HEALTH CARE FOR ALL

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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.
[4] Id. 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 publically 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.

Member representation in ACO governance 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]

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[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.

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[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

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[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

[17] Massachusetts 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.

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[18] 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.

[19] National Center for Chronic Disease Prevention and Health Promotion, (2002). *Fact Sheet: "Preventing Dental Cavities."* Centers for Disease Control and Prevention.

[20] 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.

[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.

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[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

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[24] The 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/eohhs/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;

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[32] Chawla, 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.

[33] See 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 is 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 and 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.

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[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

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[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.

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[52] 42 C.F.R. § 438.68.

[53] Ruttenberg, 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

[54] National Quality Forum. (Aug. 2012). Healthcare Disparities and Cultural Competency Consensus Standards. Retrieved from http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx.

[55] Blue 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 measures[57] 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.

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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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mographic_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.