents, if these individuals otherwise meet the eligibility criteria in the state.

Q19. Filing an Application for a Different State: How does the application process work for an individual who is incarcerated and is preparing for release, but is not yet living in the state to which he or she is applying and intending to reside?

A19. Individuals who are incarcerated are permitted to file applications through modalities generally available to applicants in accordance with §435.907- i.e., online, by telephone and by mail. However, as a practical matter, states may need to employ a variety of approaches to assist with the determinations of eligibility and enrollment for individuals in this situation, depending on the systems' capability and operations in the state. We encourage states to work cooperatively with corrections facilities operated in their own and other states, as well as with the Federal Bureau of Prisons, to achieve as coordinated and seamless a process for these individuals as possible. CMS is available for technical assistance.

Q20. Agreements with Medicaid Managed Care Plans: How can states that use Medicaid managed care plans prevent capitated payments from being made on behalf of individuals who are incarcerated?

A20. States should establish agreements with their Medicaid managed care plans to ensure timely reporting in order to prevent capitated payments being made on behalf of individuals who are incarcerated. Contracts should exclude individuals who are incarcerated from the managed care plan, or provide for disenrollment from the plan when an enrollee becomes incarcerated. States should establish in their contracts that the state will recoup a capitated payment made on behalf of an enrollee who is incarcerated or a portion of a capitation payment for an individual who becomes incarcerated mid-month.

Q21. Eligibility under Alternative Benefit Plans: Is FFP available for inmates eligible under the new adult group for inpatient services covered under Medicaid Alternative Benefit Plans (ABPs)?

A21. The coverage exclusion applies generally to medical assistance, whether provided through an ABP or other coverage. FFP is available for services received during an inpatient

stay only pursuant to the inmate payment exclusion exception provided in statute and described in Section 3 of this document. States are not eligible for federal payments for services inconsistent with the exclusion.

Section 3: Services Covered Under the Exception to the General Coverage

Exclusion for Inmates

Q22. Services, Settings, and Conditions: *For which services and settings is FFP generally available under the inpatient exception to the general coverage exclusion for inmates?*

A22. To qualify for the inpatient exception, services must be covered under the state's Medicaid Plan, delivered in a prescribed setting in a way that is consistent with other terms of the state's Medicaid Plan, and provided by a certified or enrolled provider that maintains compliance with federal requirements. In this document, we use the term "federal requirements" to refer to all federal requirements, including the CMS Conditions of Participation (CoPs).

Under the law at section 1905(a)(29)(A) of the Act, FFP is only available for inpatient services furnished to patients in a medical institution (including services furnished by such providers during the inpatient stay, which is defined in CFR 435.1010 as a stay of 24 hours or more in which there is an admission of the individual to the facility as an inpatient on the orders of the practitioner responsible for the care of the patient).

Additional information about federal requirements for medical institutions is available through the Center for Clinical Standards and Quality, Survey & Certification Group and CMS interpretive guidelines for surveyors at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html>

Q23. Services Not Available to Others: *Is FFP available for inpatient services to inmates for conditions that Medicaid would otherwise not reimburse in an inpatient setting?*

A23. No. Covered Medicaid inpatient services are the same for all Medicaid eligible individuals, including individuals who are in a medical institution but who would otherwise be in a correctional institution. FFP is not available for services that are not otherwise covered under the state plan in that setting.

Q24. Third Party Resource: *Do state, local, and correctional entities meet the definition of a third party resource, for purposes of inpatient care provided to inmates of public institutions?*

A24. We do not require states to treat state, local, and tribal correctional entities as legally liable third parties, and Medicaid may pay primary to such entities for covered inpatient

services, unless the state has elected under state law to consider these entities as legally liable third parties.

CMS maintains its policy that state and local correctional entities are considered a source of third party coverage for purposes of the hospital-specific limit on disproportionate share hospital (DSH) payments when they, in fact, are obligated to pay for the services because Medicaid payment is not available. To the extent that services are under the exception to the inmate coverage exclusion, and Medicaid pays primary, uncompensated costs not paid by state and local correctional entities would be part of the Medicaid shortfall and could support DSH payments.

