

August 31, 2016

**Comments to the Centers on Medicare and Medicaid Services on Massachusetts' Section 1115 Demonstration Request**

By electronic submission

<https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1887395>

On behalf of the Massachusetts Law Reform Institute thank you for the opportunity to comment on the Commonwealth of Massachusetts' Section 1115 Demonstration Project Amendment and Extension Request. As a legal advocacy organization representing low income families, MLRI offers the following comments in the interests of our MassHealth clients.

We support the goals of the demonstration: promoting integrated and coordinated care, improving integration of services, maintaining near universal coverage, supporting safety net providers and expanding access to services to address substance use disorders. The Commonwealth has provided many opportunities for public participation as it has developed its proposal over time and we look forward to continuing to work with the MassHealth agency on the many details of implementation which will determine how the transition to Accountable Care Organizations and managed long term services and supports will affect MassHealth beneficiaries.

However, we oppose certain specific features of the demonstration that are not necessary to achieve the demonstration's goals and do not promote the objectives of the Medicaid Act. Our comments focus on the specific changes requested to the current Demonstration in section 8 and how the proposed changes will affect the MassHealth member's experience of care and promote the objectives of the Act.

**8.2 Advancing Accountable Care**

"Massachusetts requests authority to implement a program to contract with and pay ACOs under the models described in Section 4, including for an ACO Model B pilot starting this year."

Two of the three payment models will involve Managed Care Organizations where consumer protections are well-defined. See 42 CFR Part 438. It is our understanding that the state is not seeking to waive or avoid compliance with the Medicaid managed care rules applicable to MCOs, PIHPs, and PCCMs. However, the broad authority sought for Model B ACOs with which the state will be entering into risk-based contracts that may allow or require shared savings or losses to be passed on to direct service providers, and for advanced Model B ACOs that involve pre-paying ACOs in lieu of paying direct service providers raise many concerns. It is not clear the extent to which Model B will be subject to the requirements or protections in 42 CFR Part 438. It appears that Model B will continue to employ a PIHP for behavioral health, but not clear if it, or the ACO, will also be regulated as a PCCM entity. Our fear is that Model B will fall into a regulation-free zone. Further, existing managed care consumer protections are not enough. They do not address the risk that if direct providers have a financial stake in the shared savings

or losses of the ACO, it may lead them to stint on care in ways that will not be visible to their patients.

If Model B is authorized under § 1115 “expenditure authority,” it should specifically cross-reference to essential consumer protections in 42 CFR Part 438 to the extent applicable to the role of the ACO. Among these essential protections are: §§ 438.10 (information requirements and anti-gag rule), 438.52-.54 (enrollment rights), 438.100 (enrollee rights, information on treatment options), 438.206-.210 (access to services, second opinion, out of network services, language access), 438.400 et seq. (notice and appeal rights). With respect to risk at the direct provider level, particularly in the early years of the demonstration, it should include only upside risk for meeting or exceeding quality targets. Individual provider decisions should be driven by expected outcomes not costs.

### 8.3.1 Benefit Differences Across Delivery Systems

“In order to encourage eligible MassHealth members to enroll in an MCO or ACO rather than the PCC Plan, MassHealth proposes to provide selected fewer covered benefits to members who choose the PCC Plan, such as chiropractic services, eye glasses and hearing aids. MassHealth seeks to expand its existing waiver of comparability provisions established under Section 1902(a)(10)(B) of the Act to support this proposal.”

We understand that the state is now limiting its proposals to adults over age 21 and thank CMS for its vigilance in protecting the rights of children under EPSDT. However, we remain strongly opposed to this proposal. It does not promote the objectives of the Act to deny low income parents with children, childless adults and adults with disabilities access to state plan services based on their choice of managed care plan. We are not alone in this opposition. Among the comments submitted to the Commonwealth, at least 14 comments opposed or expressed strong reservations about this proposal including comments signed by consumer groups such as the Massachusetts chapter of AARP, Health Care for All, comments from 29 consumer organizations, the comments of the ACT Coalition comprised of 58 consumer and provider organizations and of DAAHR, a disability rights coalition. Opposition or strong reservations were also included in the comments of providers groups such as the Massachusetts Hospital Association, Massachusetts Medical Society, the Massachusetts League of Community Health Centers and the Association of Behavioral Healthcare. We note that in other respects most of these comments support the demonstration’s transition to Accountable Care Organizations.

