December 16, 2015

Daniel Tsai  
Assistant Secretary for MassHealth  
Executive Office of Health and Human Services  
One Ashburton Place, 11th Floor  
Boston, MA 02108

RE: MassHealth Payment and Delivery System Transformation

Dear Assistant Secretary Tsai,

On behalf of Health Care For All (HCFA), thank you for the opportunity to participate in the MassHealth Innovations stakeholder process and to submit these comments regarding your efforts to develop new delivery system models, including Accountable Care Organizations (ACOs). MassHealth has an opportunity to promote approaches to payment reform that fundamentally transform the way care is delivered. ACOs should deliver high quality, high value care that treats the individual as a whole person and ensure coordination of care, improved communication, member support and empowerment, and ready access to health care providers, services and community-based resources and supports. We offer the following recommendations for MassHealth to consider as it moves forward with these important reforms.

**Member Protections**

ACOs must be built upon a strong foundation of robust consumer protections that ensure MassHealth member rights are safeguarded and that access to care is not impeded. As new models of care and payment are developed and providers take on increased risk, reward, and responsibility, it is important that MassHealth ensures that the evolution and application of consumer protections are keeping pace. MassHealth should prioritize the inclusion of a broad array of consumer protections as outlined in this section, as well as areas discussed in other sections such as payment design features, heightened quality reporting requirements, consumer-friendly notice and transparency requirements, emphasis on member outreach and education, and adequate protections concerning enrollment, attribution, and data sharing.

Increased levels of risk for losses coupled with influence over utilization management shift the balance of incentives enhancing the potential for ACOs to stint on care. While quality criteria and quality measurement will help control this risk, the limitless combinations of potential stunting are unlikely to be adequately covered by a finite set of measures. MassHealth must therefore monitor and ensure that members get all the care they need and that ongoing care is not interrupted. Safeguards against under-service and member selection should be incorporated at a number of different levels that include payment design features that impact an ACO’s or a provider’s behavior and additional safeguards.
layered on top of a program’s internal incentive structure to further minimize the risks of under-service and member selection.1

**Monitor and track underutilization**

One way to safeguard against potential incentives to deny or limit care, especially for members with high risk factors or multiple health conditions, is for under-service and underutilization to be tracked and monitored through both concurrent and retrospective methodologies. Under-service refers to the systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value-based payment arrangements.2

ACOs should be required to establish internal monitoring mechanisms, which should be part of ACO agreements with participating provider groups and individual providers, and/or via ACO contracts with MassHealth. Specifically, ACOs should establish performance standards, monitor for inappropriate practices including under-service and member selection, hold providers accountable, and report publicly on the information gathered through internal monitoring.

A second layer of safeguards should include MassHealth’s retrospective monitoring and analysis of claims data on an annual basis. As the payer, MassHealth can play a central role in monitoring for under-service and member selection as it would monitor for over-service, fraud and abuse. Changes in utilization could serve to identify stinting on care and the risk profile of an ACO over time could suggest avoidance of high-risk members. At a minimum, MassHealth should monitor under-service by assessing utilization, total cost of care, cost of care by service type and health outcomes over time to identify patterns of variation. In addition, MassHealth should identify populations that may be at particular risk (i.e., characterized by certain clinical conditions and/or socioeconomic factors), and conduct population-specific analyses. For example, MassHealth should monitor variations in utilization of different interventions by diagnosis. When potential under-service is flagged via monitoring claims data, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or member selection is likely to have occurred.

Additional methods of identifying problems related to underutilization include soliciting member feedback through survey-generated measures and capturing member feedback through member advocacy services such as an ombudsperson center, both of which are discussed in greater detail in other sections of these comments. MassHealth should conduct surveys of members who disenroll from ACOs to uncover systemic issues with an ACO or its care.

**Examples:**

- Oregon Medicaid’s Collaborative Care Organizations (CCOs) are required to establish mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates such as peer wellness specialists or personal health navigators, as well as develop a complaint, grievance, and appeals resolution process.3
- New Jersey has determined that collecting and analyzing patient and consumer feedback is the best mechanism to detect and remediate any potential improper limitations in care. An ACO

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2 Id. at 2.
3 OAR 410-141-3015(13).
must demonstrate its capability to collect quality data which includes patient access and utilization of services measures and have in place at the management level a quality committee responsible for receiving and addressing patient complaints and conducting ongoing monitoring to ensure access to care and prevent inappropriate provider self-referrals, reductions in care, or limitations on services.\(^4\) In an ACO’s gainsharing plan, the ACO must describe how it will provide members with a clear process to make complaints or speak up regarding a possible improper provider self-referral, or reduction or limitation of services.\(^5\) Appropriate disciplinary actions should be taken against providers/practices found to have improperly reduced care, limited services, or engaged in inappropriate self-referral which may include withholding gainshare savings or excluding a practice from the ACO.\(^6\) The number, types, and resolution process of such complaints at the provider/practice level must be reported annually to the New Jersey Department of Human Services and the public.\(^7\) As a part of the ACO certification process, participating providers are further required to submit an affirmative acknowledgement that the provider shall not organize their care delivery to reduce access to care or increase costs, shall be responsible for medically appropriate treatment and referral decisions, shall document the basis for such decisions, and shall not limit treatment and referrals to providers both within and without the ACO if medically indicated.\(^8\)

**Protect member choice of providers**

While alternative payment methods are an opportunity to improve care while reducing cost, there are risks that ACOs utilizing these new payment methodologies could restrict access to member choice of providers beyond the limitations already imposed by Managed Care Organization (MCO) networks. Individuals, particularly those with disabilities or chronic needs, benefit from continuity of care from both primary and specialty care providers who know them and their medical needs. Providers joining and leaving ACOs can disrupt relationships and hurt care. Member choice is also important to allow members to seek very specialized services that might not exist in an ACO, to participate in clinical trials, and to obtain very personalized care such as reproductive health or mental health services. Moreover, payment reform will not be successful with the public if perceived as an attempt to limit choice of providers.

**Network adequacy**

Former and prospective members of One Care often cite the provider network as a primary reason for disenrolling or not enrolling in the first place. While individuals recognize the benefits of integrated care, the prospect of losing established relationships with behavioral health professionals and other medical providers forms a barrier to participation. Some members experience an inadequate network in their area with no One Care provider located within 45 minutes or more from their home. Other members wait excessive periods of time for a culturally or linguistically appropriate provider, including behavioral health providers that speak their native language. Plans have addressed the issue through provider outreach and offering Letters of Agreement to a member’s current physician. Some providers remain reluctant to participate, however, even as MassHealth continues education and outreach efforts.

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\(^4\) N.J.A.C. 10:79A-1.5(c)(8).
\(^5\) N.J.A.C. 10:79A-1.6(d)(5).
\(^6\) N.J.A.C. 10:79A-1.6(d)(5)(iv).
\(^7\) N.J.A.C. 10:79A-1.6(d)(5).
\(^8\) N.J.A.C. 10:79A-1.5(c)(4)(ii).
Therefore, MassHealth should ensure that members have access to care across the continuum, which includes reasonable access to a sufficient number of primary care and specialty care physicians, facilities, and other providers through minimum provider and facility ratios, as well as benefits delivered in a timely fashion within a reasonable distance that takes into account travel time and access to public transportation. MassHealth should also take into account the specific needs of certain populations, including children and youth with special health care needs.

MassHealth should further ensure that ACOs make available sufficient expanded access for members. At the minimum, MassHealth should consider the following measures when evaluating the effectiveness of expanded access:

- Measures for access during office hours for urgent care should include: same-day appointments, telephone and email consultations, waiting time, and group visits;
- Measures for after-hours access should include: evening and weekend schedules, on-call evening or weekend visits, telephone and email consultations, and waiting time; and
- Measures for accessibility for members with special needs (i.e. members with physical disabilities, limited English proficiency (LEP), and those with visual, hearing, cognitive, and communication impairments).

