American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

The Massachusetts Chapter

1115 Amendment Comments
from the Massachusetts Chapter of the American Academy of Pediatrics

The Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) represents more than 1,600 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists in the Commonwealth and strongly supports the pending Massachusetts Medicaid 1115 waiver amendment. Proposed changes will take several important steps that will have a positive impact on children and families in the Commonwealth. While several of the proposed measures primarily target the adult population, the positive impact on the lives and health of children is considerable **and will pave the way for future improvements that are more youth -centered.**

The proposed expansion of coverage for individuals and families via the Connector will improve access to essential health services for families with children. MassHealth's proposal to provide all eligible members with three months of retroactive coverage will help low-income individuals and families avoid medical debt. The amendment takes important steps to include Short-Term Post Hospitalization Housing (STPHH) as an allowable Health-Related Social Needs (HRSN) service and to increase the expenditure authority for the Social Service Organization Integration Fund.

The proposed 1115 waiver amendment will allow the Commonwealth to improve access to health care services and related social supports for some of our most vulnerable individuals and families. These measures are critical to the Commonwealth's goal of improving health equity. Healthy families and healthy communities make for healthy children!

September 5, 2023

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

Re: MassHealth Section 1115 Demonstration Waiver Amendment

Dear Assistant Secretary Levine,

Mass Home Care Association (MHC) would like to thank the Executive Office of Health and Human Services (EOHHS) and MassHealth for the opportunity to submit comments on MassHealth's proposed Section 1115 Demonstration waiver amendments. MHC is the non-profit trade association of the 27 Aging Service Access Points (ASAPs) and Area Agencies on Aging (AAAs) across the Commonwealth. The mission of the ASAPs and AAAs is to help individuals live at their highest level of functioning possible, in the least restrictive setting possible, for as long as possible. Overall, we applaud the proposed amendments and appreciate MassHealth prioritizing health equity and access to care for the most underserved individuals and families in the Commonwealth, including older adults and people with disabilities.

1. Preserve CommonHealth Members' Ability to Enroll in One Care Plans

MHC strongly supports the proposal to continue to allow CommonHealth members to enroll into a One Care plan. MHC believes it is crucially important that CommonHealth members will continue to have access to this integrated care option when One Care transitions from a Duals Demonstration plan to a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan.

2. Increase the Income Limit to Medicare Savings Program Benefits for Members on MassHealth Standard to the State Statutory Limit

MHC strongly supports the increase to the income limit for Medicare Savings Program (MSP) Benefits for members on MassHealth Standard to the state statutory limit. Massachusetts has

been a leader in expanding its MSP program to include beneficiaries up to 190% FPL for the Qualified Medicare Beneficiary (QMB) program, 210% FPL for the Specified Low-Income Medicare Beneficiary (SLMB) program and 225% FPL for the Qualified Individual (QI) program. MSPs are critically important benefits for low-income older adult and disabled Medicare beneficiaries and can often result in money back in the pockets of low income older adults to pay for rent, food, or other essentials which ultimately enhance their health, economic security, and quality of life.

3. Remove the Waiver of Three Months Retroactive Eligibility

MHC applauds MassHealth's proposal to provide all eligible members with three months of retroactive coverage pursuant to the federal Medicaid statute. This provision builds on the recently approved 1115 waiver extension authority to reinstate three months of retroactive coverage for children under 19 and pregnant women, and previously to members aged 65 and older. Retroactive coverage can help low-income individuals and families avoid medical debt and allows healthcare institutions who treat patients on Medicaid to receive the payment they are entitled to for the services they render. Removing the waiver of three months of retroactive coverage will help mitigate enrollee medical debt and promote continuity of care.

4. Provide 12 Months Continuous Eligibility to Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness who are 65 and Over

MHC applauds the proposal to provide 12 months continuous coverage for all adults and 24 months continuous coverage for member age 65+ who experience homelessness. This is an effective way to mitigate the disparities in coverage and care in underserved communities by promoting consistent access to health care including the management of chronic conditions and care coordination which can improve health and wellbeing while lowering costs. The extension of the 24 months of continuous coverage to beneficiaries age 65+ who experience homelessness is of particular importance as, unfortunately, this is a rapidly growing segment of our homeless population and an extremely vulnerable group that needs access to critically important healthcare coverage.

5. Include Short-Term Post Hospitalization Housing as an Allowable Health Related Social Need Service

MHC strongly supports the inclusion of Short-Term Post Hospitalization Housing as an allowable Health Related Social Need (HRSN) service. This is a much needed service for people experiencing homelessness who often get stuck in costly hospital or nursing home settings for extended periods of time for lack of a safe place to recuperate and receive ongoing medical care. This service will help facilitate hospital and ER discharges when someone does not need that level of care, but still needs an appropriate setting in which to fully recover. MHC recommends that the Commonwealth strongly consider allowing people age 65+ who are experiencing

homelessness and who are MassHealth members, but are not enrolled in a MassHealth Accountable Care Organization, to participate in this program. As noted above, homelessness for people age 65+ has increased rapidly and the state's lack of affordable, accessible housing resources for low income older adults is woefully insufficient to meet the needs of our growing aging population. Medical respite for older adults experiencing homelessness who are discharged from hospitals or Emergency Rooms is an essential service that the state should consider including in the ARPA funded Medical Respite Pilot Program and in the future Short-Term Post Hospitalization Housing Program.

6. Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions

MHC strongly supports MassHealth's amended proposal to provide pre-release services to MassHealth eligible individuals in carceral settings. There is ample national research that demonstrates the high level of health disparities that individuals in carceral settings, especially those who have aged in those settings, have in comparison to the general public. It is crucially important that older adults in particular who are returning to the community are able to access all of the services and supports they will need to remain living independently in the community. This amended proposal is a big step in the right direction for a vulnerable segment of our population and a demonstration of the Commonwealth's commitment to health equity and access to care.

On behalf of MHC and the ASAP/AAA statewide network, thank you for this opportunity to contribute our thoughts on these innovative amendments and for prioritizing health equity and access to care. If you have any questions regarding any of the information outlined in this document, please contact me at 617-331-9467 or bcrimmins@mves.org.

Sincerely,

/s/Betsey Crimmins

Betsey Crimmins
Executive Director
Mass Home Care

September 7, 2023

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

Submitted by email to 1115WaiverComments@mass.gov

Re: MassHealth Section 1115 Demonstration Waiver Amendment Request

Dear Assistant Secretary Levine,

On behalf of the undersigned organizations and individuals, thank you for the opportunity to submit comments on MassHealth's proposed Section 1115 Demonstration waiver amendment released on August 2, 2023. We strongly support the waiver amendment, which will promote health equity, improve continuity of care, increase investments in health-related social needs (HRSNs) and expand MassHealth and ConnectorCare coverage to previously excluded populations. More detailed comments about each provision within the 1115 waiver amendment proposal are outlined below.

