ATTACHMENT A
COMPREHENSIVE PRIMARY CARE PAYMENT REFORM
RFI RESPONSE TEMPLATE

SECTION VIII.A. Respondent Information

1. **In what geographic areas in Massachusetts do you provide services?**
2. **If you provide services, how many people do you serve annually?**
3. **If you provide services, what kinds of direct services do you provide?**
4. **If you do not provide services, what is your role in the health care system?**

The Association for Behavioral Healthcare (ABH) is a statewide association representing over eighty community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily and over three-quarters of a million residents annually. This robust network of providers is the treatment system for the largest percentage of the state's adults with serious mental illness and chronic addictions and children with serious emotional disorders and trauma.

5. **If you provide services, do you do so in the context of a patient-centered medical home model? Are you NCQA certified, and if so, at which level? Are you a participant in the Patient Centered Medical Home Initiative?**
6. **If you are a PCC or primary care provider, would you respond to the Comprehensive Primary Care Payment Reform RFR, as it has been described above? Why or why not? If not, what changes would you recommend that would make this initiative interesting to you?**

SECTION VIII.B. Financial Model

1. **The CPCP is intended to support high quality, patient centered care. What features of our proposed model support these goals? What features should be modified to better advance them?**

The CPCP Reform initiative, as described in the *Clinical Delivery Model* and *Request For Information,* appears to be based upon the assumption that the locus of all Patient-Centered Health Homes should be Primary Care. ABH believes this assumption will not produce the desired outcomes of improved health status for a significant population of persons served. Patients with specialized needs may have their most frequent access and contact with the healthcare system through specialty practices including cardiology, neurology, behavioral health, and possibly others rather than with primary care services. These patients may have their overall care coordinated by and receive far more services from these practices than from primary care. ABH believes that there is a need for a range of specialty Health Homes that include Behavioral Health Homes.

The nature of the involvement of behavioral health services described in the RFI, while emphasized in the document as being key to integration, remains incompletely defined, as the RFI itself acknowledges. Patient-Centered Primary Care practices are required to screen for behavioral health, the CPCP includes "*some outpatient behavioral health services*", and the CPCP payment covers "*evaluation and management, case management, care coordination, and behavioral health coordination.*" Relationships with the robust system of community-based provider organizations currently providing care to thousands of individuals with addictions, serious mental illness, and children with trauma and serious emotional disorders, are not detailed in the RFI. ABH welcomes this opportunity to recommend a range of options for addressing the primary

care for individuals with behavioral health needs, among them the Patient-Centered Behavioral Health Home in addition to the Patient-Centered Medical Home with Integrated Behavioral Health.

For purposes of this RFI, ABH would like to make clear the distinction between the **Patient-Centered Medical Home (PCMH) with Integrated Behavioral Health** and the **Patient-Centered Behavioral Health Home (PCBHH).** We would like to provide some input on both Behavioral Health Homes and Behavioral Health services delivered inside Primary Care practices since there are so many different existing and emerging integration models and we believe innovation should be encouraged and supported.

The PCMH with Integrated Behavioral Health is a practice that delivers primary care services and also a range of community-based behavioral health services either on-site or in partnership with a community behavioral health center. A few of ABH's member providers have incorporated primary care clinics into their organizations and these medical services are fully integrated with a comprehensive range of behavioral health services. Numerous other ABH members, however, fit or may soon fit the requirements of a *Patient-Centered Behavioral Health Home*. These organizations either incorporate some primary care services into their own organizations or may instead ***be closely linked with*** primary care services with which they may have affiliated, having established close bi-directional referral and communication channels, or even co-located in the same overall facility.

Community behavioral health organizations may serve as a PCMH with Integrated Behavioral Health for some of their patients, while serving as a PCBHH for others, who choose to receive their primary care from other practices or settings.

ABH proposes that community-based behavioral health organizations which choose to assume the role of Patient-Centered Behavioral Health Homes (PCBHH) will serve as the primary locus of care for certain patients, and for these individuals, primary care services will be closely linked with the behavioral health services. The population to be served by the PCBHH will include first, those individuals who meet the criteria of the two quadrants of "High Behavioral Health" needs of Barbara Mauer's Four-Quadrant Model of integrated care. Second, the PCBHH will also include some other individuals who despite meeting the criteria of "Low Behavioral Health" also initially enter the health care system through behavioral health services rather than primary care services due to "*social factors that may complicate care delivery and impact health outcomes, such as homelessness, refugee or immigrant status, criminal justice involvement, food insecurity, and previous negative experiences with the healthcare system"* (*Section C: Clinical Delivery Models Based on Patient Complexity,* the *Clinical Delivery Model)*. For individuals receiving behavioral health care who avoid primary care services, ABH would also add the qualification "*by virtue of stigma and shame concerning addiction and/or mental illness".* Simply put, individuals who opt to self-identify their Health Home as a Behavioral Health Home rather than a PCMH should be able to do so.

