



September 1, 2016

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

*Submitted online at medicaid.gov*

Re: Comments on 1115 Medicaid Demonstration Extension Request

Dear Administrator Slavitt,

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

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

We have included below comments on specific aspects of the waiver proposal. Many of the undersigned organizations plan to also submit separate, and complementary, comments for your consideration.

## **Benefits and Cost-Sharing**

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

We support provisions in the waiver proposal intended to increase access to services for MassHealth members, including:

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

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

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

## ***Cost-Sharing***

We oppose MassHealth's proposal to implement higher cost-sharing for PCC Plan members relative to ACO/MCO members, as well as potentially increasing cost-sharing for all 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% FPL, recalibrating the premium schedule for those over 150% 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.

## ***PCC Plan Changes***

We understand that MassHealth is proposing changes to the PCC Plan in order to incentive members to enroll in an MCO and/or one of the new ACO models. However, the proposed policies will impose barriers to care for members remaining in the PCC Plan. We urge CMS to ensure the final waiver proposal does not include reduced benefits for PCC Plan members.

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

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

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.

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

Further, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a mandatory Medicaid service for children and youth under age 21.<sup>2</sup> EPSDT includes all medically necessary Medicaid services regardless of services included in the state plan, and provides comprehensive coverage for dental, vision, hearing, and medical screenings and treatment. Children enrolled in all types of managed care, including PCC Plans, “are entitled to the same EPSDT benefits they would have in a fee for service Medicaid delivery system.”<sup>3</sup> The PCC Plan cuts, if applied to children and youth, would violate EPSDT requirements.

We recently have been informed that MassHealth has removed from their waiver proposal application of the PCC benefit cuts to children under age 21. We strongly support this decision, as applying differential benefits to children and youth enrolled in different Medicaid delivery systems violates EPSDT requirements and imposes barriers to care for children and youth, especially those with special health care needs. We further encourage CMS to ensure that the overall proposal to offer fewer benefits to adults in the PCC Plan is not included in the approved waiver.

### **Appeals and Grievances**

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

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

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

<sup>3</sup> 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>.

### **Network Adequacy**

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

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 ensure MassHealth has in place mechanisms to track and assess of network adequacy with the new ACO models. For example, direct measures such as so-called "secret shopper" surveys, which have been used effectively in Medicare and other state Medicaid programs to reproduce the member experience, could be a useful tool.

### **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.

Along with the waiver proposal, MassHealth should develop plans to:

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

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

### **Access to Services and Care Delivery**

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

### **Community Partners**

One of the unique features of MassHealth's proposal is the strong emphasis on ACOs' collaboration with community-based providers. Most of these organizations already serve a high volume of MassHealth members and play a significant role in care coordination and connecting members with non-medical services. We support MassHealth's proposal to connect ACOs with community-based behavioral health and LTSS providers, who can be certified as Community Partners (CPs), and 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 also appreciate that MassHealth

plans to coordinate a stakeholder process to determine the certification criteria which CPs must meet. We believe these criteria must include cost, quality and outcomes goals as well as checks and balances to guard against excessive self-referral.

### ***Long-Term Services and Supports***

We support MassHealth's plan to phase in integration of LTSS into ACOs, and the utilization of LTSS CPs to provide care coordination and LTSS services. MassHealth, along with CMS, 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 be from an independent, conflict-free entity 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.

### ***Behavioral Health***

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

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

### ***Oral Health***

We are encouraged 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). We urge CMS to ask MassHealth to strengthen oral health integration in its ACO models by more clearly outlining a plan which includes phased-in dental services and targeted investments to help facilitate integration and more clearly outline their plan to integrate dental services into the ACO total cost of care.

