



Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

September 1, 2016

RE: Comments on MassHealth 1115 Demonstration Project Amendment and Extension Request

Dear Administrator Slavitt:

Thank you for the opportunity to submit comments on the Massachusetts Executive Office of Health and Human Services' (EOHHS) proposed Section 1115 Demonstration Project Amendment and Extension Request ("the Request") to restructure MassHealth to an Accountable Care Organization (ACO) model.

The Center for Health Law & Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. As part of this work, we collaborate with a number of community partners working to address social determinants of health by providing services such as medically tailored meals, housing stabilization services, and employment supports. One of the organizations with which we collaborate is Community Servings, a Boston based not-for-profit that prepares and delivers medically tailored meals to home-bound, critically and chronically ill individuals throughout Massachusetts.

We applaud EOHHS' commitment to prioritizing social determinants of health as part of the MassHealth ACO model. Addressing social determinants of health, especially access to healthy and medically-appropriate food, is vital to patient-centered care because of the significant impact that social determinants can have on health outcomes.

Food insecurity occurs "whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain."¹ In

¹ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 353 (1998).

general, food insecurity is linked to “poor child development, increased hospitalizations, anemia, asthma, suicidal ideation, depression and anxiety, diabetes, and chronic disease.”² By offering nutritional counseling and directly providing healthy, medically-appropriate food, food and nutrition services (FNS) improve these health outcomes. Provision of FNS has been shown to reduce emergency room visits and hospital stays, enhance treatment adherence, and improve disease management.³

Social determinants, such as food insecurity, can also play an important role in efforts to address substance use disorders (SUDs). For example, families with very low food security exhibited 10 times the rate of heroin use in the past 30 days compared to the general population.⁴ Further, individuals with SUDs who are food insecure experience “diminished physical and mental health states ... including obesity, diabetes, heart disease, hypertension, and depression.”⁵

CHLPI and Community Servings therefore encourage CMS and EOHHS to take the following steps to maximize the positive impact of the new ACOs in addressing social determinants of health:

1. Clarify the requirements around ACO flexible spending services (FSS).

Under Section 4.2.2 of the Request, EOHHS states that spending for flexible services must satisfy a number of specific criteria, including a requirement that services are “determined to be cost-effective alternatives to covered benefits and likely to generate savings.” We encourage EOHHS to eliminate or clarify this requirement to avoid unnecessary restrictions on ACOs and social service providers.

² Mariana Chilton et al., *The Intergenerational Circumstances of Food Insecurity and Adversity*, J. HUNGER & ENV'T'L NUTRITION 1-28 (2016).

³ See Su Lin Lim et al., Malnutrition and its Impact on Cost of Hospitalization, Length of Stay, Readmission and 3-Year Mortality, 31 *Clinical Nutrition* 345-350 (2012), available at [http://www.clinicalnutritionjournal.com/article/S0261-5614\(11\)00199-3/pdf](http://www.clinicalnutritionjournal.com/article/S0261-5614(11)00199-3/pdf); see also Fact Sheet HIV/AIDS, Food & Nutrition Services Needs, Cmty. Health Advisory & Info. Network (Oct. 2011), available at http://www.nyhiv.org/pdfs/chain/CHAIN%202011-5%20Brief%20Report_HIVAIDS,%20Food%20&%20Nutrition%20Service%20Needs%20Factsheet.pdf; see also Fact Sheet #2 Who Needs Food & Nutrition Services and Where Do They Go for Help?, Cmty. Health Advisory & Info. Network (Aug. 2013), available at http://www.nyhiv.org/pdfs/chain/CHAIN%202013-2%20Brief%20Report_Food%20Insecurity%20Fact%20Sheet_2.pdf; see also Fact Sheet #3 Food & Nutrition Services, HIV Medical Care, and Health Outcomes, Cmty. Health Advisory & Info. Network, available at https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_services/chain_factsheet3.pdf (last visited May 31, 2016).

⁴ Craig Gundersen & James P. Ziliak, Childhood Food Insecurity in the U.S.: Trends, Causes, and Policy Options, *THE FUTURE OF CHILDREN* 6 (2014), available at <http://futureofchildren.org/futureofchildren/publications/docs/ResearchReport-Fall2014.pdf>.

⁵ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 *BMC PUB. HEALTH* 2 (2012).