1. **Preserve CommonHealth Members' Ability to Enroll in One Care Plans**
   We strongly support MassHealth's proposal to continue to allow CommonHealth members to have the opportunity to enroll into a One Care plan. The One Care program is crucial to many people enrolled in both MassHealth and Medicare. The integrated care model that the One Care health plans adhere to encourages individuals to be in the driver's seat when it comes to their care decisions. This person-centered care model has benefited thousands of dual eligible enrollees. We applaud MassHealth for ensuring that CommonHealth members will continue to have this integrated care option when One Care transitions from a Duals Demonstration plan to a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan. We suggest one addition to the request to mirror the language for enrollees at or over age 65: "MassHealth CommonHealth members who were enrolled in One Care under age 65, who are disenrolled due to a lapse or downgrade in their MassHealth eligibility for a period of 12 months or less, may be reinstated to their One Care plan." This will help ensure comparable continuity of coverage and care for One Care members between 21-64 years old, who may have a lapse or downgrade in coverage due to a variety of factors, including administrative churn during the eligibility redeterminations process.

2. **Expand Health Connector Subsidies to Additional Individuals**
   We strongly support the request for additional expenditure authority to support the pilot expansion of ConnectorCare, the state's subsidized program for uninsured individuals without access to employer-sponsored insurance. ConnectorCare is one of the key reasons that Massachusetts has the lowest uninsurance rate in the nation.

   Despite high levels of coverage in Massachusetts, 41% of residents struggled to afford health care during the past year. Black and Hispanic/Latinx individuals are more likely to face challenges affording care, and the disparities are most acute for those with incomes over the current 300% of the federal poverty level (FPL) eligibility threshold for ConnectorCare. Many of our organizations hear regularly from consumers with incomes just above 300% FPL whose only health coverage options have high deductibles and co-pays in addition to steep premiums, too often putting care out of reach. This issue is more important than ever. As MassHealth resumes the eligibility

redeterminations process, individuals and families no longer eligible for MassHealth will need affordable health coverage options.

The two-year pilot program expanding ConnectorCare to individuals and families with incomes between 300% to 500% FPL, recently signed into law through the FY2024 state budget, will bring immense relief to between 50,000 and 70,000 residents and help maintain or strengthen the state's insurance coverage rate. Massachusetts already has expenditure authority for the current ConnectorCare program. The request for a federal match for the expanded program is essential to the state's ability to provide affordable health coverage and maintain continuity of coverage.

3. **Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard to the State Statutory Limit**
We strongly support the expansion of the three Medicare Savings Programs (MSPs), as required under the state's FY2023 budget. MSPs are important benefits for low-income elderly and disabled Medicare beneficiaries. Seniors already face challenges with the rising costs of living. Unaffordable health care only adds to this burden. Increasing the income and removing the asset test for assistance provides much needed relief. Allowing members who qualify for MassHealth Standard at higher income levels, as long as their income falls below the updated income limits for the MSPs, to benefit from both coverage and cost assistance will make health care more affordable for thousands of Massachusetts seniors.

4. **Remove the Waiver of Three Months Retroactive Eligibility**
We strongly support MassHealth's proposal to provide all eligible members with three months of retroactive coverage, in line with the federal Medicaid statute. This provision builds on the recently approved 1115 waiver extension authority to reinstate 3 months of retroactive coverage for children under 19 and pregnant individuals, and the longstanding practice for members ages 65 and older. Retroactive coverage can help prevent medical debt for low-income individuals and families. The 2021 Massachusetts Health Insurance Survey shows that 15% of families income eligible for MassHealth reported problems paying medical bills and 38% having been contacted by collection agencies about unpaid medical bills. Medical debt can affect people's credit, add challenges to meeting basic needs, and cause people to delay or avoid needed care. Inadequate retroactive coverage has also required health care providers to absorb financial losses. Removing the waiver of 3 months of retroactive coverage will help mitigate enrollee medical debt, promote continuity of care and squarely align with both the word and intent of federal Medicaid law.

5. **Provide 12 Months Continuous Eligibility for Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness Who Are 65 and Over**
We applaud MassHealth for identifying additional ways to ensure continuous coverage and reduce churn for enrollees. This waiver amendment builds on recent implementation of 12 months of postpartum coverage, 12 months of continuous eligibility for individuals (including youth) transitioning from correctional facilities and 24 months of continuous eligibility for individuals experiencing homelessness. We also stand ready to work with MassHealth to ensure successful implementation of 12 months continuous eligibility for children under 19 beginning in January 2024, as required by the federal Consolidated Appropriations Act of 2023. We strongly support MassHealth's proposed expansion of 12 months continuous eligibility to adults and equitable application of 24 months continuous eligibility for members experiencing homelessness to those 65 and older. These provisions will help to address coverage gaps many of the most underserved individuals and families in the Commonwealth face. Recently released data show that over 25% of MassHealth members lost coverage at any point during 2018. Continuous coverage policies reduce

churn for members who lose and gain eligibility over a short period of time due to administrative challenges or income volatility, promotes continuity of coverage and access to care and provides a stable foundation for MassHealth's delivery system reforms.

6. **Include Short-Term Post Hospitalization Housing (STPHH) as an allowable Health-Related Social Needs (HRSN) Service**

   We strongly support the inclusion of Short-Term Post Hospitalization Housing as an allowable HRSN service. Supportive housing for those experiencing homelessness provides a safe and stable place for members to continue their recuperation after discharge from hospital and inpatient treatment settings. The model, which includes integrated clinical services, has been shown to reduce lengths of hospital stays and improve clinical outcomes. It also has the potential to reduce health disparities, and to improve hospital wait times by providing an appropriate and supportive setting for those who no longer need an inpatient level of care.

7. **Increase the Expenditure Authority for the Social Service Organization Integration Fund**

   We strongly support the increased expenditure authority for the Social Service Organization (SSO) Integration fund. MassHealth's commitment to addressing HRSNs, particularly through the current Flexible Services Program, which connects certain members to housing and nutrition related supports, has been a crucial forward-thinking feature of the state's 1115 waiver programs. The new HRSN Program structure under development will solidify, expand, and integrate these supports into overall MassHealth programing. Doing so will require SSOs that partner with Accountable Care Organizations (ACOs) to provide the HRSN supports to evolve and enhance some of their capabilities. In particular, the updated HRSN program will likely require new referral platforms and billing mechanisms. This technical infrastructure will be challenging for many SSOs, many of which already face resource and capacity constraints. It would be a loss for the state and for MassHealth members if SSOs that provide culturally competent and locally rooted supports were unable to participate in the program because of these constraints.