In addition to ensuring that all ACOs comply with applicable state and federal laws on network adequacy, MassHealth should establish, monitor and enforce appropriate network adequacy requirements for ACOs and test adequacy through mechanisms such as “secret shopper” surveys and other methods that reflect direct member experience.¹

As part of the network adequacy determination, MassHealth should ensure that all ACOs have parameters for contracting with providers outside of the ACO if and when necessary. For members in ACOs, getting care from a provider outside the ACO could work similarly to getting care out-of-network from a PPO plan. The provider will still be subject to the ACO’s payment and coordination requirements, ensuring that members maintain continuity of care and do not face additional barriers in accessing appropriate care. In addition, MassHealth should ensure that ACOs have protections to ensure continuity of care when a provider moves out of an ACO network. This includes notification to the member in advance of the change and the option to continue seeking treatment from the provider via an out-of-network arrangement. Continuity of care, particularly for specialty and behavioral health services, is key to ensuring positive health outcomes and long-term recovery.¹⁰ It has been said that the


“best fence is a good pasture.” Good ACOs will succeed in keeping members within their system because of the benefits of coordinated care.

**Attribution methodologies**

Furthermore, attribution methods should adhere to the goals of care continuity and access and should involve member choice to the maximum extent feasible. Members should be able, though not required, to identify their primary care provider through an attestation process as a primary attribution technique, meaning that the members designate their PCP. Members should also be able to designate a non-primary care provider as their PCP for the purposes of attribution. In the event that the chosen provider’s panel is closed, the member can either select a different provider or be attributed retrospectively based on the member’s historical choices. Members who do not pick a primary care provider through attestation should be assigned based on their recent care-seeking behavior. In determining retrospective attribution, MassHealth should not only look at PCP claims but also claims from other providers, as well as non-claims-based factors such as geographical proximity, language and cultural competency, in order to determine the most appropriate assignment. However, allowing for direct member choice is always preferable to retrospective attribution.

Members should receive adequate notice about the right to choose or change providers and ACOs. Members who have been attributed to a provider should receive notice of the attribution and their right to change providers at any time. If a member’s PCP is participating in more than one ACO, the member should also have the right to change ACOs at any time. When individuals select a provider they should know if they are choosing a provider who is participating in an ACO. At the time of selection they should have information about any advantages for the member of selecting an ACO provider. It should be made clear to the member if the provider has a financial incentive to refer into network, and members should be notified of their right to go out of network and of any potential benefits to staying in the ACO network. All notices should be provided in a manner that is accessible and understandable.

Finally, MassHealth should not establish a lock-in period for members to remain in a particular ACO, including lock-in to the end of the month. Less than 6% of MassHealth members changed plans voluntarily in 2014.11 Churn is mostly driven by eligibility changes, and many MassHealth members who remain eligible fall off coverage only to return in a short period of time. Members do not change plans arbitrarily but instead change plans for better access to providers and services. Given the access barriers that members already face, MassHealth should not impose further restrictions or limitations on choice under new delivery system models. Another way to help people stay within a particular ACO and minimize churn is through implementing a 12 month continuous eligibility system for members.

**Example:**

- Oregon CCOs must ensure that members have a choice of providers within the CCO’s network, and applicants to the CCO program must describe how they will work to develop the partnerships necessary to allow for patient choice in medical, mental health and substance use disorder services, and dental care, and to facilitate access to community social and support services.12
- In New York, ACOs must provide access to care providers that are not part of the ACO.

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12 OAR 410-141-3015(15).
Ensure robust appeals and grievances procedures

Because an individual’s treating physician 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 this unusual context. The ACO grievance process should be at least as consumer-protective as current MassHealth appeals procedures. Specifically, the deadlines for members should be at least as generous as current MassHealth regulations given the special challenges involved in appeals in the provider risk-bearing context. Also, continued coverage and expedited reviews should be mandated for both internal and external reviews. These protections should be clearly available to all members in ACOs.

Providers who stand to share in ACO savings should be required to provide members with a description of all possible treatment options and the provider’s basis for deciding on the recommended treatment. 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 additional cost sharing.

In addition, ACO grievance procedures should include the following requirements:

- ACOs should have an internal level of appeal and opportunity for further appeal via external review, both of which may be expedited when necessary and requested by the member or her representative.
- All levels of appeal should be decided by independent and qualified clinical professionals.
- To allow for clear communication to members about their right to receive notice and to appeal, MassHealth should clarify what triggering events give rise to an appealable action, for both internal and external appeals. Examples of ACO situations that could constitute an appealable action include but are not limited to:
  - Referral or second opinion denied/refused by provider
  - Denial of a prescription medication
  - Refusal to do surgery/specific treatment
  - Member choices not reflected in treatment plan or member disagrees with treatment plan
  - Testing/assessment insufficient, inadequate or omitted
- MassHealth should specify the noticing requirements that ACOs must abide by to inform members of the right to appeal, which should be at least as consumer protective as existing MassHealth appeals notice requirements. The mechanism for filing complaints should include the use of online feedback forms as well as hard copy documents.
- MassHealth should require ACOs to provide members with reasonable assistance in filing appeals, which includes assistance from qualified community health workers, peer wellness specialists or personal health navigators; free interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capabilities; and reasonable accommodation or modifications as required by any disability of the member.
- ACOs should provide full transparency and access to information for members facing under-service and denials of care. Reporting requirements should be rigorous enough to monitor the implementation of the ACO appeals and grievances process and the impact on members, including reporting the number and types of internal and external grievances and appeals to MassHealth.

Furthermore, MassHealth should create, or partner with an existing entity such as the Office of Patient Protection to create, a single source of information and accountability for under-service through an ombuds program model. The ombuds office can play a key role as a one-stop source of information
related to under-service and member selection for members and providers and should report any systemic issues to ACO advisory bodies.

**Examples:**

- The Oregon Health Authority is charged with adopting by regulation safeguards for members enrolled in CCOs that protect against underutilization of services and inappropriate denials of services. In its certification application, each CCO must describe its planned or established mechanisms for a complaint, grievance, and appeals resolution process, and how it will make such a process known and accessible to members. Each CCO must further have an approved process and written procedures for a member’s right to appeal and a member’s right to file a grievance for any matter other than an appeal.

- Oregon’s CCO model includes the right for patients to be able to receive, upon request from the provider organization, summaries of the provider organization’s data regarding appeals and accessibility of services. CCOs must also maintain detailed yearly logs of all appeals and grievances for seven calendar years. In addition, CCOs must review and report to the Oregon Health Authority complaints relating to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.

- CCOs must provide members with any reasonable assistance in taking procedural steps related to filing grievances, appeals or hearing requests, which includes assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators; free interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capabilities; and reasonable accommodation or modifications as required by any disability of the member.

- In New Jersey, ACOs must provide a clear and easy way for patients or consumers to make complaints or speak up regarding a possible improper provider self-referral, or reduction or limitation of services by a participating ACO member. The mechanism for collecting complaints may include the use of online feedback forms, hard copy documents, and/or a telephone “hotline.” In addition, ACOs must report annually to the state and the public on the number of complaints received at a provider/practice level, the types of complaints received, and the resolutions implemented. ACOs must also provide for internal monitoring and take appropriate disciplinary actions against individual providers that improperly reduce care or limit services. Reporting to the state includes notification of a material concern involving patient safety within three business days.

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13 ORS 414.635.
14 OAR 410-141-3015.
16 ORS 414.651(8).
17 OAR 410-141-3260(13); OAR 410-141-3260(17).
18 OAR 410-141-3260(7).
19 NJAC 10:79A-1.6(d)(5).
20 NJAC 10:79A-1.6(d)(5); NJAC 10:79A-1.7(e).
Member Engagement at Multiple Levels

Ensuring delivery of care that meets the needs of MassHealth members and their families requires meaningful systematic engagement of members and families at both the individual and governance levels.

- **In organizational design and governance and policy making:** Members are formally integrated as advisors in design and governance of policies and procedures.

- **In direct health care:** The extent to which a member, and/or their family member or caregiver, understands their own role in the care process and how much confidence they have in taking on that role.

