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TO: Andrew M. Slavitt, Acting Administrator

Centers for Medicare and Medicaid Services (CMS)

FR: Patricia Edraos, Health Resources/Policy Director

DT: September 1, 2016

RE: Comments on the Commonwealth of Massachusetts MassHealth Section 115 Demonstration Project Amendment and Extension Request submitted on July 22, 2016

Submitted electronically via:

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

The Massachusetts League of Community Health Centers (“the League”) is pleased to comment on the above-referenced Waiver Request. We appreciate the opportunities MassHealth provided for the League and our members to provide input during the stakeholder engagement process, and we look forward to continuing to work closely with them to ensure that the Commonwealth’s goals are met.

Established in 1972, the League is a non-profit, statewide association representing and serving the needs of the state's 50 community health center organizations with more than 300 total access sites. The League serves as an information source on community-based health care to policymakers, opinion leaders and the media and provides a wide range of technical assistance to its members and communities, including: analysis of state and federal health regulatory and policy issues affecting health centers; training and education for health center administrators, clinicians and board members; promotion and management of clinical quality initiatives across the health center network; workforce development initiatives to increase recruitment of primary care physicians and to provide career training for health center employees and local residents seeking entry-level positions at health centers; health information technology development; and support to expand health access through work with local health and advocacy organizations seeking to open health centers in their communities.

We strongly support the Waiver provisions intended to increase access, including insuring funding for much-needed support for priority initiatives including sustaining and expanding the primary care workforce, providing targeted technical assistance and promotion of clinical/community linkages; insuring the continuation of the Health Safety Net and the Uncompensated Care Pool; ensuring the sustainability and affordability of the ConnectorCare program; assuring the sustainability of the CommonHealth program; providing continuous eligibility for members enrolled in the Student Health Program; expanding MassHealth substance use disorders treatment services; and eliminating copayments for some MassHealth members. We also strongly encourage the use of innovative strategies in the areas of workforce development that include the *Extension for Community Healthcare*

*Outcomes* model, (Project ECHO). Developed at the University of New Mexico, the Project ECHO model links specialist teams based in academic medical centers with front-line primary care teams in order to transfer specialty knowledge around caring for patients with complex conditions in their own communities. By providing health care primary care teams with unprecedented access to specialty knowledge through participation in ECHO, health centers can help minimize patients' reliance on specialty care, thereby reducing system costs and freeing up access for patients with complex care needs.

The League strongly opposes the proposal that members whose coverage is through the Primary Care Clinician Plan (PCC) would lose coverage for certain optional services as well as face increased copayments. We anticipate that implementation of the sweeping changes and consolidation of provider networks that are at the heart of the Proposed Waiver will be a time of great confusion to consumers, and that no matter how well implemented will cause instability in the system. Members should not be "forced" out of existing relationships in order to obtain the services they require. Doing so will have very little impact on success, while at the same time causing hardship to, and resentment by, members.

We appreciate MassHealth's reaching out to advocates and providers regarding their intention to "lock in" members to MCOs and ACOs for twelve months, but have reservations about this policy. Our major reservation is that it does not solve the "churn" problem, which is primarily caused by eligibility changes rather than MCO changes, and at the same time may lead to disruptions in current care patterns. We therefore had strongly recommended that the state include in its request to CMS the option of providing 12-month Medicaid eligibility for anyone enrolled in an MCO, and as they are formed, an ACO. We now request this to you directly. A serious look should be taken as to the cost/benefit of doing so as according to a number of studies there is a benefit. This approach would also provide a "carrot" rather than the proposed "stick" for PCC patients, leading to greater voluntary ACO/MCO participation.

We also requested MassHealth to provide out-stationed eligibility workers to the health centers and/or funding for health center outreach and enrollment staff. This is required by HRSA regulations, but has never been provided in spite of requests going back many years, and except for limited grant funding, the health centers bear the entire cost of over 400 Certified Application Counselors. System consolidation and the increased complexity of the new models will make accurate and effective communication even more necessary with patients whose first language is often not English and/or whose literacy and electronic communication skills are often limited, and we therefore request you to include provisions in the waiver which would provide the required funding for this workforce.

Our other concern with the "lock in" provision, is that in many parts of the state served by community health centers, both MCO and PCC patients frequently seek care at a community health centers that are not within their existing network. Under HRSA Section 330 grant requirements, community health centers are required to see patients regardless of their "ability to pay," and are therefore not allowed to turn patients away because they are not enrolled in their existing MCO, PCC, or ACO. To date, it has been relatively easy to switch them to a MCO that the health center does contract with, or to the health center's own PCC. Although we are hopeful that in most cases network adequacy within both the MCOs and the ACOs, as well as the provisions which would allow a person to change networks, will be

sufficient to minimize this problem, in cases where the problem remains, it will threaten the financial viability of many health centers, and result in an unprecedented call on their Federal grant funding. Therefore, at the very least, we request you to require Mass Health to provide a mechanism for payment by the MCO or ACO to out-of-network FQHCs for medically necessary services that are immediately required due to an unforeseen illness, injury or condition to enrollees of an MCO or ACO in compliance with 42 U.S.C. § 1396b(m)(2)(A)(vii), and that these be paid at no less than Medicaid rates. To this end, Mass Health could adopt the mechanism contemplated under 42 U.S.C. § 1396a(bb)(5) for the provision of wraparound/supplemental payments to FQHCs to ensure they receive full and timely PPS payments for services rendered to any Mass Health enrollees.