It is well known that having a serious mental illness or addiction puts an individual at risk of other health problems. Individuals with Serious Mental Illness die approximately 25 years earlier than the general population and a large percentage of these premature deaths are due to medical diseases such as cardiovascular, pulmonary, diabetes, cancer, and other serious illness. It is also well known that selective serotonin reuptake inhibitor (SSRI) anti-depressants are highly linked with weight gain and related illness and the second generation of anti-psychotic medications are also closely linked with weight gain, metabolic changes, increased risk of diabetes, hypertension, and cardiac disease. Individuals with serious addiction problems are at increased risk of liver damage, pancreatitis, cardiovascular problems, seizures, damage to the nervous system, and in

the case of intravenous drug-users, Hepatitis C and HIV/AIDS. It is essential that the population of individuals experiencing mental illness or the disease of addiction receive health care services to improve their health outcomes, quality of care, quality of life, and ultimately, decrease the cost of their care.

Yet as we know, for numerous reasons, many of these individuals will not seek health care until their conditions worsen and require more acute-level, expensive services, including hospitalization. Additionally, behavioral health providers know that some of these individuals are not well served by primary care practices whose staff are understandably overwhelmed and unfamiliar with working with individuals with pervasive behavioral health needs.

For all of these reasons, within the last few years, many behavioral health provider organizations have initiated efforts to closely link their services with those of primary care. A few have incorporated primary care services within their own organizations; others have affiliated closely with primary health services in local community health centers and primary care practices; still others provide behavioral health consultation, evaluation, and brief treatment within primary care practices. Most behavioral health provider organizations that had not already created such linkages with primary care services now have efforts underway to create them.

The Comprehensive Primary Care Payment (CPCP) Reform initiative reasonably assumes that cost savings in the overall healthcare system for low-income individuals with costly, complex needs will be generated through a closer interface between primary care and behavioral health services. As the RFI notes, 70% of primary care visits stem from psychosocial issues. The initiative understandably makes no assumption that any significant savings will be generated from behavioral health services, which have historically been underfunded (see reports referenced in #5 below), but rather from untreated medical conditions which ultimately result in high-cost medical services and underlying mental health and/or substance use disorders that complicate existing health conditions.

Since long-underfunded public behavioral health services in the community have operated on significantly tighter margins and have lacked the capital reserves and capacity of large primary care practices, ABH views as a positive feature of the CPCP initiative that behavioral health organizations which choose to serve as Patient-Centered Behavioral Health Homes would be able to select the *Upside Risk Track* (number 3) without bearing financial downside risk. In addition, some of these practices would be interested and able to meet the requirements for certain quality incentive payments pertaining to the delivery of behavioral health services.

2. **What would be particularly challenging about receiving payments in this fashion? How could MassHealth mitigate those challenges?**

3. **The Comprehensive Primary Care Payment is envisioned to cover evaluation and management, case management, care coordination, and behavioral health coordination. Beyond that, what services should be included in the CPCP bundle? To the extent that MassHealth includes outpatient behavioral health services in the CPCP, which services should be included?**

ABH believes that outpatient behavioral health services, in fact, all behavioral health services other than screening/referral/hand-off should be **excluded** from the Comprehensive Primary Care Payment.

Patients with behavioral health problems need to have a choice in where they receive their care

and it is important not to implement an incentive for Primary Care practices to restrict that choice or to limit the amount of care they receive. When behavioral health services are subsumed under a medical contractor, there is a risk that they will become under-utilized and under-funded. ABH suggests that utilization of ambulatory behavioral health services in fact needs to increase to address the greater medical needs and costs of known patients whose conditions are complicated by co-occurring behavioral health problems as well those of primary care patients whose behavioral health conditions have been heretofore unidentified and untreated. We believe this may not happen if behavioral health services are included in a Per Member Per Month (PMPM) payment combined with primary care services.

