



September 2, 2016

Submitted electronically via Medicaid.gov

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Comments on MassHealth 1115 Medicaid Demonstration Project Amendment and Extension Request

Dear Acting Administrator Slavitt:

The Center for Consumer Engagement in Health Innovation at Community Catalyst appreciates the opportunity to provide comments on MassHealth's Section 1115 Demonstration Project Amendment and Extension Request ("1115 request").

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation (Center) is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers.

Thus, working to ensure care is person and family centered is at the core of what we do. We have also been working to improve home and community-based services for consumers for the last five years, producing tools for consumer advocates and other stakeholders to use in seeking improvements, as well as weighing in with policymakers. It is this frame and experience that we bring to these comments to CMS.

MassHealth's 1115 request is a vital opportunity to restructure the delivery system to focus on improving quality of care and promoting the health of MassHealth members while ensuring the long-term sustainability of the MassHealth program. Accountable Care Organizations (ACOs) open the door to a MassHealth system that treats a member as a whole person, rather than as disconnected symptoms.

We work closely with advocacy partners in Massachusetts including the Boston Center for Independent Living, Disability Advocates Advancing our Healthcare Rights, the Disability

Policy Consortium and Health Care for All. They have all been deeply engaged in the state's stakeholder engagement process throughout the development of this waiver proposal and plan to continue working with MassHealth officials to ensure that implementation of the demonstration improves access to and quality of care for MassHealth members. As a result of this process, the Commonwealth's 1115 request contains numerous commendable elements such as:

- The **overarching goal of promoting member-driven, integrated, coordinated care** that includes physical health, behavioral health, long-term services and supports (LTSS), and social services.
- **Provisions intended to increase access to services**, including:
 - Eliminating copays for MassHealth members with income at or below 50 percent of the federal poverty level (FPL).
 - Providing continuous eligibility to coincide with the Student Health Insurance Program (SHIP) plan year or semester for enrollees receiving Premium Assistance.
- The **integration of oral health care**.
- The strong emphasis on **ACOs' collaboration with community-based providers** and the dedication of Delivery System Reform Incentive Payment program (DSRIP) funds for community partner capacity-building.
- **Enhanced services for beneficiaries with behavioral health diagnoses** including:
 - A strong role for Behavioral Health Community Partners (CPs) in care coordination.
 - The requirement that Behavioral Health CPs must either be a Community Service Agency (CSA) or have contracts with CSAs to provide behavioral health services to children.
 - Enhanced substance use disorders (SUD) services, including expansion of residential care and recovery supports.
 - Encouragement of preventive models such as Screening, Brief Intervention and Referral to Treatment (SBIRT).
 - Enhanced diversionary levels of care to meet the needs of members within the least restrictive, most appropriate settings.
- A restructuring framework that seeks to **incorporate linkages to social services in an effort to address social determinants of health**, including designating a portion of DSRIP funds for "flexible services."
- The **priority domains for quality measurement**:
 - Prevention and Wellness (including for sub-populations such as pediatrics, adolescents, oral, maternity)
 - Reduction of Avoidable Utilization
 - Behavioral Health/Substance Use Disorders
 - LTSS
 - Member Experience.

- **A multi-layered approach to consumer engagement and oversight**, including the requirements that:
 - ACOs include members in their governance boards.
 - ACOs establish Patient and Family Advisory Councils.
 - MassHealth creates a Delivery System Implementation Advisory Council.

Notwithstanding these commendable elements, we have included below comments on specific aspects of the waiver proposal which we believe must be addressed before CMS approves the 1115 request. Please note that many of these comments echo written comments, which we fully support, from our Massachusetts advocacy partner organizations noted above.

Benefits and Cost-Sharing

As noted above, there are numerous elements of the 1115 request which we support and which we believe will promote access for MassHealth beneficiaries to high-quality medical and social support services. We strongly oppose, however, the following proposed changes that would restrict access to care:

- Imposing 12-month Managed Care Organization (MCO) lock-in periods.
- Eliminating coverage of certain services in the Primary Care Clinician (PCC) plan.
- Increasing copays, and expanding the list of services to which copays apply, for PCC members.
- Potentially increasing premiums for enrollees with incomes at or above 150 percent FPL.

