COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
REQUEST FOR INFORMATION

Related to MassHealth's Community Partner Program

Response Form

Issued: September 16, 2016

Respondent Information Cover Sheet

Include the following information for the individual who should be contacted for purposes of discussing any aspect of the Respondent's completed Response Form:

First Name: [Leo] **Last Name: [Sarkissian]**

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- **I am responding to this RFI on behalf of the Organization listed above: Yes: [X] No: [ ]**
- **The information in this response is my own individual opinion: Yes: [ ] No: [X]**

Please select all of the provider types that describes your organization

a) CMHC	[ ]
b) CHC	[ ]
c) PCP	[ ]
d) SUD residential facility	[ ]
e) Acute hospital	[ ]
f) Other mental health clinic	[ ]
g) Other mental health provider	[ ]
h) PACE	[ ]
i) ASAP	[ ]
j) ILC	[ ]
k) Patient advocacy	[XXX]
l) Other	[ ]

If answered "Other", please describe your organization:

MassHealth Request for Information: MassHealth's Community Partner Program

Respondent Name: [Leo V. Sarkissian] Organization (if applicable) [The Arc of Massachusetts]

Response to: **Question #:** [1]

Restate **Question Member Engagement (for each response below, since there are bulleted multiple questions within each question, each bullet reflects a question followed by a bulleted corresponding answer):**

- [Are there certain entities that you are concerned might be conflicted in conducting assessments and choice counseling? If so, what are they and what are the 2 or 3 steps you recommend that MassHealth take to minimize/prevent such conflict? **(limit to 150 words)**

- All organizations will potentially have a conflict. However the most significant conflict would be with the ACO/MCO which would have a financial motivation to provide less supports than indicated by an assessment, e.g., referring a 30 year old with a disability to an adult day health program instead of a more robust day habilitation or employment (if latter is possible). I recommend that all LTSS CPs should be required to provide three LTSS provider referrals (except areas where MH decides 3 are not within reasonable distance). Random, limited reviews of cases referred by MH or ACO can address a variety of potential conflicts. If a review finds that a CP self-refers only, it should be warned once and if it continues, terminated by MH as a CP. The review should be conducted by MH however and not the ACO/MCO. In no case should an ACO/MCO serve as a CP.

- Assuming that the ACO is responsible for the total cost of care and the integrated person-centered care plan and that LTSS providers continue to provide LTSS care, what are the key elements of the LTSS CP's member-facing role? How does this differ by specific LTSS CP subpopulations or degree of complexity of LTSS need? **(limit to 150 words)**]
- The role of the CP should be to conduct an assessment related to social-psychological and community living needs in the broadest sense. Support needs to be addressed through the ACO or through program agencies (e.g., DS, Mental Health, EA, etc.) or waivers can be achieved through referrals to those agencies. Key CP elements include: LTSS supports and services expertise including generic services (community map of supports to support navigation), demonstrate capacity or partners in physical, intellectual, developmental, behavioral including frail elder, experience with housing subsidies, community action agencies, SSA and TANF and person-centered assessments. Assuming more direction prior to MH issuing an RFR, the CP's plan to address sub-populations should reflect a realistic financial plan to obtain consultation from partners as needed. No one agency will have expertise for all sub-populations-LTSS providers tend to be structured around services provided.

Response to: **Question #:** [2]

Restate **Question- LTSS-specific input for integrated person centered care plan:**

- [What are the 3 or 4 most important activities needed to better integrate LTSS and physical health, resulting in improved communication, coordination, overall better member experience and quality of care and why? What are the existing connection points within the system that could benefit from greater oversight or formalization? **(limit to 150 words)**
- Key activities: Leading role to ensure such an integrated plan; connecting member and his natural supports (family, friend, etc.) to the process, and community mapping. Given human capacity there is no way to remove silos (ability to have expertise in many areas simultaneously), the CP can lead to ensure communication across systems given that LTSS supports are the most frequently provided supports and closest to the member. The amount of work that the lead would have would depend on the natural support system of the member of MH (family, partner, close friend) but that work would fade as a plan is implemented, giving way to the key LTSS provider (most frequent support) to take on this role. Recommend that there be a review by the CP six months after the plan begins to ensure that quality supports are being delivered consistent with member choice.