**Ensure consumer representation and input in ACO governance bodies and advisory councils**

Individual patients and consumers are the heart of the care system, and must be valued as members of the design and governance teams for the payment reform structures. Bringing the perspectives of members and families directly into the planning, delivery, and evaluation of health care, and thereby improving its quality and safety, is what patient- and family-centered care is all about. When consumers and families, providers, and health care administrators work in partnership, the quality and safety of health care rise, costs decrease, and provider and consumer satisfaction increase.

MassHealth has a marvelous opportunity to accelerate progress toward patient-centered care delivery by vigorously endorsing or requiring that ACO design and governance teams include independent consumers among their members. We urge MassHealth to ensure meaningful involvement of members and consumer advocates in the following ways:

- **Sufficient representation on the ACO’s Governance Board.** Sufficient representation requires having more than one member, family caregiver, and/or consumer advocate representative on an ACO’s governance board. Having multiple consumer advocates and member representatives on a governance board will ensure more sufficient representation of the ACO’s member population and avoid isolating the representative. ACO governing boards should also include representatives from community-based organizations, including those concerned with public health. In addition, ACOs should ensure consumer advocate and member representation on the governance board reflects the diverse member population it serves.

- **Representatives are meaningfully engaged in decision-making.** All representatives on the governance entity (including consumer advocate and member representatives) must have an equal seat and say at the table and an opportunity to share their perspectives and influence decisions as they are being made.

- **ACOs should form Member Advisory Councils.** These councils should address issues related to the ACO’s quality, member experience, and affordability goals from the member perspective,

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22 Institute for Patient- and Family-Centered Care. (2014). *Advancing the Practice of Patient- And Family-Centered Care: How To Get Started.* Bethesda, MD.
including continuous quality improvement. This can be one overarching council to look at care across the practice and/or subcommittees or smaller councils for particular areas. Councils should:

- Have membership that currently receives care at the ACO. Membership should reflect the populations/community served by ACO (including age, race, ethnicity and languages).
- Hold meetings at least quarterly, with agendas developed in collaboration with the group, and distributed in advance of the meeting.
- Regularly share member satisfaction/complaints and other relevant data.
- Have a documented “feedback loop” in which recommendations are carried up to the leadership of the ACO. Appropriate follow-up should be then demonstrated to the governance entity to ensure accountability.
- Develop and implement written policies and procedures that include, at a minimum, purposes and goals, membership eligibility, officers, orientation and continuing education, and roles and responsibilities of members.
- Have a named staff member responsible for managing the work of the Council and integrating the work of the Advisory Council in other ACO Committees.
- Write an annual report on the work to be made publicly available.
- Develop and implement a plan to regularly communicate with members, including a process to receive direct input and recommendations from members and communicate back with members regarding any responses or actions taken.

- All representatives receive orientation and onboarding support to facilitate their successful participation, as well as ongoing opportunities to connect with peers in other ACOs. Successful partnerships with consumer advocate and member representatives on ACO governing boards and Advisory Councils require a greater level of ACO support, including providing orientation and onboarding support. ACOs should describe in their applications an orientation and onboarding process for consumer advocate and member representatives on governance boards, other internal multi-stakeholder entities, and Advisory Councils. We encourage MassHealth to offer guidance and assistance to ACOs with respect to developing onboarding and orientation processes. MassHealth should also facilitate an ongoing process to allow all consumer representatives on these boards to learn from each other, share best practices, and interact with experts on issues related to ACOs.

It is also essential to ensure adequate support for ACOs and other stakeholders to help them effectively integrate consumer advocates and members and families into the work of the board. Non-profit consumer groups could be engaged to manage this process. We urge MassHealth to work with ACOs in the application phase to determine how the ACO will:

- Communicate the important role consumer advocates and member representatives play in governance and decision-making;
- Create an expectation that consumer advocate and member input will be valued, respected and incorporated in ACO operations; and
- Provide training and resources to support effective collaboration with consumer advocate and member representatives.

Finally, it is important for ACOs to monitor and continuously assess the degree to which consumer advocate and member representatives are being meaningfully engaged and whether changes being made through the ACO are actually improving member care experiences and outcomes. This information
must be part of MassHealth’s evaluation of ACOs. We encourage MassHealth to work with ACOs and consumers to determine the most appropriate ways to track and share this information.

Example:

- Each CCO in the Oregon Medicaid program must have a governing body that includes at least two members of the community at large to ensure that the CCO’s decision-making is consistent with the values of the members of the community, as well as at least one member of the CCO’s Community Advisory Council. The Community Advisory Council that each CCO is required to maintain must include representatives of the community and each county government served by the CCO but consumer/member representatives must constitute the majority of the membership.

**Promote member engagement and activation in care**

Member satisfaction and engagement/activation measures must be included among the quality indicators and should impact ACO payment rates. Numerous studies have shown that individuals who are more actively involved in their health care experience better health outcomes and incur lower costs. Many health care organizations are employing strategies to better engage individuals, such as educating them about their conditions and involving them more fully in their care. Such engagement allows individuals and providers to be full partners in care, improving outcomes and lowering cost.

Examples of approaches to achieve member engagement in direct care include:

- **Using shared decision making.** In this approach, members and providers together consider the member’s condition, treatment options, the medical evidence behind the treatment options, the benefits and risks of treatment, and members’ preferences, and then arrive at and execute a treatment plan. Shared decision making often includes the use of decision aids.

- **Using trained health coaches.** These coaches provide members with knowledge and awareness of their treatment options, help them to sort out their treatment preferences, and encourage them to communicate those preferences to their health care providers. Certified Peer Specialists are additionally helpful.

- **Helping members become “activated.”** Members who have the skills, ability, and willingness to manage their own health and health care experience better health outcomes at lower costs.

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23 ORS 414.625(o).
24 ORS 414.627(1).
compared to less activated members. The “Patient Activation Measure” is a validated survey that scores the degree to which someone sees himself or herself as a manager of his or her health and care. Interventions that tailor support to the individual’s level of activation and that build skills and confidence are effective in increasing patient activation.

- Provide patients with access to all their medical records, including behavioral health records. Patient portals, which provide members with access to their medical information as well as a means to communicate with their providers, have been shown to increase patient engagement. In addition, opening up behavioral health records to members decreases provider stigma by requiring providers to describe behaviors in non-judgmental terms.

- Helping increase “patient confidence.” Health confidence measures the individuals’ level of knowledge, skills, and self-efficacy about taking an active role in their health care and managing their health conditions. Its assessment can result in immediate provider action and lead directly to improved patient engagement. If an individual’s health confidence is low, motivational interviewing can be used to help the individual to reflect on personal strengths, identify behavioral goals and develop a support plan.

ACOs should be required to measure and publicly report on these quality measures in a way that is understandable by MassHealth members. ACOs should also conduct annual surveys or use the results from an accepted statewide survey to evaluate patient and family experiences on access, communication, coordination, whole person care/self-management support, and deploy plans to improve on those results.

**Promote patient-centered quality measures**

ACOs must be accountable first and foremost to their members, and quality measures must reflect this goal. While patient experience measures are an important first step, measure sets should also prioritize inclusion of cross-cutting patient-reported outcomes measures (PROMs), and measures that more robustly capture members’ views regarding the care they received. These kinds of high impact quality measures, which are meaningful to both consumers and providers, will help ACOs drive quality improvement and increase value. Examples of validated PROMs include the Patient Reported Outcomes Measurement Information System (PROMIS), the Patient Health Questionnaire-9 (PHQ-9), Hip disability and Osteoarthritis Outcome Score (HOOS), Knee injury and Osteoarthritis Outcome Score (KOOS), and other tools endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA). Meaningfully engaging members as partners in care and delivering member-centered care that meets the needs of members and families is the best way to encourage members to stay within the ACO when seeking care.

Maximization of the potential for PROMs and patient experience measures to improve care delivery and health outcomes likely requires evolving our electronic health information infrastructure such that it supports collection and use of PROMs and other high-value measures. We support interoperability so

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that data can be transmitted between providers in real time and integrated into their work flow and care delivery.

Example.

