Disability Advocates Advancing our Healthcare Rights

July 15, 2016

Daniel Tsai
Assistant Secretary for MassHealth
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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 housing[3] 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 224[8], 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 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,

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