Many of the examples of FSS described in the Request—such as housing stabilization, physical activity, and nutrition—should not be, in most cases, a substitution for other health care services. Instead, these services should supplement existing MassHealth benefits and strengthen their effect on overall patient health. For example, nutrition services, such as medically tailored home-delivered meals provide an array of benefits—addressing management of blood glucose, increasing the effect of medication that must be taken with food, managing protein levels for kidney disease, maintaining healthy weight, etc.—that help patients manage their health conditions, adhere to treatment plans, and follow the instructions of their physicians and providers. Over time, these benefits will reduce avoidable hospitalizations and use of emergency care. In that respect, food and nutrition services ultimately provide an inexpensive alternative to the utilization of costly health care services. However, the immediate impact of services that address social determinants of health is improved patient engagement and adherence in routine care. EOHHS should therefore either remove or clarify the requirement that FSS be “alternatives to covered benefits” to avoid creating an unnecessary barrier to the provision of key social services.

We also recommend that EOHHS eliminate or clarify how it will define the term “cost-effective.” The purpose of funding flexible services is to enable delivery of innovative and promising interventions that meet the needs the ACO’s patient population. In order to make the promise of this funding real with respect to patient outcomes and cost, ACOs should be able to draw from a wide array of possible interventions. In some contexts, “cost-effective” is used to indicate that a study has been published examining the return on investment (ROI) or ratio of cost to quality-adjusted life years gained for the intervention. ACOs could therefore interpret the phrase “determined to be cost-effective” to mean that such studies must exist in order for a particular service to be covered under FSS. For many key social service interventions, this level of data may not yet exist despite compelling evidence (e.g., pilot studies and internal data) that the intervention is low-cost and high-impact. We therefore urge EOHHS to eliminate or clarify the requirement that FSS be “determined to be cost-effective.” In the event that EOHHS chooses to clarify the term “cost-effective,” we support the adoption of a broad definition to avoid limiting ACOs’ ability to provide FSS that address the unique and often overlooked needs of their patient populations.

Under the same section, the Request requires that FSS “funding is not available from other publicly-funded programs.” We urge EOHHS to provide clarification on how it will assess situations in which flexible spending may appear to be similar to a preexisting public benefit program, but is actually complementary. For example, ACOs could provide fruit and vegetable vouchers and nutritional counseling as low-cost, high-impact interventions for beneficiaries identified as food insecure. In such cases, MassHealth members should not be precluded from receiving these vouchers if they also, for example, receive SNAP benefits. To do so would inhibit ACOs from effectively using FSS to improve the care of beneficiaries who participate in

multiple public programs. Any clarification that EOHHS can provide on how it will assess similar situations in order to avoid excessive limitation of flexible services would be appreciated.

2. Provide a framework to govern the use of flexible spending funds.

In order to maximize the impact of the new ACO model in addressing social determinants of health, we encourage EOHHS to provide a framework for the use of flexible spending funds. Such a framework would both ensure oversight of the flexible spending program and provide additional clarity for ACOs by establishing a uniform process. We recommend that the framework address at least the following elements:

- i. Which parties determine how flexible spending funds will be spent.*

The Request provides only minimal guidance on who will decide how funds are spent within the FSS programs. As a result, ACOs may defer to their partner social service organizations to make these determinations. Because such organizations are often focused on specific needs or patients, such a strategy could result in only a portion of the ACO's population receiving access to FSS. In contrast, the ACOs themselves are well-positioned to assess the needs of their entire patient population and to direct the funds accordingly. Therefore, we recommend that the FSS framework require ACOs to be responsible for determining how FSS funds are spent.

- ii. The process that ACOs must use to determine their members' social service needs.*

In order to facilitate appropriate use of flexible spending funds, we also encourage EOHHS to include guidance in the FSS framework regarding how ACOs should determine the social service needs of their members. In developing this guidance, EOHHS could require ACOs to look to existing data sources and recent patient data to assess community needs. For example, in the first year of the demonstration, EOHHS could require ACOs to base their needs assessment on existing data sources such as Community Health Needs Assessments performed by non-profit hospitals in their service area and county-level data related to social determinants such as food insecurity and housing. Moving forward, EOHHS could then require ACOs to screen patients for social service needs during health care visits and use that data to drive allocation of FSS funds.