The type of punitive measure is not needed to “encourage” members to enroll in the new Accountable Care Organizations (ACO). Members will generally be attributed to an ACO based on their choice of primary care clinician. If a PCC has joined an ACO, then a member choosing that PCC will be enrolled in an ACO. Conversely, if a PCC chooses not to enroll in an ACO, a MassHealth member desiring to remain with that PCC will not be in an ACO. MassHealth beneficiaries should not be forced into the untenable choice of retaining a long time provider or forgoing eyeglasses, hearing aids, orthotics or other services. Members who do not make a plan selection, typically 30 percent of mandatory managed care enrollees, are assigned to a plan by default. This is another point at which the agency can “encourage” enrollment in ACOs without the necessity of restricting benefits. Further, to the extent ACOs succeed in achieving the demonstration’s goals, providing comparative quality information is yet another non-punitive way of encouraging ACO enrollment.

The proposal gives examples of the kinds of benefits it would not provide to members enrolled in the PCC Plan, but seeks authority to exclude any type of benefit, mandatory or optional, to adults enrolled in the PCC Plan, categorically eligible or not. It proposes to set aside fundamental precepts of the Act-- that categorically eligible individuals are entitled to all state plan services, and that people enrolled in managed care are entitled to the same services as those enrolled in fee for service--but advances no reasonable hypotheses for doing so.

Under the Medicaid Act, the state must provide all state plan services to categorically eligible individuals in its Medicaid program. 42 USC § 1396a(a)(10)(B). The state currently has a limited waiver of this provision but it is for the purpose of providing enhanced benefits in managed care not fewer benefits. Section 4.4 provides the following examples of services: chiropractic, orthotics, eye glasses and hearing aids. These are all optional services that the state has elected to provide through its state plan to categorically eligible individuals. In Massachusetts the categorically eligible include pregnant women, parents, individuals with disabilities, the elderly, and other adults. They are entitled to all state plan services regardless of their choice of managed care. See, 42 CFR § 438.206 (a).

The State's proposal also violates state law. The services identified to date were all services provided in the PCC Plan in Jan. 1, 2002. Under state law, the MassHealth agency is not empowered to offer fewer services than those covered in Jan. 1, 2002 except with respect to dental services. M.G.L.c. 118E, § 53 as amended by GAA SFY 2017, Acts of 2016. In January 2016, the Governor proposed legislation for the state fiscal year 2017 budget that would have authorized the agency to "restructure" any benefits notwithstanding c. 118E, § 53. Both the House and the Senate rejected the Governor's legislation and it was not enacted. The demonstration proposal to deny services to those enrolled in the PCC Plan would violate state law, and the Secretary has no authority to waive state law.

The proposal would penalize beneficiaries who choose a managed care option the state has elected to make available. The proposal is testing a new delivery model, ACOs, but the punitive restriction of benefits is being applied only to the PCC Plan not to MCO network physicians who are not in an ACO. The agency has advanced no reason to show why the PCC Plan is a less desirable option than an MCO. Both HEDIS reports and CAHPS show more variation among MCOs than between the PCC Plan and the MCOs. Further, access to certain hospitals is increasingly problematic in the MCOs compared to the PCC Plan. This includes hospitals that provide specialty care important for people with disabilities and complex medical needs as well as hospitals that dominate the market in rural parts of the state.

Further, the PCC Plan and the Partnership have initiated many innovative programs for people with complex medical needs such as housing supports for chronically ill and homeless adults that the state is now proposing to extend to the MCOs. The PCC Plan and the Partnership won a CMS Innovation award for its recovery peer navigators for repeated users of detox services. It also offers an integrated care management program for members with complex medical and/or behavioral needs.

Under the current demonstration, CMS has approved an innovative pediatric asthma bundled payment for the PCC Plan. Despite the years of effort that went into designing the pediatric asthma bundled payment, approved by CMS in July 2014, it has never been implemented. Now that the PCC Plan will continue to provide full benefits for children, the pediatric asthma initiative still could and should be implemented.

Finally, to the extent the demonstration is testing a hypothesis about how care delivery can be improved. The PCC Plan, with the full menu of state plan benefits, can provide a valuable source of information to compare outcomes to the new models of care.

### 8.3.2 Enhanced Benefits to Treat Substance Use Disorder

We strongly support this timely and important expansion of services for MassHealth beneficiaries across all delivery systems, and urge CMS to approve it.

### 8.3.3 [Flexible services]

“MassHealth also requests authority to include additional flexible “in lieu of” services, as described in Section 4.2.2 in the Demonstration and offer these benefits under managed care, including through MCOs and Model A ACOs.”

We support the provision for flexible services and the demonstration’s welcome recognition of the importance of social determinants of health.

### 8.3.4 Cost Sharing Differences Across Delivery Systems

“As described in Section 4.4, MassHealth proposes to implement differential copayments depending on whether a member is in the PCC Plan or FFS, or enrolled in an MCO or ACO. ...MassHealth seeks waiver authority to implement these premium and costs sharing requirements to the extent that they exceed limits established under section 1902(a)(14) of the Act and implementing regulations.”

