



251 West Central Street
Suite 21
Natick, MA 01760

T 508.647.8385
F 508.647.8311
www.ABHmass.org

Vicker V. DiGravio III PRESIDENT / CEO
Karin Jeffers, LMHC CHAIR

ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE

September 1, 2016

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: The Association for Behavioral Healthcare's Comments on the Massachusetts Section 1115 Demonstration Application

The Association for Behavioral Healthcare (ABH) is a Massachusetts association representing more than eighty community-based mental health and addiction treatment provider organizations statewide. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people.

ABH believes the Commonwealth's proposal recognizes the need for better care integration among physical health, behavioral health, long-term services and supports and health-related social services. The proposal includes significant design elements to move toward this goal.

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

Community-Based Service Expertise

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

Based on the experience of our members, ABH believes that there must be **explicit requirements that ACOs partner with existing community-based behavioral health service providers**. Specifically, ABH recommends that ACOs be required to have partnerships across the continuum with community-based behavioral health organizations pursuant to the HPC certification criteria and demonstrate these partnerships by submitting affiliation agreements, referral agreements, and/or subcontracts with community-based behavioral health providers for

the provision of behavioral health services as evidence of these partnerships to MassHealth. For Models A (if an existing MCO) and C, the MCO should be required to ensure care continuity by demonstrating that their networks includes a **minimum threshold of those provider organizations that provided 80% of the last 12 months' non-hospital behavioral health spend for the ACO's enrolled members.**

Member Choice: BH Service Provider

MassHealth members' choice of primary care clinician (PCC) will drive how they receive care and how their care is coordinated. Section 4.1.8 states that “[w]hile special attention will be paid to maintaining primary care relationships in assignment and attributions, members will need access to accurate information about the full range of health services offered.” ***Preserving the treating relationship between a MassHealth member and his or her behavioral healthcare provider is as important as preserving primary care relationships***, and for some MassHealth members, it will be more important. MassHealth, its MCOs and its ACOs must make similar efforts to maintain these relationships. Specifically, we recommend improvements to ensure informed member choice,¹ required inclusion of existing specialty and behavioral healthcare providers on interdisciplinary care teams, and concrete measures to ensure continuity of care.²

Service Investment, Model Changes and Access

ABH is concerned about the persistence of insufficient access to community-based outpatient services for MassHealth members. Both Community Partner organizations and ACOs will struggle to access these services without a significant investment by MassHealth in the community-based system.

Outpatient services are the bedrock of community-based behavioral healthcare services. Care coordination and care management will not be effective if treatment services cannot be accessed within a reasonable period of time. ABH understands that the DSRIP initiative is not intended to be a rate increase for providers. However, we remain concerned that without a sustained ***investment*** in outpatient behavioral healthcare services for safety net providers,³ access issues will grow worse for MassHealth members. Low reimbursement rates make it difficult if not impossible to attract and retain staff, at the professional and paraprofessional level, and vacancies can cause access delays.⁴ A recent ABH member survey indicated challenges to broad access to sustainable outpatient services including lengthening assessment wait times, reduced capacity and financial instability. **ABH recommends that MassHealth make additional, sustainable investment in outpatient behavioral health services.**

¹ E.g., a member should be able to learn with a single phone call or website visit whether his/her providers – including primary care, behavioral health, and other specialty – participate in the ACO and/or MCO that s/he is considering.

² ACOs should be required to demonstrate that their networks include providers who delivered at least 80% of the last 12 months' non-hospital behavioral health spend for the ACO's attributed members in the preceding year or another recent 12-month period that MassHealth can use to make this calculation. It is crucial during this period of significant transformation in the delivery system that continuity of treatment be maintained for this vulnerable population.

³ 90% of ABH respondents report a third-party payer mix that was at least 63% publicly funded (MassHealth and Medicare). For half of our members, MassHealth and Medicare accounted for 90% of third-party revenue.

⁴ A 2013 Massachusetts Behavioral Health Partnership/PCG Health analysis to determine whether MBHP's outpatient rates covered the cost of a range of outpatient services showed that almost all outpatient services were paid at rates significantly below cost. It is important to note that MBHP rates, still below costs, typically *exceed* the MassHealth fee-for-service schedule where a comparable service exists.

The ACO initiative should also incorporate lessons from the Children’s Behavioral Health Initiative (CBHI), which has embraced non-medical staff such as family partners to help families achieve better outcomes for their children, and it has piloted an alternative payment model (APM) for its care coordination and family partner services.⁵ In addition, the initiative has required that the MCEs be uniquely aligned in terms of services offered and access to these services. This approach has improved experience and outcomes for families. These lessons could be applied to other populations.