Q25. Outpatient Services: Is FFP available, under the inmate coverage exclusion exception, for outpatient services furnished by or in a local hospital emergency department, an urgent care center, a clinic, or a Federally Qualified Health Center/Rural Health Clinic?

A25. No. FFP is not available for outpatient services for inmates, including but not limited to services in a local hospital emergency department, an urgent care center, a clinic, or a Federally Qualified Health Center/Rural Health Clinic.

Q26. Contracts with Health Care Management Entities: Some state and local correctional entities contract with a health care management entity to provide medical services to inmates. Is FFP available for services to inmates provided by the health care management entity?

A26. No. FFP is not available for services furnished in a correctional institution to an inmate regardless of whether those services are provided through a health care management entity under contract with a correctional institution or between the health care management entity and the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe. FFP is available for inpatient services in a medical institution furnished by qualified providers with a provider agreement with the State Medicaid Agency under the circumstances described above. To the extent that state or local entities contract with a health care management entity to provide medical services to inmates, that health care management entity would be a liable third party for services under its contract. To the extent that services furnished during an inpatient stay in a medical institution affiliated with a health care management entity under contract with state or local entities are not included in the contract, the Medicaid program can pay for such services when within the scope of Medicaid coverage and provided to eligible individuals by a provider meeting federal and state requirements and Conditions of Participation.

Q27. Correctional Hospitals or Nursing Facilities: Can hospitals or nursing homes that exclusively serve inmates qualify for FFP?

A27. No. Hospitals, nursing facilities, or other medical institutions operated primarily or exclusively to serve inmates are considered correctional institutions and FFP would not be available for services. Nursing facilities and all medical institutions under this exception to the general exclusion must be operated as medical institutions generally available to the public, organized primarily for the provision of medical care, meet federal requirements discussed in A21, and meet the additional requirements of the definition of medical institution at 42 CFR 435.1010.

Q28. Additional Considerations: *In addition to the considerations included under the previous Qs & As, what other criteria must be applied when determining whether FFP would be available for costs of inpatient care provided to individuals otherwise in a correctional institution?*

A28. FFP is available for such inpatient care when the other factors identified in federal guidance are met and when:

- The overall nature of the medical institution is one of community interaction such that members of the general public may be admitted to receive services and admission into the medical institution or into specific beds within the institution is not limited to individuals under the responsibility of the correctional facility.
 - o For nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID, the same staff (i.e., physicians, nurses, aides) are generally available between any unit or wing and the remainder of the medical institution (Note: this does not preclude the deployment of staff with specialized expertise or experience working with individuals under the jurisdiction of the correctional system);
 - o For nursing facilities and ICFs/IID, the same services are provided between the units, departments or other locations and the remainder of the medical institution;
 - o For hospitals, the individuals are admitted to specific medical units based not on their status as inmates of a correctional institution, but rather based on their treatment needs and plan of care and generally are placed in units also serving other individuals with similar treatment needs and plans of care; and
- Allowable medical services are those provided under the state Medicaid Plan, at approved rates, as would be the case for any other similarly situated Medicaid beneficiary.

Q29. Hospital Conditions of Participation: *What requirements pertain to hospitals and other medical institutions serving inpatients who otherwise would be in correctional institutions? To which Conditions of Participation should hospitals pay special attention?*

A29. Hospitals and other medical institutions must meet all Medicaid requirements when serving patients who would otherwise be in correctional institutions as described above. This will be discussed in more detail in an upcoming companion CMS Survey and Certification memorandum.

Q30. Compliance: *Will states be able to take time to bring their claiming into compliance based on this guidance?*

A30. This guidance is intended to provide further clarification of policy. States that find that they are out of compliance with this guidance should contact their regional offices, including Medicaid Survey and Certification contacts, as soon as they are aware so that agreement can be reached on a path forward.