We specifically recommend that the waiver identify more fully 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.
- *Pilot value based financing for dental care.* The current system is not meeting the significant need for oral health care. Oral disease is almost completely preventable, but it continues to be a significant problem for both children and adults. The dental community should have the opportunity to test new methods of service delivery and payment. We recommend that a dental-specific pilot be launched to encourage innovation and identify best practices. MassHealth’s proposed waiver indicates plans to include dental into the TCOC model, but more details are needed within the waiver.
- *Ensure needed investments in workforce development and Health Information Technology that will integrate medical and dental teams.*

### **Children’s Health**

Children and youth have specialized needs that are not adequately addressed in a system built for adults. While children make up 34% of MassHealth membership<sup>4</sup>, the waiver proposal does not specify how the different ACO models will address the unique needs of children. ACOs should emphasize prevention and early interventions with children and their families. Unlike most adult care models, the family plays a far more critical role in managing a child’s care. Family experiences can provide a wealth of useful data and information in shaping some of the core elements of an ACO. All ACOs that serve children should have the ability to support the family and make linkages with other state agencies and with key community resources, such as schools (including Head Start programs), social services providers, state agencies and other services, such as Early Intervention.

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

### **Population Health and Prevention**

#### ***Social Determinants of Health***

We 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, we are concerned that the waiver proposal does not adequately ensure that ACO collaboration with social services providers will be meaningful and will most effectively address the needs of members. In order to ensure meaningful collaboration, we recommend that the final waiver contain more detailed parameters for the following:

- *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 per member per year (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

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<sup>4</sup> 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](http://www.bluecrossfoundation.org/sites/default/files/download/publication/MassHealthBasics_Chartpack_FY2015_FINAL_1.pdf).

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.

MassHealth should also take a broad and flexible approach in determining the criteria that must be met to pay for such flexible services, to encourage ACOs to innovate around how to use DSRIP funds to address social determinants of health.

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).<sup>5</sup> We recommend that MassHealth consult with DPH and incorporate lessons learned from PWTF, especially in regards to community partnerships. Another promising idea to ensure members have the broadest access to social services agencies is through a social services "hub." Such a hub can offer a single point of coordinated access to a wide range of social services which have a documented impact on health outcomes and on reducing the cost of care. With any model connecting medical care to social supports, MassHealth should work to promote access to all available services, such as nutrition (e.g. SNAP and WIC), housing, income, and child care supports.

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

### **Community Health Workers**

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

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<sup>5</sup> 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).

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

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

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

### **Quality and Outcome Metrics**

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

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

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

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

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

### ***Monitor and Track Underutilization***

Increased levels of risk for losses coupled with influence over utilization management shift the balance of incentives for providers, increasing the potential for ACOs to stint on care. 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. MassHealth should further conduct retrospective monitoring of under-service by assessing claims data and health outcomes over time to identify patterns of variation, which should be part of ACOs' quality metrics and reporting.

### **Transparency, Oversight and Member Engagement**

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

and procedures. In addition, the ACO-level PFACs must coordinate closely with the already established hospital-level PFACs.

We further applaud MassHealth for its plans to establish a Delivery System Implementation Advisory Council, which we understand will have a meaningful role in identifying issues and solutions in MassHealth restructuring and ACO implementation. The council should have significant authority, and include stakeholders, both clinical and non-clinical, including members, community-based organizations, and social services agencies, as well as key state legislators and other policymakers. The council should also serve as a public forum to provide accountability to make sure the demonstration is meeting its goals, and to identify areas for improvement.

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

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

Sincerely,

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Action for Boston Community Development,  
Inc.  
AIDS Action Committee of Massachusetts  
Alliance of Massachusetts YMCAs  
The Arc of Massachusetts  
Boston Center for Independent Living  
Center for Living & Working, Inc.  
Children's Mental Health Campaign  
Community Servings  
Disability Law Center  
Disability Policy Consortium  
Easter Seals Massachusetts  
Ethos  
Federation for Children with Special Needs  
The Greater Boston Food Bank  
Greater Boston Interfaith Organization

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

Cc: Vikki Wachino, Deputy Administrator and Director, Center for Medicaid and CHIP Services  
Eliot Fishman, Director, State Demonstrations Group  
Dan Tsai, Assistant Secretary for MassHealth, Massachusetts Executive Office of Health and Human  
Services