- Blue Cross Blue Shield of MA has incorporated PROMS for mental health, orthopedics, oncology and cardiology as a complementary measure set for both its Alternative Quality Contract (AQC) and PPO payment reform models. Beginning with contracts in 2016, these measures will be used alongside the core quality measure set. Unlike the core quality measure set, where payment is based on performance, however, payment for the PROMs and other measures in the complementary measure set will be based on adoption and use to improve patient care. Since the BCBSMA introduction of PROMs in 2014 as a voluntary component of the AQC program, the reception from providers has been very positive. While introduction of PROMs into routine practice requires adaptation of both work flow and culture that are not trivial, providers have conveyed the significant clinical value in having the PROMS data and the usefulness of being able to monitor patients’ progress over time using these measures.

- In California, the Intensive Outpatient Care Program (IOCP), which is funded by the Center for Medicare and Medicaid Innovation, collects functional health status information and uses other standard survey instruments to screen for depression and to measure the patient’s ability to engage in improving their health. Patients are screened again following treatment to ensure that their condition has improved.  

Comprehensive data collection and public reporting

Stratified data collection

Holding ACOs accountable for improved member health and experience of care will require quality measures that are focused on outcomes and member-reported data. Stratified data collection is another critical component of measuring success, appropriately targeting population health interventions, addressing and reducing health disparities, and improving how ACOs deliver care.

To achieve more equitable health care outcomes, it is crucial that ACOs incorporate disparity reduction goals into overall quality improvement goals and adopt tools that support disparities measurement and interventions. We therefore urge MassHealth to require that ACOs work towards collecting standardized data on key demographic and social status measures, including outcomes and patient-reported experiences. This analysis should start by reporting stratified outcomes and other quality indicators by disability status, homelessness (or unstable housing), age, primary language, race and ethnicity, geography, gender identity and sexual orientation, at a minimum. Additional factors could include food insecurity, exposure to violence and unemployment. Stratifying measures this way is an important tool for uncovering disparities and quality gaps as well as targeting intervention points and strategies. Reporting this data will allow MassHealth and the public to assess how well ACOs are serving the entire spectrum of MassHealth members.

Additionally, MassHealth should require ACOs to use the new consensus metrics, developed by the National Quality Forum (NQF), to assess cultural competency and language services. Implementing

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these measures is critical to address provider biases, poor patient-provider communication, and poor health literacy. Collection and reporting of data on these measures also will help create a long-term agenda for improving health care quality for vulnerable populations and others adversely affected by disparities.

**Promote transparency and accountability through public reporting**

Public reporting can improve both health care performance and value. We strongly recommend that ACOs be required to publicly report quality and cost information at the provider level, as well as at the ACO level. Providing transparent information on cost and quality performance at the individual provider level as well as the ACO level will help members to make informed decisions with respect to choice of provider and care setting. Providing transparent cost and quality information may also help members to understand the potential benefits that an ACO can provide. ACOs are best equipped to provide more specific information about how care will be better coordinated in their specific integrated systems.

We also recommend that MassHealth publicly report on an annual basis the following information: the names of the ACOs with which it - directly or through MCOs - has contracts; the number of lives attributed to each ACO; the financial structure of ACOs and participating providers, including surplus or deficit margins; ACO leadership structures; and provider incentives in ACOs. MassHealth should further work in conjunction with the Office of Patient Protection, or another entity serving an ombuds function, to publicly report on an annual basis the number and types of internal and external grievances and complaints filed with the ACO and if and how they have been resolved.

**Consumer friendly education and outreach**

All individuals receiving care, or eligible to receive care, through an ACO must be fully informed about what this means for them and how to protect themselves if necessary. ACOs should educate their members on what an ACO is, the benefits of care under the ACO, and the responsibilities and rights that accompany receiving care from an ACO, including the right to receive care from a provider outside of the ACO, the right to file a grievance or complaint with the ACO, and how to go about taking these actions. Additional information should include a description of financial incentives for ACO providers and the ACO as a whole, including incentives to manage the total cost of care and improve quality, definitions of under-service and member selection, and how the ACO is monitoring for under-service.

In the context of value-based care delivery, individuals should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one’s provider, how to evaluate if one is receiving appropriate care, and what to do if one is concerned about the extent or type of care that has been ordered.

Information on MassHealth ACOs should be provided in ways that are accessible and understandable to all members, which means that the information must be relevant and communicated via a set of consistent messages. While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different ACO models), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as individuals’ insurance or health status changes, and give providers standard guidance about engaging members that aligns with what members are being told. Information should be made available both in advance of receiving care (e.g. at the time of enrollment) and at the point of care (e.g. in writing in the provider office). To help ensure that this information is effectively shared and
communicated, written materials should include taglines in at least 18 languages and large print that inform members of written translation services in all prevalent (500 or 5 percent of potentially attributed individuals) languages, as well as oral assistance for all members with limited English proficiency and assistance for people who are deaf and need American Sign Language.

MassHealth should also encourage ACOs to work collaboratively with community-based organizations (CBOs), including those that represent communities of color and/or non-English speaking beneficiaries, around education and outreach. Members are more likely to trust CBOs and local community groups, which will in turn create more buy-in from the member perspective to join/stay in the ACO.

Finally, we recommend that MassHealth convene a work group to advise them on the content to be contained in the core messages described above, and also on the appropriate media and means through which messages should be disseminated. This work group should recommend specific language to be incorporated in member communications. The work group should be composed predominately of members, consumer advocates, and providers. It should also include representatives of payers and state government agencies, and individuals with experience and expertise in communications, including communications with populations believed to be at particular risk of under-service or otherwise difficult to engage.

Data sharing

Offering members electronic access to their medical records and other health information may help them understand the importance of and minimize concerns regarding data sharing. According to a national survey by the National Partnership for Women & Families, online access appears to be a catalyst for transparency and understanding that helps individuals trust their records, and perhaps better understand how data-sharing across providers contributes to well-coordinated care.36 Offering individuals real-time, electronic access to their complete health information will not only enhance patient engagement, but may strengthen trust and alleviate concerns regarding data sharing, thereby minimizing the number of members who opt-out.

MassHealth should require ACOs to describe their ability to provide members access to their own electronic health records and related clinical knowledge needed to make informed choices about their care, including electronic health information in non-English languages. A 2014 survey found that individuals with online access to health information in their providers’ EHRs overwhelmingly use this capability: 86 percent log on at least once a year, and 55 percent log on three or more times per year.37

The data from this survey clearly show that online access has a positive impact on a wide range of activities that are essential to improved health outcomes and better care, including knowledge of health and the ability to communicate with providers. More frequent online access has an even more dramatic impact. Individuals who used online access three or more times per year reported a markedly greater impact (20 percentage points higher) across these domains of care. Even more significantly, the more often individuals access their health information online, the more they report that it motivates them to do something to improve their health – 71 percent, compared with 39 percent who used online access

37 Id.
less frequently. This ability to access personal health information clearly has profound implications for engaging members and improving health status.

**Access to Services and Care Delivery**

**Incorporate oral health services**

As one of the founding tenets of ACOs is the coordinated health care of whole persons, MassHealth ACOs must include the opportunity to improve the oral health of their members. To this end, oral health should be included within the scope of ACO services. Dental integration in ACOs will help eliminate the arbitrary separation of care based on body part. Including oral health services can help focus on the importance of routine preventive care, and the savings accrued through increased prevention can be shared throughout the ACO. The evidence on both improvements in quality of life and cost savings through dental care is striking: poor dental health is at epidemic proportions, and untreated dental disease is costly and extremely preventable.

Fifteen years ago the Surgeon General issued a report that exposed the epidemic of poor oral health in America, but the problem persists. Although largely preventable, dental caries and periodontal disease continue to be among the most common chronic diseases in the US. Untreated dental disease is also costly to the Commonwealth. Between 2008 and 2011, MassHealth paid over $11 million for emergency department visits for dental conditions of members 18 and older. Individuals who go to the emergency department for dental care generally receive short-term symptomatic relief without treating the underlying condition. Unsurprisingly, in 2011 repeat visits represented nearly 30% of ED use for dental conditions in Massachusetts. Most dental disease is preventable and prevention is extremely cost-effective. There is increasing evidence to suggest that the provision of dental care actually lowers overall health care costs. Cigna estimates that every dollar spent on preventive dental care could save $8 to $50 in restorative and emergency treatments. Even those who are noncompliant with medical care but who receive dental care realize significant savings on overall health care costs. Incorporating dental services into ACOs may need to be phased in, but creating opportunities to increase the profile of oral health within the primary care system and decrease overall costs can begin in the early phases of implementation. It will also be important to ensure that reimbursement rates are sufficient to incentivize dental professionals to provide care to the MassHealth population.