In an incremental financial model, ABH recommends that the PCBHH organizations receive a PMPM payment initially that supports only the *enhanced components* required to meet the criteria for Patient-Centered Behavioral Health Homes. These components might include nursing to provide health education and promotion for patients, training and consultation for staff, and coordination of medical care with pediatricians/primary care practices. Additionally, the PMPM would cover the cost of employing Community Health Workers and Peers as Health Navigators, and specialized staff to develop, generate and analyze enhanced data reporting. Not included in the PMPM, but central to a Behavioral Health Home are Electronic Health Records and the sharing of behavioral health information with primary care practices. Behavioral health providers will be eligible for IT infrastructure funding through the recently-enacted Massachusetts Payment Reform Legislation and many have taken steps necessary for their prescribing staff to qualify for Meaningful Use reimbursements.

At the present time, there is no reliable data on which to base a PMPM that covers the cost of services. The cost of behavioral health services is not currently known since (1) utilization needs to increase for behavioral health services in order to help decrease medical costs, and (2) most behavioral health services have historically been significantly underfunded. A plan should be developed to move toward a comprehensive PMPM in subsequent years once sufficient data is available to recommend utilization and pricing targets.

Behavioral health provider organizations that choose not to participate as PCBHHs, as indicated in the RFI, should continue to be paid on a fee-for-service basis.

4. Do the shared savings tracks offer an appropriate range of paths for the diverse providers that may be interested in becoming Participants?

ABH believes that most behavioral health providers that choose to serve as Patient-Centered Behavioral Health Homes would be interested in the Upside Risk Track, often in combination with quality incentive payments. Based on information from both Massachusetts practices and those in the state of Missouri, whose program of Community Mental Health Center (CMHC) Healthcare Homes is considered the most sophisticated national model, ABH believes that a behavioral health panel of 3000-5000 members is too large as a threshold level. Primary Care Medical Homes are based on the expectation that the top 10% of the patients will have chronic conditions; in a Patient-Centered Behavioral Health Home, the majority of patients have chronic conditions. ABH would strongly recommend a smaller panel be adopted as the threshold for a Patient Centered Behavioral Health Home, for which the intensity of needs precludes spreading risk across a “panel” that includes some healthier individuals. Representatives of the Missouri CMHC Healthcare Homes program have recommended patient populations of 250-500 individuals.

5. Do you have any additional feedback on considerations in developing the finance model?

Reports that include *EOHHS' Financial Health of Providers in the* Massachusetts *Human Service System* (October 2007, DMA Strategies) and the more recent *Report of the Massachusetts Department of Mental Health Task Force on Staff and Client Safety* (June 2011) have concluded that behavioral health services in Massachusetts have historically been underfunded and that:

> *"the Commonwealth does not currently have a well-resourced and well-integrated system of services and treatment. This is in part the result of budget cuts that have significantly impacted the availability of services, including hospitalization and related resources, for individuals served by the Department of Mental Health, as well as inadequate reimbursement rates from both MassHealth and commercial insurers for outpatient and inpatient mental health services.* "

Funding for behavioral health services under the Comprehensive Primary Care Payment Reform initiative, whether for Patient-Centered Behavioral Health Homes or reimbursement of behavioral health services delivered outside a Health Home, must fairly and adequately reimburse the provider organization which delivers them. The outpatient behavioral health service system, which has experienced increasingly large losses over the last dozen years (many clinics have closed as a result), will be unable to meet the needs of either Medical Homes or Behavioral Health Homes without rates of reimbursement which cover the costs.

SECTION VIII.C. Quality Metrics

1. **Are there additional domains of measurement that MassHealth should consider adding?**
2. **Within the enumerated domains, or any others that are suggested, are there any additional measures MassHealth should consider, given the above-described goals?**

   Because there are few if any validated process measures of enhanced coordination between behavioral health and primary care providers, we encourage MassHealth to include a plan to add measures that may be currently under development, particularly around communication between primary care and behavioral health providers.

3. **Which measures, if any, would you suggest removing from consideration, and why?**
4. **Which measures would you recommend be tied to financial incentives for quality performance? Is there a minimum denominator size for measures tied to incentives? Are there other criteria that MassHealth needs to consider when determining measures for incentive payments?**
5. **Which measures would you recommend be used as reporting-only metrics?**
6. **Would you recommend adding a measure on hospital readmissions? If so, which types of readmissions would you recommend as a measure? Which specific measure? Would you recommend a behavioral health readmission measure?**

   ABH recommends the inclusion of a measure of behavioral health readmission and to utilize a short readmission timeframe of 7 or 14 days. A readmission rate of 30 days, for example, would not be an accurate measure of quality in a prior admission.