The authority requested to charge premiums and copayments in excess of those permitted under the Medicaid Act is not presented with sufficient detail to enable meaningful comment. Federal regulations require a comprehensive description of the § 1115 application or extension with “sufficient level of detail to ensure meaningful input from the public including: ...the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State’s current program features.” 42 CFR § 431.408(a)(1)(i)(B).

In § 8.3.4 the proposal states that differential copayments will remain nominal (as required by the Act), and refers to updating cost sharing in accordance with the ACA, yet it seeks authority to “exceed limits” established under the Act. Section 4.4 refers to updating the out of pocket cost sharing schedule including premiums and copayments in 2018, eliminating copayments for those under 50% FPL, recalibrating the premium schedule for those over 150% FPL and expanding the list of services to which copayments apply. We support the decision to eliminate copayments for the poorest of the poor. We do not have enough information to address the planned premium changes, and have grave concerns over expanding the number of services subject to copayments.

However, none of these changes, as described, would require a waiver of the cost-sharing protections incorporated by reference in § 1902(a)(14).

Congress has provided detailed standards for premiums and cost-sharing and given the states substantial flexibility within prescribed parameters. It has also limited the Secretary's power to authorize cost sharing under any waiver unless the demonstration satisfies five specific conditions: testing a unique use of copayments, a 2-year limitation, benefits to recipients that outweigh risks, and use of a control group. 42 USC § 1390o(f). See, *Newton-Nations v. Betlach*, 660 F.3d 370 (9<sup>th</sup> Cir. 2011). If the MassHealth agency contemplates changes that will exceed the limits of the Act, the proposal does not describe how it will satisfy the conditions for a cost sharing waiver.

For these reasons, we urge CMS not to grant any explicit waiver of Medicaid premium and cost-sharing protections or any implicit waiver under the expenditure authority.

#### 8.4 Extending CommonHealth for Working Adults Age 65 and Older

"MassHealth proposes to extend CommonHealth eligibility under the demonstration to adults age 65 and older who are working, notwithstanding disabilities that would meet the federal definition of "permanent and total disability" if these adults were under the age of 65."

We urge CMS to approve the request to include working disabled seniors in the demonstration. However, we are concerned that the language in the proposal is not clear that the scope of the federally-reimbursed program will be the same as the scope of the current state-funded program. Under the current state regulation, 130 Code of Mass. Regs. § 519.012(A): "MassHealth CommonHealth for working disabled adults is available to community residents 65 years of age and older in the same manner as they are available to those younger than 65 years old." The current program extends not just to working disabled individuals already enrolled in CommonHealth at the time they turn 65 but also to disabled working adult who initially apply for benefits at age 65 or older or who were on MassHealth Standard when they turned 65. It is our understanding that the state did not intend to restrict the program to only those working disabled adults already on CommonHealth when they turn 65 despite the language in the request suggesting otherwise. We urge CMS to approve CommonHealth for working disabled seniors not just for those turning 65 on CommonHealth but for all seniors who meet the current state eligibility requirements.

#### 8.5 Student Health Insurance Program (SHIP): ensuring MassHealth is "payer of last resort"

We support the availability of premium assistance for student health plans and the proposal to provide continuous eligibility to coincide with the student health insurance coverage period. However, we oppose the proposal to make premium assistance mandatory. For students who require behavioral health services, premium assistance is likely to reduce their access to affordable care. When MassHealth is primary, these students are enrolled in managed care and have access to a broad network of behavioral health providers with only nominal copayments. However, except for students under age 21, when MassHealth is secondary, the beneficiary is enrolled in fee for service. MassHealth fee for service refuses to allow licensed mental health practitioners, other than psychiatrists, to enroll as participating providers of therapy services. This means a student will have great difficulty obtaining therapy services from a provider who participates in both MassHealth and the student health plan. If a student sees a provider who does not participate in MassHealth, the student will bear the entire cost of the deductibles, copays and

other cost sharing in the student health plan. This situation could be remedied by the agency, but until it is, premium assistance for students should not be mandatory. Students should be able to decide for themselves whether the advantages of the private plan outweigh the likely added costs for seeing a therapist in private practice.

#### 8.6 Requested changes to the Safety Net Care Pool

We support the requested authorization for ConnectorCare subsidies for cost sharing in addition to premium subsidies. Affordable premiums and cost sharing have been vital to the success of ConnectorCare and the success of the Commonwealth in reducing the number of the uninsured. We urge CMS to approve this change.

Thank you again for the opportunity to comment.

Yours truly,

Vicky Pulos, Senior Health Law Attorney  
Massachusetts Law Reform Institute  
40 Court Street, 8<sup>th</sup> floor  
Boston, MA 02108  
617-357-0700 Ext. 318  
vpulos@mlri.org