**Examples:**

- One Care members report the availability of dental care is a significant incentive for enrolling in the program. A recent report found that 48% of individuals who voluntarily enrolled in One Care described getting better dental benefits as a primary reason.

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38 Id.
• Oregon’s Coordinated Care Organizations (CCOs) have a global Medicaid budget with capitated and non-capitated components and are responsible for allocating the budget. CCOs must coordinate all care, including physical, medical, behavioral, and dental health care, for people enrolled in Medicaid or dually eligible for Medicare and Medicaid.\textsuperscript{43} CCOs are specifically required to have formal contractual relationships with dental care organizations that serve members. Dental care services are capitated under the current Medicaid managed care program and are part of a CCO’s global budget.\textsuperscript{44}

• ACOs in New Jersey and Minnesota are also leaders in incorporating dental care into their core services. New Jersey ACO gainsharing plans submitted to the Department of Human Services will be evaluated in part on whether a gainsharing plan provides funding for improved access to dental services for high-risk individuals likely to inappropriately access an emergency department and general hospital for untreated dental conditions.\textsuperscript{45} Hennepin Health in Hennepin County Minnesota has ACOs with advanced integration of dental care, including shared risk and incentives based on performance and outcomes.

\textit{Incentives to integrate Oral Care into Primary Care Settings}

As overall health includes oral health, we also recommend that oral health be included as a component of routine primary care. Even when individuals have access to dental insurance, they may not have access to a dentist. For example, in 2014 47\% of MassHealth enrollees ages 1-21 did not see a dentist.\textsuperscript{46}

We recommend that ACOs include mandates for primary care settings to incorporate routine oral health exams and risk assessments. This approach capitalizes on PCP access to individuals as well as primary care’s expertise in care coordination and prevention education.

The Health Resource and Service Administration (HRSA) has identified five core oral health clinical domains and competencies to be incorporated into primary care education and practice:\textsuperscript{47}

- Risk assessment
- Oral Health Evaluation
- Preventive Intervention (including fluoride varnish)
- Communication and Education
- Interprofessional Collaborative Practice (including structured referrals and, ideally, establishing a dental home)

To successfully integrate oral health care into primary care settings, appropriate education and training will be required. In addition, changes to front desk practices can be beneficial to support individuals in establishing a dental home.


\textsuperscript{44} Vujicic, M and Nasseh, K. (2013). \textit{Accountable Care Organizations Present Key Opportunities for Dental Profession [research brief]}. American Dental Association and the Health Policy Resources Center. Retrieved from http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0413_2ashx

\textsuperscript{45} N.J.A.C. 10:79A-1.6(a)(1)(v).


Examples:
- Many Patient Centered Medical Homes stress oral health as part of primary care. Other projects integrating oral care into the primary care setting are currently being piloted across the country. In Massachusetts, the Dorchester House Multi Service Center in Boston implemented a medical-dental integration project focused on preventing and treating oral disease in children 0-5 years old. This project included oral health screening, risk assessment, and fluoride varnish application during the PCP visit and connected patients with a timely dental appointment at the Dorchester House Dental clinic.

Create a bi-directional referral network and structured referrals
Many individuals screened during a primary care visit will meet the criteria for a referral to dentistry. An established primary care-dentistry referral network will be essential to allow those referrals to take place. Ideally the referral network is created at the ACO level rather than practice-by-practice. The bi-directional nature of the network will allow PCPs to connect their patients with dentists, and for dentists to connect their patients with PCPs. The referral network should be “structured” to allow the PCP and the dentist to share important information related to the member’s care and notify providers when a referred appointment has been scheduled.

Incentives for co-location and virtual integration and full integration
Incentives for full integration of medical and dental practice should be considered. Similar to behavioral health integration, full integration of medical and dental care includes co-located practices and integrated electronic health records, as well as joint team meetings and intermingled offices for medical and dental providers.

Dental Quality Committee
A committee or workgroup should be established to identify clinical quality and health outcome measures and decrease disparities in oral health. Establishing these measures will create incentives for dentistry to start thinking about value-based care and help spur innovations in dental care delivery. We know that co-location is a critical factor in service access for consumers and patients, and represents a significant and important advancement in our current health care delivery system.

Example:
- As part of its CCO legislation, Oregon established a nine-member Metrics and Scoring Committee, charged with identifying objective outcome and quality measures and benchmarks, including outcome and quality measures for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCOs. The Dental Quality Metrics Workgroup identified five metrics to be implemented, the first, Sealants on permanent molars for children, was implemented in July 2015.

Promote care coordination and chronic disease self-management programs.
True member-centered care will require ACOs to implement payment methodologies that pay for coordination, wellness and prevention services that are currently not traditionally reimbursed. The payment system should support teams that can deliver culturally competent, coordinated preventive and primary care that focuses on the individual’s physical, behavioral and oral health. Care management should include the provision of services to create and implement thorough and appropriate treatment plans, including wellness, recovery, and transportation to recommended medical, social, and physical activities, peer assistance, exercise support, food delivery and equipment. ACOs should be required to document in the certification application how they are pursuing a team-based approach to care.
Complex and high-risk members are two populations that need and will benefit from care management the most, and attention to these populations will result in the best potential for costs savings and improved health outcomes.\(^4^8\)

MassHealth should further require ACOs to demonstrate that they have mechanisms in place to conduct member outreach and education on the necessity and benefits of care coordination, including group visits and chronic disease self-management programs; demonstrate an ability to effectively involve members in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrate an ability to engage and activate members at home to improve self-management, through methods such as home visits or telemedicine; and utilize shared decision-making tools and processes through robust program requirements and quality measures.

Individualized care plans are a core element of effective care coordination, and represent an important opportunity for improved system delivery and enhanced member care experience and improved outcomes. We urge MassHealth to emphasize care planning in ACO requirements. We encourage MassHealth to think of them as shared care plans, which are jointly maintained and updated by members, family caregivers with member consent, and members of their care team.\(^4^9\) In addition to including these functions in ACO payment structures, MassHealth should provide a mechanism to disseminate best practices and promote shared learning among caregivers about these tools.

**Examples:**

- **Massachusetts community health centers have achieved strong results using these types of services for diabetes patients.** The Commonwealth Care Alliance (CCA), an ACO-like provider in Massachusetts, has also succeeded at using a team-based, consumer-directed care approach for individuals with complex medical and behavioral health needs, resulting in improved health and better self-management of chronic illness. Model legislation and other resources on shared decision-making are available from the Informed Medical Decisions Foundation.\(^5^0\)

- **One Care, another ACO-like model for individuals with disabilities, provides examples of successful care coordination resulting in significant improvements in the well-being of participants.** The Interdisciplinary Care Team (ICT) ensures that a member’s non-medical needs are addressed meeting a continuum of care in the home and the community that supports medical treatments. Assistance with maintaining the home environment, connecting individuals to day habilitation programs, and peer support services have directly reduced emergency room visits and hospitalizations in specific cases.

- **CCOs in Oregon must ensure that each member has a stable relationship with a care team that is responsible for providing their primary and preventive care and for comprehensive care management in all settings.** The care team must be identified for each member and is responsible for the flow of information with other providers and for conducting patient follow-up. Additionally, Oregon CCOs are explicitly directed to prioritize working with members who

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have high health care needs, multiple chronic conditions, mental illness, or substance use disorders using individualized care plans to address the needs of each member. CCOs are to ensure that individual members are involved with the process of developing their own individualized care plans and must be able to describe how plans reflect the member or caregiver’s preferences and goals.\textsuperscript{51}

\textit{Promote the integration of mental health, substance use disorder and behavioral health services with primary care services}

HCFA believes that ACOs and other accountable care models should fully integrate mental health and substance use disorder services (referred to henceforth as behavioral health) with primary care services. Many consumers with behavioral health needs face barriers to accessing primary care, including provider stigmatization of persons with mental health diagnoses. At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and other health care needs. There may be more than one model for integrating behavioral and physical health services, including co-located models employed by the ACO or by a partner behavioral health agency, formal partnerships between ACOs and community-based behavioral health providers, or the federal Health Homes opportunity.