- How prescriptive should MH be in developing the LTSS CP standards and the LTSS CP/ACO relationship? Please include on your answer references to the governance model, distribution of functions, and instrument to avoid conflicts of interest **(limit to 150 words)**

- MH should be prescriptive. I assume that most cases of the CP (except for those self-referred for one support) will be complex and thus require assessments (person-centered --PCAP), navigation and assistance to obtain quality care. Most community agencies are non-profit and overseen by boards, which include a mix of stakeholders, community and business leaders; CPs should have a strong community presence, thus leveraging generic or community resources. CP's values should reflect the UN Convention on the Rights for People with Disabilities. The CP should be free to develop a plan without ACO/MCO interference and a clear appeal process during PA denials should be in place to avoid conflict of interest. To address conflict of interest within the CP a review conducted by MH annually of cases could determine this and eventually through the database of member services and providers.

- If a member had both a BH CP and an LTSS CP, what are the 2 or 3 most critical areas for an LTSS CP and a BH CP to work collaboratively regarding integration of care for them? **(limit to 150 words)**

- Assuming there is a need for two CPs in such a situation, the important areas on integration are: role clarification for stabilizing Health & BH, and addressing social determinants. The BH CP would focus on the complicated interaction between health entities including hospitals, general and specialized health personnel in conjunction

with the PCP. Historically medical care is fragmented and PCPs have limited time, so the BH CP would lead in resolving diagnostic questions while developing a PCAP (person centered plan) which leads to quality care. The LTSS CP would work on addressing the community living supports needed and social determinants (address housing-day to day needs, is there a natural support network, employment support, etc.) Ideally the LTSS CP would inform the BH CP on these aspects of the PCAP. If the individual needs continued CP support, the lead should depend on what elements of the plan are the most problematic.

- How can existing LTSS providers, PCPs, ACOs, and other providers be encouraged to participate in providing input into the person-centered care plan? **(limit to 150 words)**

- This is why the LTSS CP (or BH CP) needs to be the lead. Health and BH care continue to reflect hurried and limited access. MassHealth(MH) needs to address this issue as it is starker for Medicaid recipients. Reimbursement levels for PCPs or specialists have to be increased as it takes more time during physicals or other procedures to address the needs of people with disabilities. People who have intellectual impairments, many with ASD, frail elders, many with brain injury and those with chronic psychiatric diagnoses need more time during physicals to answer questions. Too often those in wheelchairs are often left in them for the entire physical. ACO/MCOs must incentivize and value this investment of time especially during PCAP process (assessment). MH can collect data from CPs documenting compliance with different procedures and corresponding outcomes for members since ACO/MCOs will implement their processes differently.

- What specific partnerships not covered in the previous questions are necessary to enable CPs to best serve the needs of members? **(limit to 150 words)**]

- I/DD community agencies are most obvious in their absence from the list on the cover sheet so there will be no way to track those agencies as they will be listed in “other”. Disability advocacy organizations such as ours do not consider our constituents, “patients”. We and commissions for people with disabilities could be partners to address local or social barriers. Partnerships with community entities such as elder services, food pantries, clubs where people can join to address isolation (social determinants) are not considered. MH historically doesn’t have employment support but this is a key issue for people with disabilities (except frail elders). For members with disabilities and complex medical needs, it’s important to have nursing capacity (beyond ACO) or a partner which provides this role to ensure proper care. There are private options such as our program, “Support brokers” which assists people to develop and implement person centered plans.