7. **Of the above list of measures, which are the five or ten that you would consider to be of the highest importance for measuring the quality of care?**
8. **Do you have any overall comments on the set of measures presented here you would like to make?**

9. As the field of quality measurement is constantly evolving, should MassHealth consider making changes to the measurement set over time? How often should measures be changed? If so, how should that be accomplished?

Based on the historical experience of ABH's member providers in implementing quality and outcome measurement, gathering data, and utilizing that data in quality improvement projects, ABH strongly recommends that the Payment Reform initiative begin with fewer measures at the start of the initiative. The tasks of training and supporting staff to collect data, setting up manual and electronic systems for data input and reporting, and the process of analysis and utilization of that data in quality improvement projects all take far more extensive time, education, and resources to implement than one initially projects. Once the systems are in place, it is then easier to add or modify the specific measures.

10. Do you recommend sub-measure analysis for specific populations, e.g. children, pregnant women, behavioral health conditions? If yes, how should this sub-measure analysis impact assessment of quality performance?

ABH recommends including baseline and subsequent penetration rates of behavioral health services for the MassHealth population covered under Comprehensive Payment Reform practice contracts. In addition, it would be very important to include measures from primary care that indicated the number of people screened for behavioral health issues, how many had a positive screen, and were engaged in treatment. All of these measures would ensure that primary care practices were not under-identifying and under-referring for behavioral health care, and that behavioral health practices were successful in member engagement. The data would provide a further review of the process from hand-off to treatment engagement.

11. This initiative will likely require CAHPS measure collection at the practice level. How should MassHealth align with concurrent efforts by practices and other payors to support survey data collection?

ABH strongly recommends that MassHealth examine all of its concurrent managed care contracts and current or impending initiatives and develop an assessment of the payors' contractual requirements and management processes in order to align these across the numerous, important initiatives underway. It is becoming increasingly difficult for members and providers to navigate the many differences and to meet the screening, data, reporting, service authorization, claims-processing, quality measurement and improvement, and other required components of all of the ongoing simultaneous initiatives. At a minimum, all payors involved in any single initiative should be required to use the same reporting requirements/format/structure. In the interest of more efficiently and cost-effectively managing the care of members, this alignment will be essential.

SECTION VIII.D. Clinical Delivery Model

1. To the extent that you have experience implementing the twelve capabilities of the Patient Centered Medical Home and behavioral health integration, what approaches have you used? Please describe the challenges you have faced, and what role a managed care entity might play in managing those challenges?

ABH is extremely concerned that in crafting its clinical delivery model, MassHealth has failed to address the needs of a significant population of its covered members, that of adult individuals with

serious mental illness and addictions and children with serious emotional disorders/trauma.

Recently-enacted Payment Reform legislation in Massachusetts included explicit language (Section 15, Chapter 224 of the Acts of 2012) which stated that:

> "*nothing in this section shall be construed as prohibiting a primary care provider behavioral health provider or specialty care provider from being certified as a patient-centered medical home; provided that such providers meet the standards set by the commission in accordance with this section or are recognized by the National Committee for Quality Assurance as a patient-centered medical home."*

Some of the assumptions made in the Clinical Delivery Model simply do not hold true for individuals with serious behavioral health needs. In *Section I: Patient-Centered Medical Home (PCMH),* the statement about Point of First Contact: "*Primary care is the entryway into our health care system"* is not accurate when considering individuals with serious BH conditions. For many of these individuals, behavioral health services are their entry-point to the health care system and represent the care-givers with whom they are the most comfortable and familiar. Additionally, under *Continuous or Longitudinal Care*, the statement: "*Primary care is a service that knows the patient in context over time, and as such, can more accurately discern a patient's needs and concerns"* also frequently does not hold true when applied to individuals with serious behavioral health needs, as well as for other patients whose most frequent contacts with healthcare providers are through other specialty services such as cardiology or neurology. Many patients with serious mental health or addictions problems are apprehensive and avoid going to their primary care clinicians' offices. It has also been the experience of behavioral health providers that numerous primary care clinicians are not trained or comfortable in treating individuals with serious behavioral health conditions.