   The increased expenditure authority for the SSO Integration Fund would address this challenge by making sure SSOs have the financial resources they need to upgrade their infrastructure and capacity to successfully participate in the HRSN program. The proposed fund is essential to maintaining and expanding the incredible partnerships between community based SSOs and ACOs in a way that will maintain and grow the HRSN supports MassHealth members need.

8. **Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions**

   We strongly support MassHealth's amended proposal to provide pre-release services to MassHealth eligible individuals in carceral settings. This proposal makes a powerful case for the value of pre-release services to strengthen access to community resources that address the health care and HRSN of this population, improve health outcomes, address racial health inequities, and reduce emergency department visits and inpatient hospital admissions for returning individuals. We appreciate that MassHealth is committed to extending services as broadly as possible in light of the April 2023 guidance from the Centers for Medicare and Medicaid Services (CMS) and the 1115 waivers CMS has already approved for California and Washington.

   However, there are many important decisions that will be made in developing the final proposal, negotiating the terms of approval from CMS, finalizing an implementation and reinvestment plan, implementing pre-release services in the facilities operated by Department of Corrections, the

fourteen county sheriffs, and the Department of Youth Services, and monitoring and evaluating the outcomes. We strongly urge MassHealth to enlarge the interagency Coordinating Council with which it has been working since 2021 to include a broader group of stakeholders, particularly those with lived experience. The CMS guidance relies on recommendations from the federal advisory committee that included not just representatives of the jail and prison systems, but also managed care organizations, health care providers and Medicaid beneficiaries. CMS strongly encourages states to engage individuals with lived experience who were formerly incarcerated in both the design and implementation of demonstration proposals. California convened a robust advisory group including reentry service providers, managed care plans, people with lived experience and community-based organizations. We urge MassHealth to bring community into the planning for the transition from incarceration to community-based settings.

We appreciate MassHealth's leadership in prioritizing health equity and access to care for the most underserved individuals and families in the Commonwealth. Our organizations look forward to partnering with you to successfully implement the provisions outlined in the proposed 1115 waiver amendment. Please do not hesitate to reach out to Suzanne Curry at Health Care For All at scurry@hcfama.org with any questions or to discuss this comment letter further.

Sincerely,

1199 SEIU - Massachusetts
AccessHealth MA
Association for Behavioral Healthcare
Boston Center for Independent Living
The Brookline Center for Community Mental Health
Center for Health Law and Policy Innovation of Harvard Law School
Center for Innovation in Social Work & Health, BU School of Social Work
Community Teamwork
Disability Law Center
Disability Policy Consortium
Easterseals Massachusetts
The Greater Boston Food Bank
Greater Boston Legal Services
Health Care For All
Health Law Advocates
Joint Committee for Children's Health Care in Everett
Justice Center of Southeast Massachusetts
The Latino Health Insurance Program, Inc.
MA Chapter of the American Academy of Pediatrics
Massachusetts Association of Community Health Workers
Massachusetts Association for Infant Mental Health
Massachusetts Association for Mental Health
Massachusetts Law Reform Institute
Massachusetts Medical Society
Massachusetts Public Health Association
Massachusetts Senior Action Council
Mass. Health & Hospital Association
Mass Home Care Association
John McDonough, Harvard T.H. Chan School of Public Health

MLPB
Northeast Independent Living Program, Inc.
Parent/Professional Advocacy League, Inc.
Project Bread
Public Health Institute of Western MA
Rosenfeld & Rafik, P.C.
Vinfen

COMMUNITY CARE COOPERATIVE

September 8, 2023

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

Submitted by email to 1115WaiverComments@mass.gov

Re: MassHealth Section 1115 Demonstration Waiver Amendment

Dear Assistant Secretary Levine,

On behalf of Community Care Cooperative (C3), thank you for the opportunity to submit comments on MassHealth's proposed Section 1115 Demonstration waiver amendment released on August 2, 2023. We strongly support the proposed waiver amendment and the efforts to expand investments in interventions to address health equity, health-related social needs, and to assure access to MassHealth and ConnectorCare coverage and continuous enrollment for priority populations.

In particular, we'd like to comment on three provisions of the proposed amendment:

Include Short-Term Post Hospitalization Housing (STPHH) as an allowable Health-Related Social Needs (HRSN) Service

We applaud MassHealth for your efforts to make STPHH available to members and we strongly support the inclusion of Short-Term Post Hospitalization Housing as an allowable HRSN service. Community Care Cooperative and our health centers are eager to expand access to short-term post hospitalization housing for our members experiencing homelessness as a safe and medically appropriate option for recuperation after hospitalization or other treatment. This model of short-term supportive housing with integrated clinical services has been successfully implemented by the Lynn Community Health Center. Several C3 federally-qualified health centers and our community organization partners are now working to establish similar programs in other parts of the state; however, funding is a limiting factor to these programs' long term success. Inclusion of STPHH as an allowable HRSN service will facilitate sustainable access to medical respite beds for members who need them. This change has the potential to reduce length of hospitalization, improve hospital wait times, and improve health disparities. As an ACO with a robust HRSN program, we stand ready to work with eligible providers to incorporate STPHH into our HRSN Housing programs in 2025.

Increase the Expenditure Authority for the Social Service Organization Integration Fund

We strongly support the increased expenditure authority for the Social Service Organization (SSO) Integration fund. We applaud MassHealth's commitment to addressing HRSNs through the Flexible Services Program (FSP) as a demonstration program. Funding previously available to SSOs was critical to expanding capacity for staffing, technology, and other infrastructure needs that allowed those organizations to effectively partner with our ACO to implement FSP. As MassHealth moves to the new

COMMUNITY CARE COOPERATIVE

HRSN Program structure, we anticipate that SSOs seeking to become enrolled HRSN providers with MassHealth will require additional support to adapt to requirements to manage contracts, referral technology, coding and billing. The SSO Integration Fund will provide valuable financial resources to support capacity and infrastructure investments by SSOs across the state. We encourage MassHealth to consider opportunities to strategically invest a portion of these funds for smaller SSOs and BIPOC-led organizations to assure that ACOs continue to have SSO partners with community roots and who can deliver HRSN services that are linguistically and culturally relevant for our members.

We also strongly support the opportunity to leverage the SSO Integration Fund to provide technical assistance to SSOs through trainings, learning communities and technical assistance. With a portfolio of more than 20 SSOs currently partnering for the C3 Flexible Services program, we see the benefits of sharing best practices, workflows, and offering trainings for our nutrition and housing providers that are tailored to better address the needs of our members engaged in Flexible Services. This will be particularly valuable as new workflows such as coding for HRSN services become necessary.

