September 1, 2016

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell,

We write in response to your request for public comment on Massachusetts pending proposal to restructure its MassHealth delivery system through a Medicaid Section 1115 waiver. Massachusetts has submitted a far reaching proposal with many worthy goals. However, one aspect of this proposal, which seeks to direct Medicaid beneficiaries into coordinated care delivery models (i.e. ACOs and MCOs) by limiting benefits and raising copays on Medicaid beneficiaries who remain in the state's disfavored delivery system (i.e. the Primary Care Clinician, or "PCC" plan), concerns us greatly. While the state's goal to improve coordination of care is laudable, we do not believe this is the right approach to achieving this goal. We also note that the delivery system proposals will likely exclude many small providers and those providing care to underserved communities, which could lead to increased disparities in quality and care.

Massachusetts seeks to eliminate certain state plan benefits including orthotics, eye glasses, hearing aids, and chiropractic services for categorically eligible beneficiaries who choose to remain in the PCC plan (See Section 4.4 Approval of this request would not promote the purposes of the Medicaid Act, and it would set a dangerous precedent, because it would violate a fundamental precepts of the Medicaid program- that categorically eligible individuals are entitled to receive all state plan services, and that children and youth under age 21 are entitled to all medically necessary services under the Early and Periodic Screening Diagnostic and Treatment (EPSDT)program.

CMS has informed states that children enrolled in all types of managed care, including PCC Plans, "are entitled to the same EPSDT benefits they would have in a fee for service Medicaid delivery system[1]." Children and youth are entitled to medically necessary chiropractic services, orthotics, eye glasses and hearing aids even if these services are not in the state plan regardless of the state's delivery system.

Access to certain hospitals is increasingly problematic for beneficiaries enrolled in managed care in Massachusetts – including hospitals that provide specialty care for people with disabilities and complex medical needs and beneficiaries living in rural areas. This is likely one reason why children and adults with disabilities are disproportionately represented in the PCC plan, and are at even greater risk if benefits are limited and copays are raised.

We are also concerned that the proposal focuses delivery system transformation efforts on providers who are able to accept financial risk. Aligning financial incentives through a risk-bearing model may ultimately improve health outcomes and increase the value of the care offered by Massachusetts providers; however, many smaller providers and those caring for underserved communities also provide high-quality, essential care but may not be well-suited to an ACO-like structure. It is

[1]Centers for Medicare and Medicaid Services, *EPSDT--A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, June 2014, pp.29-31.

imperative that these providers continue to have an opportunity to participate in delivery system improvements such as pay-for-performance programs. Leaving these providers out of the testing of innovative new models would unnecessarily harm the communities they serve.

In addition to providing opportunities for a wide range of providers to participate in delivery system changes, the proposed models of care should include rigorous public reporting of quality measures, particularly in relation to the inclusion of long term services and supports (LTSS) in the managed care plan contracts. The waiver proposal does not appear to include specific metrics and goals by which alternative payment models and managed LTSS would be measured. It will be essential to the success of these models to include frequent public reporting of these measures to allow for maximum transparency and oversight.

We urge CMS not to approve the feature of the state's proposal to deny low income families with children, and individuals with disabilities access to state plan services and charge higher copays based on their choice of plan. We believe alternative approaches make more sense – such as auto-assigning beneficiaries that do not make an active choice within 90 days into ACOs and MCO's that deliver the highest quality care.

Thank you for your willingness to consider our comments. If you need additional information please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (Solomon@cbpp.org).

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