It must be noted that some behavioral health provider organizations (both mental health and addictions) have been working for a number of years to address the primary care needs of their patients through various arrangements: developing close affiliations with local community health centers and primary care practices, placing behavioral health clinicians in primary care settings for rapid consultation and hand-off to treatment provided either on-site or at the behavioral health clinic, co-locating with primary care practices and implementing steps for bi-directional referrals and communication, and a few have incorporated primary care clinics or professionals into their own organizations. Many others are currently in different stages of developing various arrangements to address their patients' concurrent primary care needs.

In addition, some of the same organizations which have been working to closely link primary and behavioral health care have also incorporated into their systems some of the other components of the Comprehensive Primary Care Payment Reform and Health Homes. They utilize electronic records and e-scripts, incorporate patient-centered and recovery-oriented practices and involve peer specialists and family members where possible in their services. The provider organizations expend significant time and resources coordinating their clients' care, utilize a multi-disciplinary team to provide treatment, focus significant resources on identifying and treating their highest-risk clients, and manage quality and outcomes through data. And as noted above, many other behavioral health providers are in various stages of developing/implementing these components with the goal of soon qualifying to become Patient-Centered Behavioral Health Homes.

Some specific modalities or types of services, such as Community Support Programs (CSPs), have been especially effective in their community outreach efforts with professional and para-professional staff to meet with clients, (some individuals with serious mental illness and addictions

are hard to locate), engage them in addressing their needs, help them schedule and keep primary and behavioral health appointments, take medications as needed, and resolve many other social service needs which prevent them from focusing on their health status.

It must also be noted, however, that a number of barriers to integration currently exist in regulation and reimbursement/billing requirements. ABH appreciates the work that the Department of Public Health and MassHealth are currently undertaking to identify and address the specific barriers and ABH is working collaboratively with them and the Massachusetts League of Community Health Centers on that effort.

ABH would like to note that in the *Clinical Delivery Model, Section 2. Clinical Delivery Models for Behavioral Health and Primary Care Integration*, the *Subsection A. Approaches to Integration* refers in the model of five levels of collaboration to "close collaboration in a fully-integrated system" and ***"primary care and behavioral medicine as part of a care team".*** We would like to clarify that "*behavioral medicine*" is not the same as "*behavioral health*" services and should not be used interchangeably. Behavioral medicine is a specific segment of psychosomatic medicine focused on influencing medical and psychosomatic disorders using behavior therapy techniques such as biofeedback and relaxation training. Behavioral health services involve a range of methodologies and best practices aimed at treating mental and substance use disorders, including counseling, medication, group and family therapy, and evidence-based practices such as cognitive-behavioral treatment, motivational counseling, and dialectical behavior treatment.

2. Are there domains of behavioral health integration other than the five listed here that should be added?

Many of the measures indicated under Behavioral Health Integration appear to be more relevant for a Patient-Centered Medical Home than a Patient-Centered Behavioral Health Home. However, the measure entitled "*Follow-up after hospitalization for mental illness (includes children and adults*)" could apply to Behavioral Health Homes but should also extend to inpatient care for addictions (such as detox). The measures related to antidepressant and ADHD medication management and a measure related to engagement in addiction treatment could also apply to a Behavioral Health Home.

For patients on SSRI medications and second generation anti-psychotic medication, very specific medical screenings should be required on a routine basis to pro-actively identify and treat related metabolic, diabetes, cardiovascular and other diseases that are closely associated with these medications and contribute to the early death rate for individuals with serious mental illness. For patients with longstanding addictions, medical screenings must be required to identify potential serious illnesses related to an addiction to alcohol or other drugs.

3. Do the elements of integration within each domain appropriately cover the range of that domain? Are there any additional elements to consider including?

4. Does the defined set of "foundational elements" strike an appropriate balance between setting an ambitious goal and maintaining a feasible target for practices?

Yes they do.

5. Does the delivery model as specified strike an appropriate balance between being broad enough to allow practices to innovate in how they achieve elements of integration and being

specific enough to ensure adherence to high standards?

As noted elsewhere in this response, ABH believes that the clinical delivery model described in the RFI should be broadened to encompass Patient-Centered Behavioral Health Homes, which we maintain are essential to any initiative intended to address the coordination of primary and behavioral health care in the Commonwealth.