We view integrated health care as a coordinated system that combines medical, behavioral, and oral health services to address the whole person, not just one aspect of his or her condition(s). In this model, with the consent of the member, medical and behavioral health providers partner to coordinate the prevention, diagnosis, treatment, and follow-up of both behavioral and physical conditions; and consumers, behavioral health professionals, peers and family partners are key members of the team. However, physical health care providers may not provide the same quality of care to persons with psychiatric diagnoses as to those without mental health histories.\textsuperscript{52} Therefore, it should be up to the individual enrollee whether and to what extent psychiatric information is shared among his or her physical health care providers. Members will be able to share such information with providers who inspire trust, a necessary element of any health care relationship.

\textit{Community-Based Behavioral Health Providers}

Throughout MassHealth’s stakeholder process, we have heard numerous times the concept of “buy vs. build.” We appreciate that MassHealth is encouraging ACOs to “buy” services already offered within the community rather than “build” new capacity within their organizations. HCFA believes that MassHealth should promote strong clinical partnerships between ACOs and community-based behavioral health care providers.

Community-based behavioral health providers have an important role in the integration of physical and behavioral health services for a number of reasons:

- Established roots in the community and existing connections to community-based supports and services, including partnerships with non-medical community resources, translate into improved patient experiences through care coordination.

\textsuperscript{51} OAR 410-141-3015(16); OAR 410-141-3014(19); OAR 410-141-3015(17).

• Community-based providers can leverage existing partnerships with other providers such as hospitals, community health centers, locally-based physician practices, community action agencies and others.

• Community-based providers have a broad perspective of the health care delivery system and the key role that community services can play in addressing social determinants of health such as housing stability and food security.

• Community-based providers are well-positioned to devote the time and effort to locate and engage members with complex needs, to work with them in their homes and communities, and to access services and coordinate care with primary care, behavioral health, and other services and supports on a local level.

• Consumers value long-term, trusting relationships with community-based behavioral health providers. Utilizing community-based providers ensures greater continuity of care for patients who already access services in the community. In addition, these established relationships may increase acceptance of primary care services.

• Community-based behavioral health provider organizations deliver care in lower cost community settings.

MassHealth should implement payment incentives to ensure ACOs partner with community-based behavioral health organizations, for example, bonus payments for ACOs that demonstrate positive working relationships with community partners. Structural safeguards – such as requiring ACO governance boards to include community-based behavioral health provider representation – should also be put into place to ensure that these providers are appropriately utilized and that community expertise is preserved. MassHealth should work with community-based behavioral health providers to enhance members’ access to these services by promoting such policies as extended hours. MassHealth should also reduce administrative barriers, such as unnecessary utilization management criteria, that impose obstacles to accessing needed community-based care.

Recovery Model & Peer Supports

Behavioral health integration requires access to services that help consumers manage their conditions successfully. As such, ACOs should partner with organizations to deliver recovery coaching and peer supports and services provided by peer support workers, certified peer specialists, recovery learning communities, and licensed alcohol and drug counselors. Peer supports provide a unique and important role in the delivery of behavioral health care and can enhance the care that is provided in integrated settings.

Peer support services are delivered by individuals who have common life experiences with the people they are serving. Studies have shown that the use of peers may reduce costs and improve health outcomes, including decreased hospitalizations; improved quality of life; and reduction of the number of major life problems.53 Peers also play an important role in increasing access as they have the potential to reach individuals who may not otherwise receive care, especially behavioral health care, and are viewed as more credible by some individuals. The use of peers may also reduce the overall need for behavioral health services over time. Twenty-two states provide reimbursement for peer support through their Medicaid programs. Today, MassHealth reimburses for Family Support and Training as part of the Children’s Behavioral Health Initiative (CBHI), which provides linkages to community

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resources and a one-to-one relationship between a Family Partner and a parent or caregiver to help improve the capacity of the parent/caregiver and support youth in the community.  

Behavioral Health Services for Children and Youth

Children and youth have specialized needs that are not adequately addressed in a system built for adults. Accountable care models should emphasize prevention and early interventions with children and their families; children also require providers to consult with more “collateral contacts,” such as parents, teachers, and other service providers. MassHealth should leverage the expertise of CBHI’s community-based, child-serving provider organizations to coordinate care, enhance care quality, deliver care in lower cover cost community settings whenever appropriate, and improve the patient experience for child and youth MassHealth members and their families.

Another important point to consider is that a significant portion of services provided to children with behavioral health needs may not currently be reimbursed by MassHealth, which also may be relevant for adults with serious mental illness (including substance use disorders) and other disabilities. MassHealth and ACOs themselves should develop partnerships and closely coordinate with the Departments of Children and Families (DCF), Mental Health (DMH), Developmental Services (DDS), Elementary and Secondary Education (DESE), the Bureau of Substance Abuse Services (BSAS) within the Department of Public Health (DPH), and other non-billing behavioral health providers. We also ask MassHealth to consider how CBHI services fit within an accountable care model, as this program currently coordinates behavioral health services for youth and their families. Ultimately, the question is how MassHealth can hold these systems accountable for helping to care for complex children and youth who are attributed to an ACO.

Care coordination is key for behavioral health integration, especially for youth. Quality and performance metrics that are specific to children’s behavioral health are essential, especially for children’s behavioral health services. Although there is as of yet no set of well-developed and validated measures, the Massachusetts Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration grant project awarded in 2010 offers key care coordination measures, including:

- Needs assessment for care coordination;
- Care planning and communication;
- Facilitating care transitions between inpatient and ambulatory settings;
- Connecting with community resources and schools; and
- Transitioning to adult behavioral health care.

Examples:

- With the One Care program, co-located services have resulted in increased recognition of behavioral health needs previously undetected by primary care physicians. It allows for a broader reach to underserved populations that are less likely to seek care from mental health specialists and improves access to services.

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• Under statutory requirements, Oregon CCOs are responsible for coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services. CCOs must provide fully integrated person-centered care and services designed to offer choice, independence, and dignity across the delivery system. It is further required that the governing board of each CCO include a mental health or chemical dependency treatment provider to ensure the interests of mental health and chemical dependency providers and patients are represented in the decision-making process.56
• In New Jersey Medicaid ACOs, the organization’s gainsharing plan to be approved by the Department of Human Services will be partly evaluated on whether or not the ACO provides funding for interdisciplinary collaboration between behavioral health and primary care providers for patients with complex care needs likely to inappropriately access emergency department services and general hospital services for preventable conditions.57
• The Kaiser Family Foundation compiled a review of behavioral health integration efforts in several states that run the continuum from focus on universal screening and providing care navigators to co-location, health homes, and systems-level integration.58

Ensure access to member-centered long-term services and supports (LTSS)

HCFA believes that people with disabilities and chronic conditions and seniors should have choice, control and access to a full array of quality services, including LTSS, that assure optimal outcomes, such as independence, health and quality of life. HCFA also believes that this portion of our health care delivery system is among the most fragmented and poised for improvement. Massachusetts has made great strides in shifting utilization and spending of long-term services and supports (LTSS) from institutional settings to the community. Preliminary 2015 numbers show that the percent of MassHealth spending on community-based LTSS has risen to 65%, as compared to institutional settings.59 Even so, many people still need to put together a patchwork of services to get what they need, and the pieces of their care quilt rarely focus on shared care planning. Importantly, LTSS services must be member-driven and controlled. As such, we request that each member in need of LTSS have access to an independent, conflict-free LTSS coordinator to assess the member’s needs and develop a consumer-centered care plan. With the development of accountable care models, MassHealth has the opportunity to value person-centered LTSS for members, and to break down life-threatening barriers to care transitions.