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July 15, 2016

Daniel Tsai
Assistant Secretary of MassHealth
Executive Office of Health and Human Services
Office of MassHealth
1 Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

Steward Health Care System LLC (Steward) writes to offer comments regarding the Section 1115 Demonstration Project Amendment and Extension Request ("Section 1115 Request"). We also write to express our strong support for the Administration's Section 1115 Request. The many innovative concepts included in this Section 1115 Request represent another major milestone that the Governor Baker -Polito Administration are advancing to improve health care access and reforms for Massachusetts residents. Steward continues to support these efforts, but also stands ready to implement these essential health care delivery reforms which will enhance access, lower costs and improve coordinated care for residents.

In that same spirit of collaboration and partnership, Steward respectfully submits this letter and requests EOHHS' consideration of the following:

- Publish detailed financial and spending information for proposals included in the request
- Provide additional details related to:
 - o Total cost of care methodology for accountable care organizations (ACOs);
 - o Expectations for the intersection of managed care organizations and ACOs;
- Clarify the role of MassHealth's behavioral health vendor in the ACO program;
- Ensure adequate DSRIP funding for state operation/implementation is dedicated to appropriate data infrastructure.

As you know, Steward is New England's largest community-based accountable care organization, encompassing ten hospital campuses and over 2,700 physicians and specialists, as well as advanced practitioners, nurses, home health, behavioral health and allied services professionals. All of Steward's acute care hospitals are classified as Medicaid disproportionate share hospitals (DSH). Steward serves a critical role providing care to low-income and vulnerable populations in the communities where our patients live and work. Steward was among the first in the nation to participate in Medicare's Pioneer ACO program and we are proud to be one of only 18 ACOs in the nation -just one of two in Massachusetts -participating in Medicare's Next Generation ACO program. We also eagerly anticipate the opportunity to

collaborate with MassHealth and community providers to implement an accountable care model for Medicaid members.

Since 2011, Steward has publicly advocated to both the Federal and State authorities regarding the inefficiency and quality shortfalls inherent in the Massachusetts Medicaid reimbursement model. The Section 1115 Request could not come at a more critical time. At over \$16B in annual spending -and now the State's largest payer with 1.8 million members- MassHealth provides coverage to about 25% of the Commonwealth's residents and makes up almost half of the State's annual operating budget.

Steward was one of the first providers in Massachusetts to move away from fee-for-service reimbursements and adopt value-based contracts with commercial insurers, especially contracts with downside risk. Steward was also one of the first providers in Massachusetts to publicly demonstrate that providers can deliver better care to patients at lower medical cost over time when they are reimbursed under global, risk-based payments that align incentives for providers across the care continuum.

Steward fully supports the Section 1115 Request and its goals, which include:

1. Advance payment and delivery system reforms that promote member-driven accountable care for MassHealth members that is coordinated and holds providers accountable for the total cost and quality of care;
2. Improve integration of physical health, behavioral health, long term care support services, and health related support services;
3. Maintain near universal coverage;
4. Sustainably support safety net providers to ensure continued access to care; and,
5. Address the ongoing substance abuse crisis through enhanced access to services.

There are certain areas of the Section 1115 Request where more information would be beneficial so that health care providers and community partners can proactively plan ahead to achieve these delivery system transformation goals, as well as to comprehensively understand the intricacies of this timely transition to alternative payments and accountable care models. We respectfully request EOHHS' consideration of the following for the final document:

Publish Detailed Financial and Spending Information

Steward recommends that MassHealth supplement the Section 1115 Request with additional financial data and detailed programmatic spending information to inform health care providers as they prepare for this important transition to accountable care. For example, while the document states that \$1.8B will be available over the next 5 years for Delivery System Reform Incentive Payments, the following details would be beneficial:

- The range of Per Member Per Year (PMPY) DSRIP payments for ACOs, and associated increased schedules for "ACOs with a higher percentage of revenue derived from the MassHealth/uninsured population"(page 43);
- The amount that will be dedicated for a "glide path" for certain safety net hospitals to transition to ACOs, in dollars or percentage;
- Percentage dedicated to investment in primary care and the associated activities fundable through those earmarked funds;
- Range of PMPY DSRIP payments by ACO model type, as well as for Behavioral Health and Long-Term Care Support Services Community Partners (CP), respectively.