Response to: **Question #:** [3]

Restate **Question-Member Population:**

- [Given delivery system capacity and funding availability, which subpopulations of members with LTSS needs would you prioritize to receive the services of LTSS CPs? In what order of priority would you rank these subpopulations? Please be specific with the factors that define these subpopulations of members. **(limit to 150 words)**

- Please highly prioritize those with I/DD (and other cognitive/intellectual limiting conditions) given the track record in health care. Examples continue (now compounded by incidence rise of ASD) of barriers to quality health care for this population, this includes delaying specialist assessment in emergency rooms, not examining individuals out of their wheelchairs during PCP visits and not ensuring effective communication. Other subpopulations include those living in poverty including the homeless (regardless of reason, with or without disability) and those with language barriers. I don't believe you can rank among these populations. In terms of the factors, I think the last two are self-evident. But there is considerable research on those with I/DD both in our state, nationally (surgeon general) and in the literature. The Arc manages training at three medical schools and two nursing (graduate) schools at the present time with teaching goals including bias, communication and knowledge of the population.

- What are the 2 most important factors in how members are paired with specific LTSS CPs (e.g., member choice, regional considerations, existing member-provider relationships)? Please explain why. **(limit to 150 words)**

- Regional considerations will be critical given transportation barriers and the need for the care team to be accessible locally for the member. Beyond this, member choice should be respected. Given that LTSS CPs will be required to have more than one ACO relationship, existing member or provider connections may not be relevant to the pairing process. But a member may choose a CP because of familiarity with that agency. A reasonable time period could be allowed for members to choose a different CP than assigned or to request reassignment for concern about quality or time delays in PCAP process. We are aware that as we complete the RFI, the ACO RFR has been released. We are concerned some potentially effective CPs may not be considered by MassHealth solely because they do not have an agreement with an ACO once the CP RFR is released.

- Would a member with both complex LTSS needs and high BH needs benefit from interacting with both a BH CP and LTSS CP? **(limit to 150 words)**]

- It may be important to have two CPs for individuals who have chronic psychiatric conditions, whose condition intermittently destabilizes. Members with I/DD in general would benefit from a LTSS CP regardless of their BH diagnosis. Those with ASD who have significant behavioral conditions most likely require both a BH CP

and LTSS CP, although the mental health or BH system has not responded well to this population. A new licensing category (behavioral analyst) has been established in Massachusetts. Note (#2, bullet 3) previous response on role delineation. Individuals with dual diagnosis (including substance abuse) may not require both CP entities as well as those with chronic psychiatric conditions who appear to be stable in terms of their life situation (housing, etc.) but continue to have episodes where hospitalization has been needed. Those with stable BH situation but economically disadvantaged may not require a LTSS CP.

Response to: **Question #:** [4]

Restate **Question- Procurement and Capacity of LTSS CPs:**

- [What are the most important characteristics / qualifications that will help determine whether or not an LTSS CP can effectively provide choice counseling, navigation of LTSS, and LTSS expertise to members with complex LTSS needs? Please explain your response and provide 3-4 examples. For example, you may highlight capabilities such as the below:
    - Staff model
    - EMR / HIT capabilities
    - Connectivity with LTSS providers
    - Connectivity with other (non-LTSS) providers, ACOs, and BH CPs
    - Care management information systems
    - Direct knowledge of community-based services and available providers
    - Connections to community-based organizations **(limit to 300 words)**

- Demonstrated ability in community mapping (knowledge of community) for navigation; person centered planning (PCAP) including disability knowledge, agreement or past record with consultative partners, positive interagency communications and the financial capacity to adapt to this new role (staffing model and building ACO/MCOs connections) are most essential. Agency X is an I/DD provider who serves children and adults, those with brain injury and parents with cognitive limitations. It has worked with TANF, DDS, DMH, schools, local housing entities, medical practices and demonstrates a grasp of its community. X has worked with local community partners with expertise with frail elders and those with cerebral palsy sometimes served by the local ILC. Although much of its PCAP activities are in silos – residential, family support and parenting programs, it plans to fund support brokers (number, full-time vs. part-time or mix, DSRIP dependent), who will now comprise the front-end for members in the ACO/MCO.