With respect to payment for services to health center patients enrolled in an ACO of which a health center is a member, we are concerned that the federal requirement that Medicaid programs must insure that a Federally Qualified Health Center is paid at its PPS/APM rates was written to apply to MCOs, and it unclear whether these apply to ACOs. Unless it is affirmed that ACOs are considered to be “managed care organizations” and therefore equivalent to MCOs and that MassHealth has the same obligation to ensure FQHC payments to participating FQHCs either directly or through a state-provided “wrap”, our members are at risk. We therefore strongly request you to do this so that FQHCs participating in ACOs do not lose their FQHC-protections because of what is in effect a change of name for a “managed care organization.”

Our other comments with respect to MCOs are related to expectations that they will be “key partners” in the new models. As part of this partnership we request that provisions around ACO/MCO contracting should be strengthened; that the state should be required to set requirements for homogeneity between MCOs and ACOs for data and other reporting, including credentialing requirements, and including a model contract and requirements for a common set of outcome metrics and a MassHealth developed Value Based Payment (VBP) framework that all MCOs must comply with; and that providers, should be given a decision-making role in deciding where care-management functions should be located.

The most serious concern by our members about the current Waiver Proposal is the requirement that a provider can be a member of only one ACO. The secondary concern is that it is likely that for various reasons, with rural location being the major one, some of our members will not be able to form or participate in any one ACO. In the late 1980’s attempts were made to limit provider participation in only one Managed Care Organization (MCO) and quickly failed because of the access issues these caused to members and the financial issues these caused to providers. The “lock in” provisions are likely to compound the problem. A much harder look should be taken to prevailing patient care patterns before imposing such a stringent requirement. At a minimum, we recommend that if a primary care provider organization has the Medicaid patient volume and managerial capability to participate in more than one ACO, it be allowed to do so. We request clarification of how a provider organization can be a member of an ACO while also providing services to patients of, and being reimbursed by another ACO or MCO. We also strongly request you to require that the state provide technical assistance and waiver-related supplementary funding to community health centers, and possibly other types of providers, who, due to local conditions are not able to form ACOs or to join ACOs that meet the needs of their patients, but

which are able to design programs which will meet the Commonwealth's goals of improving quality and controlling costs.

Another major concern is the relatively low bargaining power of primary care providers, and specifically community health centers, compared to tertiary care providers. Although we are heartened by MassHealth's plans to attribute ACO membership based on a member's use of primary care providers, this in itself does not change the relative bargaining power, particularly given the state's existing health care system. For example, within the past year two major hospitals discontinued their contracts with two MCOs which covered a large number of health center Medicaid patients, leaving the only options for those patients to either cease using those hospitals or enroll in the PCC program. If a hospital or health system chooses to exclude particular health centers, what would the options be for their patients? Or, if a hospital or health system based-ACO offers disadvantageous terms for participation, the health center would have little leverage. We are also concerned that health centers whose commercial insurance contracts run through physician-hospital organizations will be forced to terminate those contracts if they opt to be part of a different ACO, again giving the system that "holds" these, disproportional bargaining power. We therefore urge you to carefully consider these issues and, to the extent possible, insure that primary care providers are able to play a strong role, not only by supporting the state's patient attribution plans, but also by including provisions that will require the state to establish safeguards that will maximize a patient's opportunity to be cared for by the primary care provider of his or her choice.

It is unfortunate that in spite of a number of requests from the League and other organizations, that dental services are not included as ACO services, and that only partial coverage is provided for adults covered by Medicaid. Not only would easily accessible oral health services improve the overall health of our patients, but given the disproportionate use of emergency room services by persons covered by Medicaid, save money. Although adult coverage is an optional service, we believe it that it could be required as a waiver provision, and urge you to do so.

We support provisions which would waive prior approval for substance use disorder treatment, and also request the opportunity to discuss the possibility of "carving out" certain community health center services, including but not limited to School-based Health Center services, where prior approval processes actually interfere with the provision of cost-saving services.

Areas in which we hope to have further clarification are: how MassHealth has defined the population eligible for Long-term support services (LTSS); what the requirements are to become a Certified Community Provider (CCP) and Certified Behavioral Health Provider (CBHP); how funding will flow from the state and from the ACOs to LTSS, CCPs and CBHPs; how pharmacy services, particularly 340b pharmacy services, will be handled; the amount of flexibility that will be allowed to ACOs with respect to their services; the decision rules related to the use of Safety Net care funds, in particular the extent to which health centers, as safety net providers, will receive them; and other details on how MassHealth plans to align the Health Safety Net with MassHealth programs. With respect to behavioral health, many community health centers currently provide mental health and substance use disorder services

and are concerned as to how they will fit in under the certification process. Others which have Elder Service Plans/PACE programs have similar questions regarding their services to the elderly.

Thank you for this opportunity to comment. If you have questions I can be reached at 617-988-2236 or

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