Finally, we support the plan to implement a statement HRSN referral platform to standardize the referrals workflows and billing processes used by HRSN providers. We encourage MassHealth to convene a stakeholder group of ACOs and SSOs to provide input on the selection of an HRSN electronic referral platform that both meets the future needs of the program and minimizes the disruption of workflows from the current Flexible Services approach for our health centers and SSO partners.

Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions

We strongly support MassHealth's amended proposal to provide services to eligible individuals prior to release from carceral facilities. These pre-release activities will assure that individuals access necessary care coordination for physical and behavioral health care services as well as supports for health-related social needs to facilitate successful release from incarceration and community re-entry. We appreciate the thoughtful process that has been undertaken with the interagency Coordinating Council thus far, and encourage expansion of this group to include ACOs, behavioral health and community-based organizations as the implementation plans are finalized to ensure that pathways from facility-based care coordinators to ACOs are streamlined for success.

We appreciate the innovation and leadership that MassHealth has demonstrated in prioritizing health equity and access to care, including these changes outlined in the proposed 1115 waiver amendment. We look forward to the opportunity to continue to serve C3 members through these expanded pathways.

Sincerely,

Christina Severin

President & CEO

Community Care Cooperative

ABH

ASSOCIATION FOR BEHAVIORAL HEALTHCARE

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Lydia Conley PRESIDENT / CEO
Kenneth J. Bates CHAIR

September 8, 2023

EOHHS Office of Medicaid
One Ashburton Place 3rd Floor
Boston, MA 02108

Re: ABH Recommendations for the 1115 Amendment Comments

To Whom It May Concern:

On behalf of the Association for Behavioral Healthcare (ABH), thank you for the opportunity to offer feedback on the MassHealth Section 1115 Demonstration Amendment Request proposed on August 2, 2023. ABH is a statewide association representing 81 community-based mental health and addiction treatment provider organizations across Massachusetts.

Our members are the primary network for MassHealth members seeking behavioral healthcare treatment and recovery services throughout the Commonwealth. Our members deliver a comprehensive range of services and are deeply embedded in their local communities and in the MassHealth delivery system. More than 75% of ABH members operate MassHealth community mental health centers delivering outpatient services to adults and children, and ABH represents 25 of 26 Community Behavioral Health Centers. Further, we represent 100% of the Behavioral Health Community Partner (BH CP) entities and 100% of Community Service Agencies for MassHealth youth with serious emotional disturbances. Relative to substance use disorder treatment services, we represent the vast majority of Opioid Treatment Providers (OTP), and our members provide safety net and substance use treatment in Acute Treatment Services, Clinical Support Services (CSS), and outpatient addictions services across the entire state.

ABH deeply appreciates the Commonwealth's commitment expanding health equity, healthcare coverage, and opportunities for innovations to continue to provide needed supports and innovations to the healthcare delivery system. We fully support the expansion of benefits, considerations to retroactive eligibility, and continuous coverage for adults and members experiencing homelessness. We offer the following comments and recommendations:

1. **<u>Preserve CommonHealth Members' Ability to Enroll In One Care</u>**
   ABH appreciates the Commonwealth's commitment to continue to allow CommonHealth members to enroll in One Care. One Care has been a critical design advance in integrated care and endorse MassHealth's proposal to allow continued enrollment when the program converts to a D-SNP. We further endorse Health Care For All's recommendation to allow "MassHealth CommonHealth members who were enrolled in One Care under age 65, who are disenrolled due to a lapse or downgrade in their MassHealth eligibility for a period of 12 months or less, may be reinstated to their One Care plan." This will reduce gaps in coverage and allow for members to continue to access necessary care and supports should breaks in coverage occur. The person-centered, integrated care model of One

Care plans has been beneficial to dual-eligible members across Massachusetts and enrollment in these plans will allow for continuity of care, and ongoing member choice in accessing needed resources and supports.

2. **Expand Marketplace (Health Connector) Subsidies to Additional Individuals**
   ABH ***strongly*** supports MassHealth's request to pilot expand income eligibility for individuals to access coverage through ConnectorCare plans as authorized by recent state law. The pilot will remedy coverage hardships and is even more important given the ongoing MassHealth eligibility renewal activities. Further, as our colleagues at Health Care For All noted, expanded affordable coverage options will directly address health inequities and allow health care access for individuals who might otherwise not seek out preventative or urgent care due to lack of coverage. We endorse this proposal that will ensure that Massachusetts remains among the leaders in affordable healthcare coverage.

3. **Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard to the State Statutory Limit**
   ABH supports expanding access to Medicare Standard benefits for elderly and disabled Medicare beneficiaries pursuant to the SFY23 budget. The proposal will streamline enrollment and provide crucial coverage and cost assistance to help make healthcare more affordable for qualified enrollees and reduce some of the administrative burdens for successful enrollment.

4. **Remove the Waiver of Three Months Retroactive Eligibility**
   ABH ***strongly*** supports the Commonwealth's proposal for three months of retroactive eligibility for ***all*** Medicaid enrollees. Retroactive eligibility will help support enrollment and engagement in services to address health needs and transition of care for individuals throughout the health care delivery system. Further, it is likely to prevent medical debt for low-income individuals and families, a significant source of financial, emotional, and physical stress. Lack of coverage and access to care can causes individuals to postpone seeking needed treatment, resulting in increased health cost and fostering health disparities. Finally, retroactive coverage can mitigate financial losses often absorbed by providers within the safety net delivery system.

5. **Provide 12 Months Continuous Eligibility to Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness who are 65 and over**
   ABH strongly supports continuous eligibility for all MassHealth adults who are experiencing homelessness. These provisions will help to address gaps in coverage for many underserved members and families throughout the Commonwealth. Continuous coverage for homeless adults will allow for continuity of care and successful transition planning with and for this vulnerable population that experiences complex mental health, substance use disorder, and somatic health needs. We would also encourage MassHealth to consider clear definitions for homelessness and those individuals at risk of homelessness to be included. The 24 months of continuous coverage for individuals over 65 will address care gaps for this population. Consideration should be given to a grace period prior to members turning 65 to allow for continuity of care and ensure members are given the allotted time and resources to engage in needed services.

   Overall, Continuous eligibility reduce disenrollments for administrative or other challenges and promote continuity and access to needed care and services within the healthcare delivery system.