- What activities outside of CP-required activities (if any) would disqualify an entity from becoming an LTSS CP? Can an entity avoid disqualification if they do not perform those activities for LTSS CP members? **(limit to 150 words)**

- I can't imagine any role would disqualify except that an ACO or MCO should not

fulfill this role. Practicing solely self-referral should result in a warning and then, if repeated, termination of the CP role. MassHealth should have an annual random review to determine this matter as well as utilize data in year two to evaluate % of self-referrals in a systematic manner. A hard cap of receiving self-referrals even if based on choice should be imposed at a reasonable percentage (30-35%?).

- Should there be more LTSS CPs that are smaller in scale, or fewer LTSS CPs that have more members each? Please comment on how larger / smaller LTSS CPs might better serve members (e.g., facilitate member choice, better leverage infrastructure investments, facilitate ACO contracting, etc.). **(limit to 150 words)**

- Higher number of smaller CPs makes sense given region size, non-alignment between MCO vs. LTSS regions, and community mapping requirements. Rural areas may not be able to have as many given population size and related financial impact. We strongly believe that the entire system should have a funded data infrastructure using a common portal which extends from MassHealth to the specific provider. This is not only more cost-effective but it also allows for comparison among ACO/MCOs, CPs, health entities, health providers, LTSS providers, etc. This will help to reduce IT infrastructure costs. All entities will require ongoing training on the data system. Providers can be linked in through desktop computers or tablets to allow for data input. Software purchased centrally that meets the requirements for all levels of this "innovation" is essential. Further, an appropriate assessment instrument is needed for non-elders with disabilities (the OneCare tool is designed for elders).

- MassHealth is considering two options for LTSS CP requirements; 1) Require CPs to have subject matter expertise and experience across a broad range of LTSS subpopulations (older adults, adults with physical disabilities, children with physical disabilities, members with brain injury, members with intellectual or developmental disabilities, and members with co-occurring LTSS and BH needs) or 2) have subject matter expertise and experience for at least three LTSS subpopulations. Please answer each of the following questions in 1 or 2 sentences.

    - Will permitting LTSS CPs to stay specialized by LTSS subpopulations allow them to better serve their members? Or is there benefit in providing a "one-stop-shop" entity for ACOs to turn to for all their LTSS support needs?
    - Subject matter expertise may break down as follows: age, mobility, intellectual or developmental disability, mental health status and presence of substance abuse. Aging and disability staff may access similar LTSS supports, but assess and intervene differently (note limitations of the MDS-HC). Even I/DD staff who are good navigators with individuals of different ages, varying mobility and health needs, may have difficulty translating their expertise to those who are older. "One stop" CPs are not realistic given range of expertise needed. The presence of BH CPs partially addresses the issue. Possible approach: CPs who demonstrate partnerships with other entities (consultative or formal), or develop CPs to address the I/DD population which is specialized and have them partner with ILCs and ASAPs to address the

remaining populations. Not having a clear sense of how MH wishes to allocate between BH and LTSS CPs (and word limits) prevents a more specific answer.

- If specialized, will LTSS CP entities have enough scale to support the fixed cost of infrastructure needed?
- As noted in question 4, bullet 3, IT infrastructure should be built for entire project, leaving personnel as the major cost (assuming space needs are minimal). Given word limits, one example of playing out the CP question. Focus on CPs primarily for members with mobility issues, I/DD, and behavioral health conditions who are not seniors. Require CPs to fund a per member fee to lead ASAPs in a region for screening of seniors (ASAPs already are designed for this role). A similar consideration for the BH CP if the LTSS CP determines this consultation is needed.