Cost-Sharing

We oppose MassHealth’s proposal to implement higher cost-sharing for PCC Plan members relative to ACO/MCO members, and, broadly increasing cost-sharing for MassHealth members. The waiver proposal refers to updating the out-of-pocket cost-sharing schedule including premiums and copays in 2018 – eliminating copays for those under 50 percent FPL, recalibrating the premium schedule for those over 150 percent FPL and expanding the list of services to which copays apply. However, the waiver proposal does not include a sufficient amount of detail to allow for meaningful comment. We understand that MassHealth intends to initiate a public stakeholder process before implementing these changes, which we appreciate. However, we believe that MassHealth should include more details in the waiver proposal itself explaining the rationale for waiving federal parameters around nominal cost-sharing and plans for reassessing premiums and copays in the MassHealth program. As many studies have shown, cost-sharing can have a negative impact on Medicaid beneficiaries’ access to critical health services.¹

¹ Kaiser Commission on Medicaid and the Uninsured, Premiums and Cost-Sharing in Medicaid (2013). Available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>; Ku, Leighton and Wachino, V., The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings (2005). Available at <http://www.cbpp.org/archiveSite/5-31-05health2.pdf>

PCC Plan Changes

Concurrent with its 1115 waiver proposal, MassHealth is proposing changes to the PCC Plan that penalize members who do not enroll in an MCO and/or one of the new ACO models. Specifically, the state proposes to:

- Eliminate coverage of chiropractic services, eyeglasses, hearing aids, orthotics or other state plan services.
- Increase copays.
- Expand the list of services to which copays apply.

These proposed changes will impose undue barriers to care for members remaining in the PCC Plan. The PCC Plan is a lifeline for medically complex patients, including many people with disabilities. The narrow provider networks and other restrictions that are part of the newly proposed MassHealth models may not meet their needs. Switching to an MCO and/or one of the new ACO models may disrupt their ability to see the providers they know and trust. Members should not have to choose between seeing their preferred providers and having access to the full range of MassHealth benefits.

Moreover, the state's proposal violates a fundamental precept of the Medicaid program: that categorically eligible individuals are entitled to receive all state plan services, and that children and youth under age 21 are entitled to all medically necessary services under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program. Upholding access to EPSDT, a mandatory benefit which 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, is critical. The screenings and services included in the EPSDT benefit are vital to children's long-term health and wellness because they are designed to identify problems and address them as early as possible. Without timely access to these important benefits, children may not receive the services they need to grow and thrive.

While we understand that MassHealth has stated its intention to limit PCC benefit cuts to adults 21 and over, we ask CMS to ensure that EPSDT benefits are preserved and also to reject the proposal to offer fewer benefits to adults in the PCC Plan.

Appeals and Grievances

We strongly support MassHealth's proposal that members in all ACO models have access to an ACO-specific grievance process, as well as existing appeals and grievance procedures for eligibility and coverage determinations. We also support the state's proposal for an external ombudsperson resource to help resolve members' problems or concerns.

We request that more details on the ACO-specific grievance process and the scope of responsibilities of the external ombudsperson be included in the waiver Special Terms and

Conditions (STCs). We also recommend that the One Care ombudsperson program be considered an applicable model, with certain improvements, including the ability to track and report systemic issues, and expanded capacity.

Network Adequacy

MassHealth should establish and make publicly and easily available its network adequacy standards for MCOs, the PCC Plan and ACOs, including time and distance standards. The standards should be developed in consultation with consumers, advocates and stakeholders. In addition, all ACOs should have continuity of care provisions and parameters for contracting with providers outside of the ACO. Finally, we ask CMS to require in the STCs that MassHealth put into place mechanisms to track and assess network adequacy in the new ACO models. For example, direct measures such as so-called “secret shopper” surveys, visits to providers and/or focus groups with consumers could be useful tools.

Member Education and Assistance

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

We urge CMS to require in the STC that MassHealth:

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

Community Partners

We are enthusiastic about the 1115 request’s strong emphasis on ACOs’ collaboration with community-based providers and support MassHealth’s proposal to connect ACOs with community-based behavioral health and LTSS providers, who can be certified as Community Partners (CPs) and receive direct DSRIP funds to build their capacity to work with ACOs. We request that CMS require in the STCs that MassHealth coordinate a public stakeholder process to determine the certification criteria which CPs must meet.

Long-Term Services and Supports

Because beneficiaries requiring LTSS are among the most vulnerable populations in Medicaid, we support MassHealth's plan to take a cautious approach to phasing in these services and taking into account lessons learned through the One Care program. We also support the utilization of LTSS CPs to offer care coordination and LTSS services. MassHealth should ensure that ACOs rely on community-based providers' expertise in serving people with disabilities and not over-medicalize the LTSS needs of members.

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

Oral Health

We are encouraged that the MassHealth's waiver proposal indicates plans to promote the integration of oral health into primary health care through a range of methods (e.g., inclusion of an oral health metrics in the ACO quality measure slate, contractual expectations for ACOs). However, we urge CMS to require in the STCs that MassHealth strengthen oral health integration in its ACO models by more clearly outlining a plan which includes phased-in dental services, targeted investments to help facilitate integration, and clarity around how dental services will be incorporated into the ACO total cost of care. We specifically recommend that the STCs require MassHealth to more fully and publicly develop the plan to:

- Integrate oral health into the usual and expected care provided on the primary care side. This includes establishing a meaningful oral health quality metric which is tied to national discussions and also established in consultation with Massachusetts oral health stakeholders.
- Phase in value-based financing for dental care. Because this will represent a significant change for the dental community, we recommend that a dental-specific pilot be launched to encourage innovation and identify best practices.
- Ensure needed investments in workforce development and Health Information Technology that will integrate medical and dental teams.