6. **Include Short-Term Post Hospitalization Housing as an allowable Health- Related Social Needs Service**

ABH supports Short-Term Post Hospitalization Housing (STPHH) as an allowable Health Related Social Needs (HRSN) service. The inclusion of these integrated clinical services in a safe and supportive setting will help to address ongoing healthcare needs and reduce more intensive medical interventions and care disruption for members discharged to the community without this needed support. Allowing this type of setting will also address health disparities and improve health outcomes for this extremely vulnerable population. We encourage opportunities for collaboration with community providers for integrated care and to ensure behavioral health, HRSN providers, and other community health supports will be necessary to ensure integrated care models and involvement of the healthcare delivery systems and maximize coordination of services to ensure continuity of care and addressing health needs of members post-hospitalization.

7. **Increase the Expenditure Authority for Social Service Organizations Integration Fund**

The Commonwealth has been the leader among states in leveraging Medicaid authority to support members' health related social needs (HRSN) in the prior Demonstration. Further, the brokering of social service organization participation and direct investment in community organizations were tremendous in ensuring member choice and healthcare integration. ABH applauds the Commonwealth's request for additional funding and opportunities to improve continuity of care and access to needed resources and services. We ask the Commonwealth to consider in its waiver amendment request, to expand participation eligibility in the SSO Integration Fund to Community Partners who are qualified as SSOs. While there has been a perception that CPs have infrastructure resources, distinct infrastructure payments have been eliminated with the CP re-launch. With all of the exciting changes and enhancements, including the addition of the BH CPs in Nursing Facilities, the need for infrastructure resources are increasing. With this proposal, MassHealth is acknowledging added infrastructure needs and additional programmatic expectations that will be required to provide the needed support to transition to specialized CSPs and other Behavioral Health community resources under the managed care framework. If CP/SSOs are to be effective collaborative partners with providers and system partners, they need equitable access to infrastructure and other supports.

8. **Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions**

ABH **strongly supports** the proposal for strengthening continuity of care and supports for individuals in carceral settings, including engagement 90 days prior to release. Fatal overdose rates are unprecedented, with opioid-related overdoses increasing by 9% from 2020[1]. Adherence to any of the three FDA-approved medications for opioid use disorder (MOUD): methadone, buprenorphine, and naltrexone, have been shown to be effective in reducing elicit opioid use, retaining individuals in treatment, and reducing the risk of overdose mortality, reduced risk of HIV, and HCV transmission, reduced criminal justice involvement, and greater likelihood of employment[2].

[1] Data Brief: Opiod-Related Overdose Deather among Massachusetts Residents (June 2023). https://www.mass.gov/doc/opioid-related-overdose-deaths-among-ma-residents-june-2023/download]

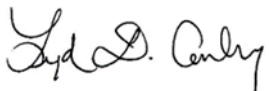
[2] NIDA. 2021, December 3. How effective are medications to treat opioid use disorder?. Retrieved from https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder

ABH strongly encourages a requirement that all three FDA-approved medications be available to incarcerated individuals as they prepare for release. A Washington state study found that the risk of death from overdose was 129 times higher in the first two weeks after release from prison compared to the general population. Methadone or buprenorphine treatment during this transitional time decrease the risk of death by 75 percent[3]. A California study showed that the opioid dependent patients allowed to continue methadone treatment specifically, during incarceration, are less likely to be re-arrested than those who are detoxified in jail. Over 97 percent of those receiving methadone continued treatment after release[4]. Methadone may even be preferred to buprenorphine for individuals "at high risk of treatment drop out and subsequent fentanyl overdose [5]." It is important that all covered medications be readily available to members.

We would also encourage an affirmative requirement to partner with community providers as successful community transitions for the many individuals with substance use disorders will be predicated to large extent on rapid access to behavioral healthcare in home communities. ABH encourages broad stakeholder engagement for opportunities to maximize these successful transitions and engagement of members in community treatment post-release, and ensuring addressing unmet social needs to reduce the risk of repeat incarcerations and other detrimental outcomes.

Once again, ABH applauds MassHealth on the 1115 Waiver Amendment and consideration to coverage, health equity, and increased support and resource considerations for vulnerable and underserved members of the Commonwealth. Successful implementation and sustainability of these programs will require feedback and engagement of stakeholders including community behavioral health providers. We thank you for the opportunity to provide feedback on the proposed Amendment request. ABH remains committed to working with EOHHS and MassHealth to ensure that the behavioral health needs of the residents of Massachusetts are successfully met.

Sincerely,



Lydia D. Conley
President and CEO

[3]NIDA. 2017, December 14. Treating Opioid Addiction in Criminal Justice Settings. Retrieved from https://nida.nih.gov/publications/treating-opioid-addiction-in-criminal-justice-settings
[4]NIDA. 2017, December 14. Treating Opioid Addiction in Criminal Justice Settings. Retrieved from https://nida.nih.gov/publications/treating-opioid-addiction-in-criminal-justice-settings on 2023, September 6
[5]Bromley, L., Kahan, M., Regenstreif, L., Srivastava, A., Wyman, J., & Dabam, F. (2021). Methadone treatment for people who use fentanyl: Recommendations. *Tor METAPHI. Published online*, *30*.

- Thank you for the opportunity to share comments on the proposed 1115 waiver. As the team Medical director who has seen the Lynn community health center Recuperative care center be built and started from its inception, I am excited that the state has recognized the value of medical respite care and is finding a way to fund these very vital services. We want to thank the state for creating the waiver to help support new respites in Massachusetts and to help our Recuperative care center expand.
- As you know our funding sources have continued to be piece meal by multiple grants and now with our value-based model payment this puts medical respite at higher risk of not being adequately funded and will be difficult for our services to continue. While the expansion grant is helpful it still leaves us with a major funding gap to continue services for the initial 10 beds we have currently. I have highlighted some concerns about the 1115 waiver below.

- Payment would be limited to patients coming out of a hospitalization. Many of the RCC's patients have been admitted from settings other than a hospital, including shelters and the streets. The ER and hospital do not hold on to clients long enough to be directly placed into medical respite care. The Lynn community health center and other community agencies like Glyss, Elliot are valuable contributors to referring our clients to the respite for services. If the waiver only covers post-hospitalization Respite stays, it will leave a substantial number of our patients without a payment source. Many of our cases are brought in by community referrals, one example is a client who was seen in our urgent care and was diagnosed with a tumor in his mouth. He had been living in an encampment, so our team went there to see him, obtained emergency mass health status, and connected him to cancer care. He stayed at the RCC for almost a year, completing his radiation, and being fed through a G tube. He is now living in a shelter setting but has been successful with oncology follow up and is working in the Salem community.
- Payment would be limited to MassHealth ACO members. Many of the RCC's patients are not in an ACO. While the state feels it is the job of the health center to contract with the various ACO's to ensure fair payment is received. This is a difficult and heavy administrative task for health centers to do on their own, proving the value of respite care takes longitudinal data and studies that may be difficult to prove. The state should ensure that funding for the "respite rate" is guaranteed which would help decrease the burden on health centers and hopefully encourage health centers to partner and open respite programs. Again, limiting the funding source to ACO only clients would leave many of our patients without a payment source. The Recuperative care center serves a large population of disabled elderly clients (Medicare and HSN) who will not be funded for respite care.