In addition, regarding the Safety Net Care Pool (SNCP), the following details would assist providers to better understand the SNCP's future state:

- The Safety Net Provider Payments funding distribution by hospital;
- The total HSN funding amount;
- Uncompensated Care Pool funding distribution by provider type (e.g. hospitals, CHCs)
- MassHealth's methodology to determine hospitals that qualify for the Safety Net Provider Payments pool, including identification of the eleven hospitals that the state proposes will qualify.

Clarify Total Cost of Care Methodology for ACOs

While we strongly support MassHealth's transition from fee-for-service to accountable care, additional information on how the Total Cost of Care (TCOC) benchmark will be calculated is essential as providers consider shifting to ACOs. Steward recommends using MassHealth's newly proposed hospital rates resulting from the assessment impact to calculate the total cost of care benchmark. We also urge MassHealth to make adjustments to account for behavioral health patients and publish information regarding the reimbursements associated with the Commonwealth's behavioral health contractor when calculating TCOC.

Clarify Expectations for the Intersection of Managed Care Organizations and ACOs

As noted in the waiver document, Managed Care Organizations (MCOs) will play a significant role in the ACO models. Steward urges MassHealth to clarify if the budgeted total cost of care amount, including administrative functions required to support total cost of care management, for Models A and C will be higher compared to Model B. We also request additional clarity regarding how administrative costs will be factored into budgeted rates for different models. Lastly Steward recommends MassHealth makes clear who "drives" the relationship in the Model A and C ACOs. ACOs need clear authority to drive care management, utilization, data analytics, etc. and rely on MCOs for administrative support such as claims administration in order to successfully drive value for patients.

Clarify the Role of MassHealth's Behavioral Health Vendor in the ACO Program

According to the Section 1115 Request, behavioral health costs will be included in the total cost of care, but it is not clear how ACOs will have appropriate authority and control to meet Total Cost of Care targets for populations with behavioral health needs. Specifically:

- ACOs need clear and tangible authority under a Medicaid ACO to control care management, care coordination, and transitions of care across the continuum, as well as to be accountable for the communication/feedback loop between primary care and behavioral health.
- Especially for a population with high behavioral health needs, care management and care coordination should not have artificial barriers between behavioral health services and non-behavioral health services. When both a behavioral health carve out and an ACO are managing care for the same member, their care management approaches may be at odds with each other, compromising quality and increasing total cost of care.
- An ACO cannot drive financial alignment across providers throughout the full continuum of care without responsibility and authority for services across the full continuum of care -including both physical and behavioral.

Ensure Adequate DSRIP Funding for State Operations/Implementation is Dedicated to Appropriate Data Infrastructure

Payment and delivery system reforms outlined in the Section 1115 Request require timely access to claims data for MassHealth patients in order to accurately assess member risk and prioritize opportunities for ACOs to drive value for MassHealth. When outlining investments in the State Operations/Implementation category, we encourage EOHHS to invest in its data infrastructure and resources to share accurate and timely data with ACOs as frequently as possible regarding the members for which ACOs are accountable.

Thank you for the opportunity to comment on the Section 1115 Request. Steward is strongly supports the Administration's Section 1115 Request and is committed to continuing its collaboration with MassHealth.

Sincerely,

A handwritten signature in black ink, appearing to read 'Davia Morales', is written over a horizontal line. The signature is fluid and cursive.

Davia Morales
Chief Strategy Officer
Steward Health System LLC
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Boston, MA. 02116