We appreciate the need to phase in integration of LTSS into an accountable care framework and believe that inclusion of LTSS should be based on transparent, documented readiness of ACO entities and community-based LTSS provider organizations. MassHealth should look to lessons illustrated by the One Care experience, both from a financing and service delivery point of view. One Care offers evidence about how integrated LTSS can work, and provides direct experience for the development of quality metrics to evaluate these services. MassHealth should work with LTSS providers to develop standards to assure high quality and accountability for care they provide. All ACOs should be required

56 ORS 414.625(1)(e); 410-141-3015(12); ORS 414.625(2)(o)(C)(ii).
to create a detailed timeline for integrating community-based LTSS into their system, with consultation from LTSS providers, members who need LTSS and advocates. As with behavioral and oral health, community-based LTSS providers have an important role in the integration of physical, oral and behavioral health services and LTSS.

Coordination between LTSS and medical services is crucial, and MassHealth’s transformation effort offers the opportunity to protect against over-medicalizing LTSS. MassHealth ACOs must look beyond the medical model of LTSS to address everyday needs that keep people in the community as well as overarching social determinants of health. A 2013 survey conducted by the DPH and University of Massachusetts Medical School found that 85% of respondents with disabilities reported finding affordable housing as a significant health-related need. Community-based LTSS providers can help members connect to social services for help with non-medical needs that contribute to the overall health, wellbeing and security of members.

Examples:

- While Medicaid-funded long-term care services are excluded from Oregon’s CCO budget, CCOs are required to promote shared accountability with providers of LTSS services for cost, performance and incentives through contractual agreements.
- One Care offers an Independent LTSS Coordinator as part of the member’s care team, if the member chooses. The LTSS Coordinators are from community-based organizations independent from health plans.

Ensure adequate access to and appropriate standards for pediatric services

Children have distinct health care needs. Approximately 34% of MassHealth members are children and youth under the age of 21, comprising around 40% of all children in the state. ACOs should establish access and quality standards specific to pediatric primary care, behavioral health, oral health, and specialty providers. Given the significant number of children enrolled, MassHealth and providers should develop pediatric-specific approaches including relevant payment frameworks, quality standards, and delivery systems in their ACO design. An ACO established to serve adults will not necessarily have relevant pediatric expertise and capabilities, especially for children and youth with complex conditions.

A major difference between the adult and pediatric populations covered by MassHealth is the role of the family in the care and health of children. In addition to consultation with pediatric providers, active engagement of key children and family-focused consumer groups, such as Family Voices (the Federation for Children with Special Health Care Needs in Massachusetts) and the Parent/Professional Advocacy League, is crucial in the design and implementation of pediatric-serving ACOs.

For pediatric patients, the role of the family and home environment can be particularly relevant. As such, there is likely a role for home visiting, which is not a traditional service provided by institutional providers; strong partnerships with community-based organizations that do provide these services are needed.

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essential. There are many models for home-based services currently offered to children and families through the Massachusetts Home Visiting Initiative, Children’s Behavioral Health Initiative, as well as pilots such as Boston Children’s Hospital’s Community Asthma Initiative. These services not only target medical and behavioral health issues, but also bring to light other factors, such as home environment, that are important to the health of children.

Examples:

• Recognizing that children may also receive care in the school setting, Vermont has made Medicaid ACOs responsible for spending on services administered through the department of education as well as spending on care in traditional medical settings.

• Oregon CCOs are encouraged to partner with the Oregon Early Learning Council, the Youth Development Council, school health providers, and others in conducting its Community Health Assessment and subsequent Community Health Improvement Plan. CCOs will be further required, to the extent practicable, to base the Community Health Improvement Plan on research including adverse childhood experiences; evaluate the adequacy of the existing school-based health center network to meet pediatric and adolescent health care needs and make recommendations to improve that system; improve the integration of all services provided to meet the needs of children, adolescents, and families; and address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.63

Population Health and Prevention

*Promote linkages with community-based organizations and active coordination with community resources*

Given that many populations face significant social, economic, and environmental barriers beyond their immediate health concerns, it is critical that ACOs support their members with education and assistance with accessing the community resources in their area.

ACOs should also coordinate with those resources (with member permission) to exchange member information. The community c-referral system being established under the state’s SIM grant, for example, provides an opportunity for medical practices to serve their members through a broad array of services that contribute to overall health. Community-based programs can enhance practices’ understanding of members’ local resources and socio-cultural preferences, gain trust of members and families, and serve as a referral service for much-needed support.

ACOs should further partner with community-based programs and supports (e.g., community organizations, social services providers, and other agencies) to integrate those services into the physical, behavioral, and oral health care that is already being provided. This can include promotion of community-based wellness programs and activities that integrate community public health interventions


63 2014 OR regulation Text 35936 proposed changes to OAR 410-141-3145(9).
that have an emphasis on the social/environmental determinants of health and include member education and outreach provided by community health workers.

Example:
- Oregon CCOs are required to demonstrate partnerships necessary to allow for access to and coordination with social and support services, including culturally-specific community-based organizations, community-based mental health services, Medicaid-funded long-term care services, and mental health crisis management services.

Utilization of community health workers
ACOs have the opportunity to promote public and community health through strengthening the role of community health workers in connecting people to care resources and promoting overall health. The 2009 DPH study on community health workers identified several strategies to leverage community health worker skills to strengthen access to care, reduce disparities and lower health costs. These key front line providers are able to reach people where they are – in their communities and homes – outside the clinical setting, providing a bridge between traditionally underserved populations and needed health information, support, care and social services. We recommend that ACOs be directed to utilize community health workers to provide care coordination for high-risk members and to provide direct wrap-around services or linkage to wrap-around services for high-risk members. ACOs should follow evidence-informed guidelines for the ratio of community health workers and practice-based clinical supervisors for Medicaid and commercial populations.

Example:
- Oregon CCOs are required to provide members with assistance in navigating the health care delivery system and accessing community and social support services including the use of health care interpreters, community health workers, peer wellness specialists, and personal health navigators.

Support and invest in community-level changes in conditions which drive health outcomes
Prevention and public health are critical to lowering health costs and improving quality. Population health should include measuring and analyzing key population-wide health indicators to support community-level care and community-level changes in conditions. ACOs should perform an assessment of community assets and challenges (e.g., high levels of violence, poor access to healthy food) to better understand community needs and target partnerships/interventions. We believe it is necessary for an ACO to look beyond its members to address public health needs of the greater population (e.g., the service area or community where the practice is located). ACOs should collaborate with external partners to address community-based drivers of poor health. This will ensure that medical practices and public health agencies work together towards improving health at the individual, delivery system, and community levels.

Example:
- Oregon CCOs are required to participate in a community health assessment process in partnership with their local public health authority and other health and social service agencies.

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65 OAR 410-141-3015(21).
to develop a shared community health improvement plan. CCOs are also encouraged to utilize community health workers when appropriate. Under their CMS waiver, Oregon has the ability to use Medicaid dollars for health-related flexible services. In fact, CCOs are encouraged to form partnerships with local housing agencies and public health organizations (e.g. those focusing on obesity prevention or tobacco cessation) to help address the social determinants of health.66

Incentives to reduce racial, ethnic and linguistic health disparities, including incentives to provide culturally and linguistically appropriate care

While racial and ethnic disparities in access to care have decreased significantly since the passage of Chapter 58, access to insurance coverage has not solved the problem of access to quality health care for racially and ethnically diverse populations in Massachusetts. In fact, disparities in health outcomes, infant mortality, and rates of chronic disease continue to be prevalent. Commonly identified factors related to health disparities include cultural differences in understandings of the causes of illness, language barriers, implicit bias, lack of patient trust in the health care system, lack of health literacy and poor communication by all parties.

While health disparities involve multiple social, economic, and behavioral factors that impact the distribution of disease and health outcomes, the delivery system can play a key role in addressing disparities. In addition to robust data collection as described above, ACOs should be required to train their providers on cultural competence and make efforts to reduce implicit bias among caregivers. At a minimum, ACOs should be required to comply with the Culturally and Linguistically Appropriate Services (CLAS) standards issued by the HHS Office of Minority Health. The purpose of the CLAS standards is to ensure that all people entering the health care system receive equitable and effective care in a culturally and linguistically appropriate manner. The standards are meant to be inclusive of all populations, but are specifically designed to meet the needs of racially, ethnically, and linguistically diverse populations that experience unequal access to health care services.