6. **What facilitation or guidance from payor-based experts or care management professionals is useful to the practice? How should payor-based care management programs interface with practice-based care managers? Have you implemented care coordination and clinical care management? If so, please describe your model for delivering these services. What challenges did you face? How did you integrate risk stratification of patients into care coordination and care management processes?**

ABH is concerned about the multiplicity of care coordination and care management programs being implemented across the state in a range of initiatives. These include the new PCC Plan Behavioral Health contract (MBHP) which involves an extensive new Care Management Program, the Dual Eligible Demonstration, the Money Follows the Person initiative, not to mention ongoing care coordination/management activities occurring through existing DMH-funded Community-Based Flexible Support Services, MassHealth-funded Children's Behavioral Health Initiative services, DPH-BSAS-funded care coordination in addiction services, and others.

ABH strongly recommends the alignment of these multiple initiatives with regard to care coordination and care management activities. ABH also believes that it is most important that care management activities be located with the provider organization delivering the services in the community rather than overlaying another level of management/activities onto the delivery of services which becomes duplicative, adds more administrative complexity for members and providers, further removes scarce resource dollars from services, and becomes an unwelcome process for consumers/families. Multiple care managers/coordinators can be confusing and intrusive for members and their families. We strongly recommend that models of care coordination that are removed from provider services be re-considered.

A Congressional Budget Office study (*Issue Brief*, January 2012) entitled "*Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment*" found that among 34 pilots, (most of which did not reduce Medicare spending), disease management and care coordination programs, "*… in which the interaction was primarily by telephone exhibited little or no effect, on average, for either outcome"* [hospital admissions or Medicare spending]. The study also found that "*Significant in-person interaction between care managers and patients also was associated with reductions in hospital admissions and regular Medicare spending."*

7. **Do you have any pre-existing partnerships with community based clinical and non-clinical resources that assist you in providing patient-centered care? Do you interact with other state entities (e.g., DMH, DYS) in care coordination and care management? How could MassHealth leverage and support those resources?**

All of the community-based mental health and addictions providers serving the state's publicly-funded populations are deeply and historically embedded in their local communities. They have long-established relationships with local and area health care and social service agencies and do

business on a regular basis with their state agency counterparts. Care coordination and care management are fundamental components in delivering mental health and addictions treatment for the publicly-funded population and are best navigated by organizations with longstanding relationships and experience in doing so. MassHealth can best support and leverage these resources by sufficiently reimbursing the Patient-Centered Behavioral Health Homes for the expenditure of time and efforts in coordinating the care and services across these multi-system agencies.

8. What are the unique challenges that behavioral health providers may face in participating in this initiative? What steps could MassHealth take to address these?

As noted above, community-based behavioral health providers have been omitted as Patient-Centered Behavioral Health Homes from the Clinical Delivery Model. Since language regarding the relationships between primary care practices that may be selected as PCMHs and behavioral health providers remains unclear, each community-based behavioral health organization will need to make certain independent business decisions after assessing where in the system they wish to position themselves and how to achieve those roles. Will it be as a Patient–Centered Behavioral Health Home? As a contracted provider to deliver services within a Patient-Centered Medical Home? By co-locating or closely affiliating with a community health center or primary care practice? Or developing yet another arrangement? MassHealth can support these challenges by encouraging and permitting maximum system flexibility and creativity for behavioral health providers who will need to develop their own solutions in their own local communities. Most behavioral health providers have already had discussions – some occurring years ago – with their local community health centers, primary care practices, and hospitals in the process of developing ways to create more closely-integrated systems of care at the local level. MassHealth should continue to address the regulatory and reimbursement barriers to those efforts and support the developments with reimbursement that covers the cost of behavioral health care.

ABH further recommends that MassHealth allow provider organizations rolling admission to this initiative to allow for the currently developing PCBHHs and PCMHs with developing partnerships with Behavioral Health Centers, especially since behavioral health organizations have been omitted from federal financial support for Electronic Health Records and much activity is likely to be happening in the very near future.

SECTION VIII.E. Eligible Entities and Application Process

1. MassHealth is attempting to create an application process and set of eligibility criteria that make it feasible for independent practices with small staffs to band together to participate without necessarily requiring hospital involvement. Does this framework meet that goal? If you are an independent primary care practice, would you consider joining an affiliation that does not include a hospital?

2. MassHealth is attempting to strike a balance between a contract management structure that ensures that practice transformation occurs and minimizing the administrative burden on participating provider organizations. Does this approach seem likely to accomplish those goals? What feedback would you have on it?