- Payment would be limited to six months. RCC patients are there longer than six months, and a few quite a bit longer, and again, these stays (after six months) would not be covered under the MassHealth language. Medical respite can be a longer stay due to a chronic disability for example or it also can be is a typically a short term stays to address health care needs within a set time frame. While intensive case management services are performed, not all clients once feeling better feel they can stay within a program environment. Medical respites rely on program rules to ensure guests remain safe and can take the time to heal. The 6-month model is more a transitional housing model. There are also many mental health and behavioral concerns that transpire during a longer stay, resulting in some clients self-discharging from the program. Medical respite care is intensive medical management, follow up and coordination. The model being proposed does not consider the safety net need that medical respite provides clients with as their health journey changes.

- This is an example of how our Respite serves as a Safety net for clients utilizing respite services. Our team has cared for 64-year-old gentlemen who had prior to going into Respite care was in the ED (Emergency Department) over **50** times within a given year. Once he entered Respite this number drastically improved as he was admitted and stayed at RCC for several months until he was eventually housed. Unfortunately, due to his chronic substance use disorder this client failed his housing and was evicted landing him back on the streets. This specific client continued to use the Respite as a safety net post discharge from his hospital stays multiple times each year. He was always referred to each time by our local hospital Salem MGB. Our team would stabilize him medically (he was malnourished, frail and required lab monitoring for kidney failure and elevated potassium levels) Within the last 3 years the client's health further deteriorated resulting in the need for multiple RCC stays which the medical team worked on connecting him to dialysis care which the patient finally accepted. The client took over a year and multiple RCC stays to accept dialysis, and each time he was discharged to a room for rent, given his SUD (substance use disorder) he would lose this and end up back on the street. His past most recent stays at RCC he was successfully connected to Dialysis care and his health stabilized. Unfortunately, he started to use crack cocaine and with each readmission he would use drugs in the building resulting in discharge from the program. While housing has failed several times, and he lives in the local shelter he is connected to dialysis and continues to attend. His health continues to deteriorate but without this work he would be in the ICU (Intensive Care Unit) which is far more costly than respite care. This specific client would be dead if it were not for respite services. While our team has continued to build a trusting relationship, despite what we think would work best for him (housing and sobriety) he continues to make other choices. We need programming like Respite to fit what our clients need not expect the client to fit into the program provided.
- The 6-month cap for this client would not allow him to access services if needed in a potential calendar year. Respite care is a matter of life and death for our clients and there should not be a cap or time limit as suggested by the current waiver.

179 Amory Street
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COMMUNITY SERVINGS
FOOD HEALS

617.522.7777
servings.org

September 7, 2023

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

Submitted by email to 1115WaiverComments@mass.gov

Re: MassHealth Section 1115 Demonstration Waiver Amendment

Dear Assistant Secretary Levine,

On behalf of Community Servings, I appreciate the opportunity to comment on MassHealth's proposed Section 1115 Demonstration waiver amendment released on August 2, 2023.

Community Servings' mission is to actively engage the community to provide scratch-made medically tailored meals (MTMs) to individuals and their families experiencing critical or chronic illness and nutrition insecurity. We commit, in all our programs and business practices, to prioritize racial and economic justice and health equity. Community Servings has participated in the Flexible Services Program (FSP) under the 1115 waiver and has served over 5,000 individuals since March of 2020.

Community Servings strongly supports the amendment's proposal to increase funding for the SSO Integration Fund to account for increased infrastructure needs of SSOs as MassHealth transitions to its new Health Related Social Needs (HRSN) framework. We recommend that MassHealth:

- **Move forward with the proposal to increase expenditure authority for the SSO Integration Fund; and**
- **Immediately establish a stakeholder advisory group to inform the transition from the FSP to the new HRSN framework.**

Additional detail on each of these recommendations is provided below.

1. **Move forward with the proposal to increase expenditure authority for the SSO Integration Fund.**

Since March 2020, Community Servings has increased our kitchen production by 140%, and today, we reach approximately 2,200 clients per week. Our growth is attributed to a high level of community need, statewide expansion of our service area, and participation in the MassHealth ACO Flexible Services Program, of which Community Servings is the largest provider of nutritional supports with 10 contracts. We have made significant investments in our referral platform to meet the specific needs of each new ACO partner we contract with. Therefore, we strongly support MassHealth's proposals to further build out FSP infrastructure, including the potential development of a statewide electronic referral platform.

Given that these infrastructure changes would require significant time and investment, we urge MassHealth to move forward with its proposal to increase funding for the SSO Integration Fund to $25M. Access to upfront resources will be crucial for Community Servings to make these technological and administrative changes to implement the new systems that MassHealth has proposed. Additionally, we were glad to see MassHealth's proposal to provide technical assistance to help guide SSOs as they navigate new requirements (e.g., provider enrollment) to ensure that processes are as clear and efficient as possible. Many of these changes will be new to our organization, so technical assistance, along with direct exchange of communication with MassHealth will be much appreciated by our staff.

From our 33-years of providing MTMs, we have learned that large changes require significant lead-time (e.g., greater than 6 months) for successful implementation. We strongly encourage MassHealth to consider the timelines involved and provide nutrition SSOs and ACOs the adequate lead-time necessary to make these changes.

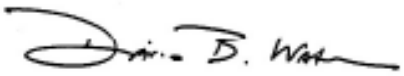
2. **Immediately establish a stakeholder advisory group to inform the transition from the FSP to the new HRSN framework.**

Many of the changes outlined in the amendment as part of the glide path process will be complex for nutrition SSOs. We urge MassHealth to gather direct input from affected stakeholders as part of its planning process. We were thrilled to see MassHealth's recent announcement that it will be establishing a Delivery System Technical Advisory Committee (DSTAC) to provide input on implementation of the 1115 waiver as a whole. Yet, we strongly believe that MassHealth should go further by also establishing a separate advisory group, inclusive of nutrition SSOs participating in the FSP, focused more specifically on the transition of the FSP program to the new HRSN framework. Through the creation of this separate advisory group, MassHealth can establish a pathway to gather timely feedback on changes that will be occurring under the transition process (e.g., provider enrollment, the statewide referral system, approaches to pricing, etc.), and potentially avoid barriers to implementation down the line.

***

Thank you again for the opportunity to provide feedback on the proposed Section 1115 demonstration waiver amendment. If you have any questions regarding these recommendations, please contact myself, Jean Terranova (JTerranova@servings.org), or Erin DiBacco (edibacco@servings.org).

