



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 partner with advocates across the country and in Massachusetts to expand access to care for vulnerable populations. In particular, we frequently collaborate with the HIV and Hepatitis C ("HCV") communities to ensure that individuals are able to access the lifesaving treatments they need. In Massachusetts we have helped lead the Massachusetts Viral Hepatitis Coalition and have been involved in state HIV advocacy for over twenty-five years. Recently, CHLPI leadership has met with key leadership in EOHHS and the Massachusetts Attorney General's Office to ensure reasonable access to HCV medications for MassHealth enrollees.

With these experiences in mind, we applaud EOHHS' commitment to ensuring access to care for individuals living with HIV and HCV. MassHealth was one of the first Medicaid programs to allow for broad and early access to HIV medications. MassHealth was also one of the first to allow for relatively unrestricted access to new, curative HCV medications in its Fee-For-Service ("FFS") program and has recently taken steps to ensure that enrollees in Managed Care Organizations ("MCOs") have the same access to care. However, we are mindful that access to the right physicians and treatments can still be challenging for MassHealth enrollees living with chronic conditions and that changes in MassHealth can have significant impacts on these individuals' ability to access care.

CHLPI therefore encourages CMS and EOHHS to take the following steps to maximize the positive impact of the new ACOs in ensuring access to care for all MassHealth enrollees, including vulnerable individuals with high health needs:

1. Allow patients freedom to enroll in the appropriate program or plan.

Under Section 4.3.1.2 of the Request, EOHHS states that MassHealth will implement twelve month enrollment periods for members. Individuals enrolled in an MCO or ACO will have ninety days to change MCOs or ACOs or to enroll in the current Primary Care Clinician (“PCC”) plan. Once those ninety days have passed, enrollees may only disenroll for limited reasons, effectively locking them into their selection for nine months. Individuals enrolled in the PCC Plan may switch to an MCO or ACO at any time, regardless of the reason.

CHLPI is concerned that this “Fixed Enrollment Period” will punish consumers for choosing an MCO or ACO and then developing health needs better met by the PCC Plan, a different MCO/ACO or another form of MassHealth. Although MassHealth promises relative parity between the offerings of the MCOs, ACOs, and the PCC Plan, there may be important utilization management differences between the offerings. For example, until recently, both MassHealth FFS and all MassHealth MCOs covered newer HCV treatments. MassHealth FFS covered these medications with relatively few restrictions, while many MCOs covered these medications with highly stringent, medically unjustifiable restrictions aimed to reduce access to curative treatments.

The lack of flexibility to adjust enrollment appropriately is problematic due to shifting health needs and to transparency issues in MassHealth offerings. Some individuals will discover only after the initial ninety day enrollment period that they have serious health conditions that change their medical treatment needs. Additionally, transparency issues may prevent MassHealth enrollees from understanding the restrictions associated with their chosen plan until after the enrollment period. Oftentimes, the differences in utilization management requirements, such as the ones that existed until recently within MassHealth in regard to HCV treatment, are virtually impossible for even well-educated and empowered consumers to uncover prior to committing to a plan because MCOs and ACOs are not forthcoming about their requirements.

CHLPI therefore encourages EOHHS to eliminate this “Fixed Enrollment Period” requirement or to be more forthcoming about the “specified reasons” for which enrollees may disenroll from their selected MCO or ACO. One of these specified reasons should be because the MCO or ACO no longer meets the health needs of the individual, or because the utilization management requirements are stricter than the requirements under the PCC Plan. Additionally, one of the specified reasons should be because the individual is medically frail, which should be interpreted broadly. This would be in keeping with the requirements of the new Medicaid Managed Care Final Rule, which requires states to allow individuals to disenroll from their chosen MCO for reasons, “including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee’s care needs.”¹

2. Avoid punishing patients for selecting the PCC Plan.

Under Section 4.4 of the Request, EOHHS states that enrollees of the PCC Plan will lose certain benefits in October 2017, such as eye glasses and hearing aids, that enrollees of the MCOs and ACOs will maintain. EOHHS is also planning to increase cost sharing for enrollees of the PCC Plan while reducing cost sharing for enrollees of the MCOs and ACOs. EOHHS will also

¹ 42 C.F.R. § 438.56(d)(2)(v).

expand the number of services that will require cost sharing.

CHLPI is concerned that coverage and cost sharing under the Request are being used to punitively push enrollees from the PCC Plan. While MCOs and ACOs are appropriate for many, if not most, MassHealth enrollees, there are good reasons why an individual may choose to remain in the PCC Plan. For example, the utilization management requirements for a key treatment could be more restrictive under the individual's options for an MCO or ACO. The individual could also have a longstanding relationship with a provider who has chosen to participate in the PCC Plan and not in any ACO offering. Preserving a relationship with a trusted medical provider is especially important for individuals living with chronic diseases that require careful management, such as HIV and HCV.

We understand that EOHHS is interested in attracting as many individuals as possible into the new value-based programs. We urge EOHHS, however, to use "carrots" rather than "sticks" to accomplish this goal. Removing important services and increasing cost sharing punishes enrollees who may have good reasons for preferring to remain in the PCC Plan. Cost sharing is best used as a tool to encourage individuals and providers to consider value-based yet still medically appropriate treatments, not to undermine access to care in a given program to the point that enrollees are pressured to pick another plan. We ask EOHHS to attract individuals into the new value-based programs by offering new, additional services rather than removing currently existing coverage in the PCC Plan. We also ask EOHHS to reconsider adding to the cost sharing burden of PCC Plan enrollees.

It is also unclear from the Request if PCC Plan providers will be required to participate in the Model B ACOs, which, according to Section 4.1.6.2 of the Request, "will have access to MassHealth's PCC Plan network." We ask EOHHS to clarify whether all primary care providers participating in the PCC Plan will be participating in a Model B ACO. If that is not the case, we ask EOHHS to revisit its changes in coverage and cost sharing to avoid penalizing enrollees for remaining in the PCC Plan in order to preserve an existing relationship with a trusted provider.

We appreciate EOHHS' dedication to ensuring meaningful access to care in its 1115 Demonstration Amendment and Extension Request, in keeping with Massachusetts's historical position as a leader among the states in health care access. We believe that access to care would be best served by allowing more flexibility for enrollees to select the appropriate plan for them throughout the year and by preserving coverage and cost sharing as it currently stands in the PCC Plan. We would be happy to work with CMS and EOHHS to address any of the comments described above.

Sincerely,



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