Example:

- Oregon CCOs have been directed to focus on these issues by developing strategies to ensure health equity (including interpretive services and promotion of cultural competence) and elimination of avoidable gaps in health care quality and outcomes as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and additions status, geography, and other cultural and socioeconomic factors. They are further required to collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis. CCOs are also required to partner with their local public health authority, hospital system, mental health authority, and Aging and People with Disability field office to conduct a shared community health assessment with a focus on health disparities.67

Flexibility in spending

As noted in prior sections, payers should be encouraged and incentivized to pay for coordination, wellness and prevention services that are not traditionally reimbursed, including: care coordination, group visits, home visits, peer support, transportation to and from medical services, culturally-appropriate interpreter services, member education and outreach provided by community health

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66 OAR 410-141-3015(8).
67 OAR 410-141-3015(24)(a); OAR 410-141-3015(24)(c); OAR 410-141-3015(8).
workers and others, shared decision-making, member transitions support, and other health-related flexible services.

**Financial Incentives and Payment Methodologies**

**Incentive payments**

Under alternative payment methodologies (APMs), providers achieve the greatest financial benefit if costs are effectively managed and quality targets are met. The cost benchmark chosen for the population cared for in an ACO using an APM contract can therefore play a fundamental role in determining whether or not an ACO receives a financial reward for adequately controlling costs. A cost benchmark should provide an incentive to reduce medically unnecessary expenditures through better care coordination, utilization management, and achievement of a healthier population, without creating perverse incentives to stint on necessary care or to avoid particularly complex members in order to meet the defined cost targets. An accurate and realistic cost benchmark will also likely incent providers to take on more complex members. Clinically complex members are likely already diagnosed with the illnesses that make them complex, which makes their costs more predictable.

Given these considerations, we recommend that MassHealth prioritize patient quality outcomes as the leading component of payment incentives, so that cost savings are not the sole motivation of provider payment reforms. With respect to developing quality and cost-based payment incentives for ACOs, we suggest that MassHealth take into account the following:

- Set cost benchmarks that promote appropriate cost management but not set unattainable targets or incent under-service or member selection.
- Reward providers for improving cost performance year over year, as opposed to achieving a fixed cost benchmark, as this will minimize pressure on historically lower performers to achieve a benchmark that is unattainable. As providers will take some time to retool their practices, it is also probably unrealistic to expect savings in the first year or two of the program.
- Reward improvements in quality, including outcomes, as this gives every practice a reason to invest in care. Providing discrete incentive payments that reward quality improvement, irrespective of whether savings are achieved, will serve as a counter-balance against any incentive to inappropriately reduce costs. If quality measures are not included in the payment formula, providers will have little to incentive to work to improve quality.
- Opportunities to earn savings should be correlated with quality performance. Using a sliding scale to increase the share of savings the ACO receives based on quality performance can incent a pattern of continuous performance improvement.
- Measure ACO quality performance via year over year changes, using members who have been continuously attributed to the ACO during the prior year, to ensure that ACOs are not penalized for accepting new members who may be more challenging to care for.
- Only allow ACOs to share in any savings if they meet threshold performance on quality measures and are not found to have engaged in under-service or member selection.
- Ensure that up-front investment funds are allocated to behavioral health, LTSS, oral health, and community-based organization providers, as well as medical providers.
- To reduce the incentive for providers to under-serve, individual providers and provider groups at the sub-ACO level should not be rewarded based on the portion of savings they individually generate. Instead, individual providers and provider groups should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel. Rewards should return to the ACO level to reflect the broad
community responsible for the savings. This will also help shift incentives to improve coordinated and team-based care.\textsuperscript{68}

In order to align incentives, payment levels should be tied to patient outcomes. “Potentially preventable events” (PPEs) is one valuable measure of outcomes that identifies health care encounters that are potentially avoidable and lead to unnecessary services and poor quality of care. PPEs can never be fully eliminated, and their measurement must include risk adjustments that take into account patient severity of disease and burden of illness, as well as socioeconomic factors (see below). ACOs with lower relative adjusted rates of PPEs – such as avoidable hospitalizations, preventable readmissions, preventable complications, or unnecessary emergency room visits – should be rewarded. The rewards will provide incentives for practices to invest in quality-improving changes that lead to improvements in their patients’ health. These measures should be used in conjunction with effective methods for tracking under-treatment, and with patient-reported outcomes measures, as mentioned above.

MassHealth should require ACOs to report and demonstrate how the entity is implementing payment incentives in order to decrease PPEs and improve outcomes. The reporting should also be transparent and made available to the public. MassHealth should build off its current policies around PPEs and include additional incentives for improving outcomes.

\textit{Example.}

- Maryland, New York and Texas are examples of states currently implementing policies that tie Medicaid payments to preventable events, while several other states are considering this.\textsuperscript{69}

\textbf{Risk adjustment should take into account socioeconomic status}

Costs of care vary substantially among individuals with similar medical conditions but varying social and economic profiles. If these factors are not taken into account, ACOs will face increased risk from caring for vulnerable or disadvantaged members. Payment adjustments must guard against ACO providers shunning high-risk members or limiting care. We can learn from the One Care program, which has faced challenges in financing because payments were not adequately adjusted to account for the needs of the population being served.

In order to reduce incentives to deny or limit medically necessary care, payer contracts with ACOs should use risk adjustment measures under alternative payment arrangements that include adjustments for social, cultural, and economic factors, so that resources are available to provide culturally and linguistically appropriate services for people who are lower income, homeless, have difficulties with English, are from ethnic and/or minority populations, and for persons with physical, mental, intellectual or sensory impairments. This will require extensive preparation, as these measures are just beginning to become available. We understand that MassHealth is working with UMass Medical School to devise appropriate adjustments. Their work should be shared with the broader community concerned about these issues, and MassHealth should prioritize starting on this path now.

In addition to adjusting payments based on socioeconomic status and other sociodemographic factors, MassHealth should also consider making similar appropriate adjustments to some ACO quality metrics\textsuperscript{68} See footnote 1, supra.\textsuperscript{69} Community Catalyst. (2011). \textit{Smart Payment Reforms Can Reduce Costs and Improve Quality: A Short Primer}. Community Catalyst. Retrieved from http://www.communitycatalyst.org/doc-store/publications/Medicaid_Payment_Reform_Savings.pdf
used in payment as well. The decision made by NQF last year to endorse adjusting outcomes measures based on these factors reflects the concern that a provider should not be penalized as a poor performer because it serves more vulnerable patients. For example, a recent study found that Medicare readmission rates varied significantly based on their patient population. The researchers concluded that "Hospitals serving healthier, more socially advantaged patients may not have to devote any resources to achieving a penalty-free readmission rate, whereas hospitals serving sicker, more socially disadvantaged patients may have to devote considerable resources to avoid a penalty."  

However, these adjustments should only be made to measures that implicate patient characteristics, and should not apply to issues solely under the provider’s control (for example, surgical checklists or hand washing). In addition, unadjusted stratified data should be made available for measuring disparities and targeting improvement efforts.

As risk adjustment methodologies that include SES are still evolving, MassHealth should also make supplemental payment adjustments to ACOs enrolling disproportionate numbers of high-need and complex patients in the interim.

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We appreciate the opportunity to provide you with our ideas of key features of member-centered delivery models. We know that MassHealth has a unique opportunity to drive change throughout the health care delivery system, and are excited at the prospect of those changes resulting in enhanced patient care and improved outcomes. We look forward to continuing to work with you to ensure the MassHealth program continues to offer accessible, affordable, quality and comprehensive services to its members. Thank you for your consideration.

Sincerely,

Amy Whitcomb Slemmer, Esq.
Executive Director
Health Care For All

cc: Ipek Demirsoy, Director of Payment and Care Delivery Innovation
Aditya Mahalingam-Dhingra, Program Lead for Accountable Care Strategy
Robin Callahan, Deputy Director
Corrine Altman Moore, Director of Policy

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