Sincerely,



David B Waters, CEO

September 8, 2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02108

Re: MassHealth Section 1115 Demonstration Amendment Request

Dear Assistant Secretary Levine:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Department of Health and Human Service's request to amend the MassHealth Section 1115 Demonstration Waiver. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

ACS CAN supports this waiver request and urges the Department to advance the following policies in its final request to the Centers for Medicare and Medicaid Services:

Removing Waiver of Retroactive Coverage

While federal Medicaid policy requires Medicaid programs to provide new members with 3 months of retroactive coverage, MassHealth currently has a waiver of this requirement. Effective January 1, 2025 MassHealth is seeking to withdraw its waiver authority under the current 1115 demonstration and revert to federal rules. This amendment would provide all eligible members retroactive coverage up to the first day of the third month before the month of application if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided.

ACS CAN strongly supports this proposal. This waiver of retroactive coverage has likely placed a substantial financial burden on enrollees and caused significant disruptions in care, particularly for individuals battling cancer. Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.[1,2] In 2019, three in ten uninsured adults went without care because of cost.[3] We agree with the Department that removing this

[1] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.
[2] Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed November 2019. https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/.
[3] Tolbert J, Nov 06 ADP, 2020. Key Facts about the Uninsured Population. KFF. Published November 6, 2020. Accessed August 17, 2021. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

waiver and providing retroactive coverage will "help support enrollment continuity, improve health status, and reduce beneficiary medical debt" – all important goals for the cancer community.

Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[4] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[5] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Massachusetts from the high costs of later stage cancer diagnosis and treatment. We urge the Department to include this proposal in its final demonstration amendment request.

Extending the Provision of Continuous Coverage
Currently, the MassHealth program provides continuous eligibility and coverage for various populations. MassHealth is requesting an amendment to the demonstration, effective January 1, 2025, to include 12 months of continuous eligibility for all adults age 19 and over; and 24 months of continuous eligibility for members experiencing homelessness who are aged 65 or over.

ACS CAN strongly supports this proposal. Providing continuous eligibility for these populations will improve continuity of care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. When individuals who do not have continuous eligibility lose coverage due to small – often temporary – fluctuations in income, it results in loss of access to health care coverage, making it difficult or impossible for those with cancer to continue treatment. For cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Research also shows the detrimental impact of coverage gaps on Medicaid enrollees who have a history of cancer. Individuals who had coverage disruptions in the previous year were less likely to report that they used preventive services, and more likely to report problems with care affordability and any cost-related medication nonadherence.[6] A 2020 systematic review of evidence found that among patients with cancer, those with Medicaid disruptions were statistically significantly more likely to have advanced stage and worse survival than patients without disruptions.[7]

Our country's recent experience with continuous Medicaid eligibility during the COVID-related public health emergency showed the value of this type of policy – both to individual Medicaid enrollees who used this critical safety net and did not have to fear coverage disruptions; and to the whole country by reducing the overall uninsured rate.[8] We urge the Department to include this proposal in its final demonstration amendment request.

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[4] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed October 2019. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.
[5] National Association of Community Health Centers. America's Health Centers' Snapshot. Published August 2021. Accessed August 2021. https://www.nachc.org/wp-content/uploads/2020/10/2021-Snapshot.pdf.
[6] Jingxuan Zhao, Xuesong Han, Leticia Nogueira, Zhiyuan Zheng, Ahmedin Jemal, K. Robin Yabroff; Health Insurance Coverage Disruptions and Access to Care and Affordability among Cancer Survivors in the United States. Cancer Epidemiol Biomarkers Prev 1 November 2020; 29 (11): 2134–2140. https://doi.org/10.1158/1055-9965.EPI-20-0518
[7] K Robin Yabroff, PhD, Katherine Reeder-Hayes, MD, Jingxuan Zhao, MPH, Michael T Halpern, MD, PhD, Ana Maria Lopez, MD, Leon Bernal-Mizrachi, MD, Anderson B Collier, MD, Joan Neuner, MD, Jonathan Phillips, MPH, William Blackstock, MD, Manali Patel, MD, Health Insurance Coverage Disruptions and Cancer Care and Outcomes: Systematic Review of Published Research, JNCI: Journal of the National Cancer Institute, Volume 112, Issue 7, July 2020, Pages 671–687, https://doi.org/10.1093/jnci/djaa048
[8] U.S. Census Bureau. Health Insurance Coverage Status and Type by Geography: 2019 and 2021. American Community Survey Briefs. September 2022. Health Insurance Coverage Status and Type by Geography: 2019 and 2021 (census.gov)

Expanding Marketplace Subsidies to Additional Individuals

The Department proposes to increase the income eligibility limit for the state's ConnectorCare program from 300% FPL to 500% FPL. The program provides subsidies for premiums and cost-sharing for individuals determined eligible for up to 100 days while they select, pay, and enroll into a plan. The goal of the program is to smooth coverage transitions and mitigate gaps in care.

ACS CAN supports this request as it will smooth coverage transitions and prevent gaps in coverage for more individuals in the state, including potentially people with cancer or survivors. Coverage gaps are detrimental to people with cancer and survivors, as discussed above.

Providing Pre-Release MassHealth Services to Certain Individuals

MassHealth's updated demonstration request proposes providing certain Medicaid covered services (including medical, behavioral health, and pharmacy services) for up to 90 days prior to expected release to qualified individuals in certain public institutions.

ACS CAN supports this proposal. Research shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[9] Cancer is the leading cause of mortality in incarcerated individuals older than 45 years and the fourth leading cause of mortality in the overall incarcerated population. Individuals who have been incarcerated are more than twice as likely to have a history of cancer than general populations.[10] ACS CAN supports taking steps like this one to prevent coverage gaps to help ensure all individuals have access to the care they need, including preventive services, cancer screenings and cancer treatment that can be lifesaving. We encourage the Department to include this proposal in its demonstration amendment request.

Conclusion

The goal of the Medicaid program is to provide health coverage and access to care for people who need it. These proposals meet this goal, and we support their inclusion in the Department's demonstration waiver request because they will improve access to and continuity of care for people in Massachusetts with cancer. If you have any questions, please feel free to contact me at marc.hymovitz@cancer.org.

Sincerely,

Marc Hymovitz
Government Relations Director, Massachusetts
American Cancer Society Cancer Action Network

[9] Ward EM, Fedewa SA, Cokkinides V, Virgo K. The association of insurance and stage at diagnosis among patients aged 55 to 74 years in the national cancer database. Cancer J. 2010 Nov-Dec;16(6):614-21. doi: 10.1097/PPO.0b013e3181ff2aec. PMID: 21131794.
[10] Aziz H, Ackah RL, Whitson A, et al. Cancer Care in the Incarcerated Population: Barriers to Quality Care and Opportunities for Improvement. JAMA Surg. 2021;156(10):964–973. doi:10.1001/jamasurg.2021.3754.

