March 15, 2016

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

Re: 12-month MassHealth Managed Care Lock-In Proposal

Dear Secretary Sudders and Assistant Secretary Tsai,

The undersigned organizations representing the interests of our clients and members who are MassHealth beneficiaries ask the Office of Medicaid to reconsider its proposal to lock beneficiaries into a managed care plan for a 12-month period. Since MassHealth first adopted managed care in the 1990s, beneficiaries have been able to change plans whenever they need to without having to go through a formal process of proving they have good cause to change plans. According to information from EOHHS, about 4-10 percent of MCO members voluntarily change plans during the year.[1] This compares to 30 percent of MCO members who involuntary change plans when their eligibility changes. While there are available policy options like 12-months continuous enrollment to address eligibility-driven plan changes, EOHHS is not addressing involuntary plan changes.[2] Instead it is proposing to make it harder for MassHealth members to voluntarily change plans. We oppose this proposal.

Some states do have a 12-month lock-in, but other states with large Medicaid enrollment do not have a lock-in. Among the states where members can change at any time are: California, Pennsylvania, Texas and Washington.[3] MassHealth leaders have said MassHealth is alone in allowing members to change plans daily. But if only 4-10 percent of members change plans voluntarily during the year, how often can members be changing frequently, much less daily? Even in states with a 12-month lock-in, voluntary plan changes will occur: members have to be allowed to change plans during a 90 day open enrollment window and for cause at any time. The Connector, for example, reported 4 percent voluntary plan changes just during its recent

[1] Report of the Working Group on Medicaid Managed Care Organizations, pp.14-15, Massachusetts House of Representatives, October 2015.
[2] According to CMS, 23 states have implemented 12-months continuous eligibility for children. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/continuous.html
[3] California https://www.healthcareoptions.dhcs.ca.gov/HCOCsp/Enrollment/default.aspx Pennsylvania: personal communication with Community Legal Aid advocate; Texas http://www.hhsc.state.tx.us/medicaid/managed-care/star/client-information.shtml#2 Washington http://www.hca.wa.gov/medicaid/Documents/MedicaidPlanSelectionFAQs.pdf

open enrollment period for 2016. Thus, it seems unlikely that a lock-in will significantly reduce the rate of plan changes. What it will do is impose more administrative costs on the agency, increase complexity for members and prevent some members from receiving timely care from the providers of their choice. Further, the imminent implementation of improvements to the redetermination process as mandated by the Affordable Care Act should substantially reduce involuntary churning and improve plan stability starting in April 2016 without the added complexity of a lock-in.[4]

There are good reasons why MassHealth members, unlike many commercially insured enrollees, should not be locked into plans. One reason is that commercial insurance networks are typically broader than MassHealth networks. Because MassHealth pays providers at rates often below commercial insurance rates (and uses its provider rates to set payment rates for the MCOs) many more publicly insured members report problems finding a provider than commercially insured members.[5] Further, MassHealth members have far lower income and poorer health compared to the general population enrolled in commercial insurance. Almost 90 percent of MassHealth enrollees have income under 133 percent of poverty ($15,660 for one person in 2015) and over two-thirds of members have income under 90 percent of poverty ($10,242 for one person in 2015).[6] Poverty is associated with many practical obstacles to obtaining care such as limited transportation, limited child care, inflexible work hours, limited English proficiency, and mobility limitations. A change in providers may be an inconvenience to a commercially insured middle income family; it can be an insuperable barrier to the very poor.