To help developing ACOs begin to plan for this process, we also encourage EOHHS to clarify how it will calculate the amount of DSRIP funding that ACOs will receive for FSS. By allowing ACOs to better estimate how much funding they will receive for FSS and how that funding will impact their overall budgets, ACOs will be better equipped to begin planning to provide FSS.

iii. *The FSS reporting requirements that ACOs must meet to ensure transparency.*

Lastly, it would be beneficial for EOHHS to establish transparency requirements regarding FSS funds. Specifically we recommend that EOHHS require each ACO to produce an annual public report describing how they determined their members' social services needs and how they are allocated FSS funds to meet those needs. By doing so, EOHHS can create greater oversight of the FSS program and motivate ACOs to carefully tailor FSS funds to member needs.

3. Emphasize the role of food and nutrition services in helping individuals with substance use disorders recover and maintain long-term abstinence.

In the Request, EOHHS demonstrates a strong commitment to enhancing services for people coping with substance use disorders (SUDs). We applaud EOHHS for its efforts to better address SUDs and ask EOHHS to encourage ACOs to consider including food and nutrition interventions as a critical facet of their SUD strategies. Food insecurity among individuals with SUDs leads to poor health outcomes from both individual and public health perspectives (see studies cited below). As a result, food and nutrition services can help these individuals to recover and maintain long-term abstinence.

From a nutritional standpoint, individuals with SUDs are more likely to be food insecure.⁶ Food insecurity for these individuals tends to become “increasingly severe.”⁷ While individuals with SUDs have a greater risk of malnutrition, the risk is greatest for injection drug users.⁸ Vitamin deficiencies experienced by people with SUDs as a result of food insecurity can lead to negative emotions such as “apathy, anxiety, irritability, and depression.”⁹

In addition, because individuals with SUDs who are food insecure tend to make riskier choices, food insecurity also impacts the public health. Several studies indicate that individuals with SUDs who are food insecure have higher chances of engaging in needle sharing¹⁰ and unprotected sex.¹¹ These activities increase the risk of disease transmission. This increased risk of transmission combined with reduced health status of individuals with SUDs means they are

⁶ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 351 (1998); see also Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 6 (2012).

⁷ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 351 (1998).

⁸ David A. Himmelgreen et al., *A Comparison of the Nutritional Status and Food Security of Drug-Using and Non-Drug-Using Hispanic Women in Hartford, Connecticut*, 107 AM. J. PHYS. ANTHROP. 352 (1998).

⁹ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 7 (2012).

¹⁰ Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 1-9 (2012).

¹¹ Kate Shannon et al., *Severe Food Insecurity is Associated with Elevated Unprotected Sex among HIV-Seropositive Injection Drug Users Independent of HAART Use*, 25 AIDS 2037-2041 (2011).

more likely to contract disease and to experience rapid disease progression, health complications, and negative treatment outcomes.¹² Given the relationship between food insecurity and SUDs, FNS can play an important role in addressing the impact of SUDs in the Commonwealth and should therefore be included as part of ACO strategies on this issue.

In closing, we appreciate EOHHS's dedication to addressing social determinants of health in its Section 1115 Demonstration Project Amendment and Extension Request. The decision to address social determinants in the new MassHealth ACO model will positively impact individuals in the Commonwealth living with chronic illness. We believe that by clarifying flexible spending requirements, providing a uniform framework for the FSS program, and emphasizing FNS as a facet of whole-person treatment for SUDs, EOHHS can maximize this impact.

Again, we applaud EOHHS's efforts to provide whole-person accountable care to MassHealth members, and we would be happy to work with CMS and the Office to address any of the comments described above.

Sincerely,



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Together with the following:

Action for Boston Community Development, Inc., Boston, MA

Children's HealthWatch, Boston, MA

Fresh Advantage® LLC, Cambridge, MA

Health Care for All, Boston, MA

Health Care Without Harm, Boston, MA

Massachusetts Law Reform Institute, Inc., Boston, MA

The Greater Boston Food Bank, Boston, MA

¹² Carol Strike et al., *Frequent Food Insecurity among Injection Drug Users: Correlates and Concerns*, 12 BMC PUB. HEALTH 7 (2012).

The Open Door, Gloucester, MA

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