- If specialized, is there risk of fragmentation and as a result increased complexity of integrating physical health and LTSS?**(limit to 300 words)**]
- Focus is on the member and integrating his care. The barrier to quality health care is well-documented for people with I/DD, mobility impairments and mental illness. A "one-stop" center could resemble the past inadequate performance of Medicaid customer centers toward those with disabilities. Specific expertise is essential. We need to find a strategy to pay for it. We also assume CPs will be focused on members who have high incidence of hospital and emergency room use. If there is success, the CP will be able to focus on others over time and address fragmentation among larger numbers of members' care over time.

Response to: **Question #:** [5]

Restate **Question- Sustainable Incentive Model:**

- [By percentage, how would you allocate LTSS CP DSRIP funding between infrastructure investment and funding of ongoing CP activities? **(limit to 150 words)**
- The answer to this question is nuanced. It also may not have an answer given that the design will dictate the answer. Some of the investment is to design staffing model and processes-the planning costs that will go away. Other components of infrastructure will reflect ongoing cost (part of IT system long term). Given recommendations in #4 about centralized IT portal system with permissions, I would suggest 30% to 35% for investment and 65% to 70% for ongoing costs. My reason for this is the belief that specific expertise is needed to access quality health care. The front-end staff for the CP are essential for success and they are needed long-term. Let's not assume that the ACO will develop the expertise or integrate it into its model of care. We do want them to integrate disabilities into their health care practices however – a deficiency recognized by health care leaders.

- In the design of LTSS CPs, where is there greatest risk of duplication with existing functions (e.g., assessments, choice counseling, input into a person-centered care plan, assistance in executing the care plan, member outreach etc.)? Please write 1 or 2 sentences referencing specific places where these functions are provided by provider, state, or other LTSS support initiatives. **(limit to 300 words)**
- Looking ahead, initial member engagement may be one place to avoid duplication for high use health care members. A member who receives PCA support may utilize a high level of care in a hospital or emergency room. The PCM may know that this is related to the lack of adequate health care and monitoring. Addressing issues already know to LTSS providers can avoid duplication. Where members' situations are stabilized (including health care), those receiving adult family/foster care could receive the LTSS CP support via the AFC provider. In cases where a member receives PCA services and independently or with the support of family or friends is managing his/her care, the CP LTSS could be on stand-by but not provide ongoing care management. Of course there would be exceptions for individuals with complex medical or behavioral conditions in a difficult period or workforce coverage is tenuous in the home.

- What metrics might be helpful in the evaluation of LTSS CP quality and performance or progress towards integration across physical health, LTSS and behavioral health? Please provide specific examples. **(limit to 300 words)**]
- Metrics include: member has a primary care clinician who sees him/her at minimum bi-annually for health/wellness and as needed for treatment; member has a specialist based on his/her condition seen according to treatment plan; members health professionals (primary, specialist, oral, behavioral health, etc.) are qualified regardless of disability or cultural background (knowledgeable and competent); Tracking the # of individuals receiving the age appropriate assessments including annual safety risk and abuse risk assessment; utilization of community services (LTSS) should stay level or increase while avoidable acute visits are reduced (utilization of $$ and community tenure); reduction of caregiver stress as demonstrated by evidence based tool; consumer/family/surrogate satisfaction with LTSS and health providers; an LTSS functional assessment which is comprehensive and includes intellectual, neurological, behavioral, and psychiatric dimensions; percentage (%) of days members are affected by immobility, skin breakdown; constipation/bowel obstruction and incidence of aspiration pneumonia; Timeliness of receiving services identified in the care plan –e.g., # of days between care plan and initial receipt of services (primary, specialist, oral, behavioral health, DME or repair of DME); and timeliness of receiving community based LTSS identified in the care plan - # of days between care plan and receipt. MassHealth could then determine whether the ACO or LTSS CP was responsible for areas of below adequate performance.

MassHealth Request for Information: MassHealth's Community Partner Program
Respondent Name: [Leo V. Sarkissian] Organization (if applicable) [The Arc of Massachusetts]
Response to: **Question #:** [6] Restate **Question:** [**Background of Potential LTSS CPs/Indication of interest** (for likely LTSS CP applicants only)] Not answered on purpose.