ABH strongly recommends that MassHealth align its numerous concurrent initiatives underway with regard to such elements are data collection and reporting, quality measurement and improvement, care coordination, provider credentialing, and processes to obtain authorization for care and submit claims. MassHealth should act to ensure that contract terms, requirements for

data reporting, timetables and formats, and contractual requirements **are the same** across all of the managed care entities**.** It is not in the interest of the MassHealth member, first and foremost, to permit every managed care payer to independently set its own requirements which will make unworkable the task of managing and coordinating quality care for that member.

ABH has some concerns about the amount of data projected for collection early in this initiative. For both MassHealth and provider organizations, the systems for data collection, aggregating, sharing, and analysis are not in place and will not be in place for an extended period of time. The infrastructure for exchanging health information across electronic systems, the standards and protections for the exchange of sensitive behavioral health information, and the IT components necessary to support a well-developed system of Health Homes, Accountable Care Organizations, Integrated Care Organizations, and other health care reform components, all require time, major resources, and extended processes of development, testing, and modification. Again, ABH advises that simplicity be the guideline in setting the initial requirements for Health Homes and payment reform.

3. **MassHealth is interested in seeking feedback about the appropriate affiliation process for smaller providers. Should smaller providers affiliating to jointly invest and meet minimum enrollee thresholds be required to form a new legal entity? What requirements should MassHealth place on these affiliations? What responsibilities should be required to sit at the PCC level (in each primary care practice) versus at the affiliation level (aggregated across primary care providers)? How should MassHealth regulate the funds flow between the affiliated entity (if there is one) and the PCCs?**

SECTION VIII.F. IT Infrastructure and Data Sharing

1. **Is it preferable to receive claims based data and analysis in a single feed across payors, or to receive a standardized set of reports from each payor? If there is an additional delay in data associated with channeling through a single feed, would that delay be worth the benefit of a simpler system?**

   ABH recommends that providers receive separate reports by payor, which have a standard design and an enforced schedule which requires all to report on the same timetable.

2. **Is it more important to provide access to raw claims data, or to a defined set of aggregated reports based on claims data? If you are a provider organization, do you currently have or plan to have the ability to analyze raw claims data? Is a list of high risk patients something your practice would find useful?**

   Behavioral health providers would like to receive <u>both</u> the raw claims data in order to be able to conduct their own analysis, but also to receive the aggregated analysis and reports from MassHealth in order to develop a full comprehension of the data.

3. **What mechanisms would work best for ensuring timely notification of ED visits and hospital admissions / discharges in the interim period while the Health Information Exchange gains scale? While hospitals and primary care practices may have one-off relationships to ensure this communication, what infrastructure might allow a broader solution? Should payors participate in this process, or is the role of the payor simply to provide incentives for hospitals to share this information?**

Payors should be required to provide incentives for hospitals, emergency departments, and the community-based Emergency Service Programs to ensure adequate communication.

SECTION VIII.G. Member Protections

Is this set of member protections sufficient? What additional member protections may be required?

There is no reference in the Member Protections section to the sharing of personal health information in an integrated medical record for individuals with behavioral health conditions. Behavioral health information remains sensitive to many people despite the good intentions of health care providers and systems to use it for the well-being of the person needing services and/or care coordination/management. Provisions must be made for those individuals who might choose to maintain that information outside of or limit its inclusion in the integrated medical record or to limit those with whom it is shared. Electronic systems will need to be created that support limiting access to certain portions of the record. The protection of substance use disorder information is contained within strong federal regulations designed to offset historic stigma and discrimination and attention must be paid to its continuing potential to adversely affect an individual's life, while balancing the need to use the information to positively impact his/her health status.

Members must be protected also from any reverse incentives or behaviors resulting from the model change to a bundled payment and a Patient-Centered Medical Home which are intended to generate savings. The model as described in the RFI does not accomplish that protection. The member is unable to dis-enroll from his/her Primary Care Clinician's Medical Home without dis-enrolling from the Participant's practice itself. A patient with a complex and costly medical condition is at some risk that a physician practice will undertreat in order to save money. This dynamic is one for which members need protection; simply permitting patients to switch practices is not a protection.

Further, what are the provisions for a member to submit an appeal or grievance to his/her Medical Home if the member has a bad experience? That member represents only one data point on the Patient Experience Survey. What are the avenues for members to address their concerns? This is especially important in a system in which providers are taking financial risk. One might learn about providing such options from models utilized in fully-capitated health systems or even national health insurance models from other countries.