Community Partner Design and Investment

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

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

Behavioral Health Community Partner Certification

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

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

Community Partner Member Assignment

Section 4.2.3.1 indicates that MassHealth will identify members who might benefit from Community Partners (CP) services. Information on these members will be provided “to the CPs as well as the ACOs to facilitate outreach to the member and *subsequent screening and*

⁵ ABH understands that early APM pilot data show better staff morale, greater staff retention, and increased focus on quality/clinical service delivery.

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

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

Community Partner Development and Capacity

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

ACO Accountability

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

- the percent of all ACO members with BH diagnoses (not only those who are BH CP participants) that receive care from community-based providers; and,
- whether their utilized network includes community-providers that collectively provided 80% of the last 12 months’ non-hospital behavioral health spend for its attributed members.

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

BH CP Accountability

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

In addition, CPs will be evaluated for at-risk DSRIP funding using composite accountability scores that include “process measures, quality measures, and ACO/MCO evaluation of CP performance, with various measures phasing in over time.” Given that the BH CP will have no ability to pay for flexible services and limited control over managed care authorization processes, ABH has **strong concerns** about this approach to quality and ACO/MCO performance evaluation.

Substance Use Disorder Services

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

Cross-Model Consistency

The proposal envisions MCOs and ACOs as complementary, with MCOs “working with ACO providers to improve care delivery and coordination” and helping “determine which care management functions are best done” by providers vs. MCOs (See proposal Executive Summary). The proposal also states that “MCOs may also help ACOs determine how best to integrate behavioral health (BH) and long-term services and supports (LTSS) Community Partners into care teams.” Because of the potential for a proliferation of arrangements, the Commonwealth should have sufficient standardization to minimize confusion among MCO-contracted providers, ACO-affiliated and -unaffiliated providers, and MassHealth members.⁶ This is consistent with the Center for Health Care Strategies (CHCS) recommendation that states establish consistently defined standards across core activities to simplify ACO administration and monitoring, while also making it easier for MCOs to administer and less expensive for specialists that might participate in multiple ACOs to participate. CHCS notes that States clearly “defining ACO and MCO roles, implementing the program effectively, and aligning ACO activities across

⁶In its MCO procurement, MassHealth should seek greater consistency across plans. For example, the PCC plan along with One Care plans pay for highly effective, evidence-based Program of Assertive Community Treatment (PACT) services, but the MCEs do not. There is no logical reason why MassHealth member access to this medically necessary service is contingent upon managed care plan type.

Medicaid payers are crucial aspects of ACO success in a managed care environment.”⁷ This will also be important in avoiding duplication of functions and services.

Transparency

During systems transformation and payment reform, it will be important to have numerous indicators against which to measure current and future states for both ACOs and MCOs. Transparency is more vital than ever with the ongoing shift of Medicaid membership to managed care and the allowance under managed care rules to allow plans to certify or attest to requirements, at least in part, such as medical loss ratio, parity compliance, network adequacy, etc.. ABH recommends non-performance based reporting and transparency requirements be mandated for ACOs and/or MCOs, as appropriate, to establish baselines and to help better understand how systems transformation is impacting MassHealth members in aggregate, but also subpopulations within the membership.⁸

Conclusion

The Demonstration extension and amendment request outlines potentially transformative proposals to meet the needs of MassHealth members with significant behavioral health needs. The Commonwealth has been transparent and proactive to an unprecedented degree throughout this process. Proper attention to the details of design and implementation will be crucial to how successful we ultimately are in achieving this transformation.

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

Sincerely,



Vicker V. DiGravio III
President/CEO

⁷ [The Balancing Act: Integrating Medicaid Accountable Care Organizations into a Managed Care Environment](#), Policy Brief, Center for Health Care Strategies (November 2013).

⁸ Examples might include 1.) annual reporting on MassHealth spending – broken down by level of care - on behavioral health services, primary, acute care, emergency services, pharmacy, and other specialties; 2.) reporting on Massachusetts Health Policy Commission-required ACO demographic information; 3.) documenting approaches to incorporating behavioral health into care management; 4.) reporting on the numbers and percentages of individuals eligible for CP participation and those that actually assigned to a CP for care coordination; 5.) reporting on methods and processes to coordinate care throughout an episode of care and during level-of-care transitions both inside and outside the ACO; 6.) documenting plans to prevent disparities in care; and 7.) documenting approaches to shared savings.