Children's Health

While children and youth make up 34 percent of MassHealth membership, the 1115 request does not specify how the different ACO models will address their unique needs. We recommend CMS require in the STCs that ACOs that serve children have the ability to support family members

and make linkages with other state agencies and with key community resources, such as schools (including Head Start programs), social services providers, state agencies and other services, such as Early Intervention programs.

Social Determinants of Health

We strongly support that MassHealth’s proposed restructuring framework seeks to incorporate linkages to social services in an effort to address social determinants of health, including designating a portion of DSRIP funds for “flexible services.” However, in order to ensure that ACO collaboration with social services providers will be meaningful and will most effectively address the needs of members, we recommend CMS require in the STCs that MassHealth convene a public process to determine the following.

- The amount of DSRIP funding allocated for flexible services. The proposed waiver states that the amount of funding dedicated to flexible services will be determined as a PMPY amount, but does not specify the overall funding amount for those services from the ACO DSRIP funding stream or parameters around how that amount will be determined. Without that information, it is difficult to determine if the funding level for flexible services will be sufficient to truly improve health status and outcomes and reduce cost.
- How DSRIP funds will directly reach social services providers. Effective linkages between clinical providers and community organizations take significant time and resources to build and maintain. Social service providers will need upfront investments for infrastructure support to establish connections with ACOs and Community Partners and ensure their ongoing functionality, including establishing new working relationships between organizations with different organizational cultures, methods of operating, and referral technology.
- How ACOs will be incentivized and held accountable for ensuring that collaboration with social services providers is both meaningful and robust. Incentives for ACOs to partner with community based social services providers must include accountability measures. MassHealth should commit to establishing clear process and outcome metrics to review ACOs and social services providers’ progress toward establishing partnerships and addressing the social determinants of health needs of members, similar to the metrics that MassHealth will establish with Community Partners.

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

Community Health Workers

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

While ACOs will have flexibility in how to structure care teams, including CHWs, we recommend that CMS require in the STCs that MassHealth formally incorporate the role of CHWs into the ACO models including as part of multi-disciplinary teams for high risk/high need members.

Quality and Outcome Metrics

Increased levels of risk for losses coupled with influence over utilization management shift the balance of incentives for providers, increasing the potential for ACOs to stint on care. MassHealth should set clear expectations for ACOs to establish internal monitoring mechanisms for under-service in order to safeguard against potential incentives to deny or limit care, especially for members with high risk factors or multiple health conditions. While we applaud MassHealth's priority domains for quality measures, we recommend that, prior to approval, CMS require MassHealth to submit a comprehensive ACO quality strategy that:

- Includes a measure of reduction in health disparities, including data collection by race, ethnicity, primary language, disability status, gender, sexual orientation, gender identity and other factors.
- Defines avoidable utilization and track progress in that area, while also measuring under-service and underutilization.
- Aligns LTSS measures with those used in the One Care program, adding specific measurement of growing community-based services.
- Broadens member experience metrics beyond the Consumer Assessment of Healthcare Providers and Systems (CAHPS) metrics to include patient reported outcomes measures, patient activation measures and the collection of open-ended patient narratives.
- Stratifies outcomes and other quality metrics by social and economic characteristics in order to appropriately target population health interventions, uncover and address health disparities, and improve how ACOs deliver care.

Oversight and Consumer Engagement

We applaud the 1115 request's proposals to create a multi-layered approach to ongoing consumer engagement and oversight. We recommend that CMS enhance these proposals by requiring in the STCs that MassHealth be held to specific expectations, for example, that:

- ACO-level PFACs must coordinate closely with the already established hospital-level PFACs.
- The Delivery System Implementation Advisory Council (Council) has significant authority to ensure the demonstration is meeting its goals, and to identify areas for improvement.
- The Council must include stakeholders, both clinical and non-clinical, including MassHealth members, community-based organizations, and social services agencies, as well as key state legislators and other policymakers.
- The Council continuously monitors and evaluates the program's implementation through the development and dissemination of a public dashboard.
- The development of system-wide, measurable goals for what we hope to accomplish by moving care to ACOs, such as reduced hospitalizations and institutionalization, improved quality of life, improved health outcomes, and reduction of health disparities.

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We appreciate the opportunity to provide feedback to CMS on MassHealth's 1115 request. Should you have any questions or wish to discuss these comments further, please contact me at 617-275-2827 or ahwang@communitycatalyst.org.

Sincerely,



Ann Hwang, MD
Director