Another important difference between MassHealth and commercial insurance is that about 65 percent of MassHealth members do not actively choose their managed care plans; they are automatically assigned to a plan by MassHealth.[7] This happens if people miss a short 14-day window to select a plan on their own. With auto-assignment, a MassHealth member may not even realize in which plan she is enrolled until she calls her doctor for an appointment and finds out her doctor is not in the member's plan network. Currently, a member can change plans in this situation. Under a lock-in, the member may not be able to change plans and see her doctor for as long as twelve months until the next open enrollment window. The most basic reason people change plans, because their family doctor is not in the MCO network, is not currently

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[4] Rules requiring improved procedures for redeterminations took effect in January 2014 but will not be implemented in MassHealth until an expected April 2016 upgrade to the HIX system. 130 CMR § 502.007.
[5] Blue Cross Blue Shield of Massachusetts Foundation, "Monitoring Access to Care in Massachusetts: Comparing Public Coverage with Employer-Sponsored Insurance Coverage," June 23, 2015.
[6] Administrative data supplied by the Office of Medicaid to the Mass. Budget and Policy Center, Oct 2015.
[7] Communication from Deputy Medicaid Director, March 14, 2016. The 65 percent figure may understate active plan choice in that it includes members automatically assigned to a plan in which they had been previously enrolled.

considered a basis for changing plans under current MassHealth rules authorizing transfers for cause.[8]The risk of harm is increased for people with disabilities when auto-assignment disrupts the continuity of their current delivery network.

The 12 month lock-in could result in harm to people with complex disabilities and result in increased cost. Consumers may find themselves in a situation where their current networks are inadequate because they don't have the right type of specialist, enough primary care providers, or a neighborhood pharmacy or when circumstances change such as a provider leaving the network of an MCO. There are many potential risks for consumers with disabilities with this approach, especially when states move to this model under pressure to save money. Restricting choice of providers is unwise in terms of quality of care and cost, particularly for enrollees with psychiatric challenges. The therapeutic alliance is the single most accurate predictor of positive treatment outcomes. [9] Building this alliance may sometimes require a change of plans to enable a member to find the right provider outside the current MCO network. People with disabilities can least afford the delays that are inevitable with a lock-in even if "cause" were more broadly defined than it is today.

Further, a lock-in with transfers for cause, unlike voluntary plan changes, will be a significant drain on administrative resources that could surely be put to better use. It requires an entire process for enforcing new deadlines, allowing claims to show cause to change plans, and providing notice and appeal rights when a request to change for cause is denied. It will require more extensive communications between members and MassHealth when members have sometimes had waits of 30-45 minutes or more to get through to MassHealth Customer Service. For families with members enrolled with the Connector, Medicare or employer-sponsored insurance, each of which has its own open enrollment period, another open enrollment period will be extremely confusing. These "mixed" insurance families will be getting two or more notices of different time periods to change plans in different programs. While it is not clear to us how the MCO lock-in will interact with an Accountable Care Organization overlay-- and we would like to better understand this-- any added complexity is likely to further bewilder members.

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[8] These rules were developed for the CarePlus program which delays voluntary plan choice to the first of the following month, but, in accordance with federal law, allows plan changes for cause to take effect at any time. 130 CMR § 508.002(E); 42 CFR § 438.56(d)(2).

[9] J. Safran, et al., *Alliance, Negotiation and Rupture Resolution*, in Handbook of Evidence Based Psychodynamic Therapy, at 208 (2009)("the quality of the patient-therapist relationship is more important than the treatment modality"). See also, J. Sharf, et al., *Dropout and Therapeutic Alliance: a Meta-Analysis of Adult Individual Psychotherapy,* 47 Pychotherapy Theory, Research, Practice, Training, 637-645 (2010).

A 12-month lock-in will do little to address the real cause of enrollment volatility, eligibility changes, while making it harder for MassHealth members to get care from the health care providers they choose and trust. We share the concern of the Office of Medicaid and the MCOs with plan volatility. However, there are far better and more effective ways to address these concerns than a 12-month lock-in. We would welcome the opportunity to meet with you and your staff to discuss these issues further. Please communicate with Vicky Pulos in reference to such a meeting or in regard to anything else concerning this letter: vpulos@mlri.org, 617-357-0700 Ext. 318.

Yours truly,

Vicky Pulos and Neil Cronin
Massachusetts Law Reform Institute

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