September 5, 2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburn Place, 3rd Floor
Boston, MA 02108

Dear Director Levine:

The American Heart Association appreciates the opportunity to submit comments on the MassHealth 1115 Medicaid Demonstration Amendment Request. The American Heart Association is the nation's oldest and largest voluntary healthcare organization dedicated to reducing death and disability from cardiovascular disease (CVD) and to be a relentless force for a world of longer healthier lives. A healthy population is essential for economic prosperity; for a strong, productive, globally competitive workforce; and for ensuring all individuals can achieve their full potential. To that end, continuous improvement is needed in the delivery of health care and in the creation of equitable policy that ensures that health care is adequate, accessible, and affordable for everyone. The American Heart Association is committed to ensuring that Massachusetts' Medicaid program provides quality and affordable healthcare coverage. Our organization appreciates the emphasis on health equity in this waiver and supports the inclusion of retroactive eligibility for all enrollees, continuous eligibility for all adults, pre-release coverage for justice-involved populations, and expanded financial assistance for marketplace coverage.

Retroactive Coverage for All Enrollees

The American Heart Association supports the proposal to reinstate retroactive coverage for all demonstration populations. Retroactive coverage is an important policy to advance health equity and a safety net for low-income families. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries. Retroactive coverage is also important for current Medicaid enrollees. Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[1] Medical debt disproportionately affects families of color in the US[2] and is a predictor of other social drivers of health such as homelessness.[3] Retroactive coverage prevents Medicaid enrollees from facing substantial costs at their doctor's office or pharmacy and subsequent delays in care. Given the importance of this policy change, we urge the state to reinstate retroactive coverage sooner than 2025. Many patients are facing gaps in coverage because of procedural disenrollments during the Medicaid unwinding process. The state should reinstate retroactive coverage as soon as possible to protect enrollees from the financial and health risks of a gap in coverage.

Continuous Eligibility for All Adults

The American Heart Association supports the proposal to provide 12-month continuous eligibility for all adults, as well as 24-month continuous eligibility for seniors experiencing homelessness. Continuous eligibility promotes health equity,[4] and increases continuity of coverage. Continuous eligibility protects

patients and families from gaps in care. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[5] We support continuous eligibility as a method to reduce these negative health outcomes for patients. This policy will also reduce churn within the program and its administrative burden on Medicaid offices. Research shows that 40% of Medicaid enrollees who lose coverage are re-enrolled in the program within a year.[6] One study estimated that the administrative cost of churn was between $400 and $600 per person in the Medicaid program.[7] Continuous eligibility eases the administrative burden that these changes in enrollment status place on the program. As discussed above, because this policy would be especially impactful during the Medicaid unwinding process, We encourage the state to move up the implementation date for this policy from January 2025. Additionally, we further urges the state to consider providing multi-year continuous eligibility for young children. Multi-year continuous eligibility would improve access to and continuity of care for children during the critical early years of life[8] while promoting health equity. Studies show that children of color are more likely to be affected by gaps in coverage that continuous eligibility would address, rendering it necessary for improving equitable access to care.[9]

Eligibility Increase for Marketplace Subsidies

Lastly we support the expansion of eligibility for ConnectorCare subsidies from 300 percent to 500 percent FPL. This program provides subsidies for premiums and cost-sharing for individuals determined eligible for up to 100 days while they select, pay, and enroll into a marketplace plan. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[10] Expanding eligibility for the subsidy program would ease the transition from Medicaid to the Marketplace and mitigate gaps in coverage.

Preserve CommonHealth Members' Ability to Enroll in One Care Plans

The American Heart Association MassHealth's proposal to continue to allow CommonHealth members to have the opportunity to enroll into a One Care plan. The integrated care model that the One Care health plans adhere to encourages individuals to have control over their care decisions. This person-centered care model has benefited thousands of dual eligible enrollees. We applaud MassHealth for ensuring that CommonHealth members will continue to have this integrated care option.

Expand Health Connector Subsidies to Additional Individuals

We strongly support the request for additional expenditure authority to support the pilot expansion of ConnectorCare, the state's subsidized programs for uninsured individuals without access to employer-sponsored insurance. ConnectorCare is one of the key reasons that Massachusetts has the lowest uninsurance rate in the nation. Despite high levels of coverage in Massachusetts, 41% of residents struggled to afford health care during the past year. Black and Hispanic/Latinx individuals are more likely to face challenges affording care, and the disparities are most acute for those with incomes over the current eligibility threshold for ConnectorCare. Consumers with incomes just above the eligibility threshold for ConnectorCare, whose only health care coverage options have high deductibles and co-pays in addition to steep premiums, ~~which too~~ often puts needed care out of reach. This issue is more important than ever. As MassHealth, along with Medicaid programs across the country, resumes the redeterminations process, several individuals and families may no longer be eligible. These residents will need affordable coverage options. The two-year pilot program expanding ConnectorCare to individuals and families up to 500% of the federal poverty level (FPL) that was recently signed into law through the FY2024 state budget will bring immense relief to tens of thousands of residents and help protect the state's insurance coverage rate.

We appreciate MassHealth's leadership in prioritizing health equity and access to care for the most underserved individuals and families in the Commonwealth. We look forward to partnering with MassHealth to successfully implement the provisions outlined in the proposed 1115 waiver amendment. Thank you for the opportunity to comment, and please do not hesitate to reach out with any questions or to discuss this comment letter further.

Sincerely,

Allyson Perron Drag
American Heart Association/ Stroke Association
Government Relations Director
300 5th Avenue, Suite 6
Waltham, MA 02451-8750

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[1] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

[2] Bennett, Neil et al. "Who Had Medical Debt in the United States?" U.S. Census Bureau. April 7, 2021. Available at: https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html

[3] Bielenberg JE, Futrell M, Stover B, Hagopian A. Presence of Any Medical Debt Associated With Two Additional Years of Homelessness in a Seattle Sample. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. 2020;57. doi:10.1177/0046958020923535

[4] Chomilo, Nathan. Building Racial Equity into the Walls of Minnesota Medicaid. Minnesota Department of Human Services. February 2022. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG

[5] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[6] Corallo, Bradley et al. "What Happens After People Lose Medicaid Coverage?" Kaiser Family Foundation. January 25, 2023. Available at: https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/

[7] Swartz, Katherine et al. "Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End Of Calendar Year Is Most Effective." Health Affairs, Vol 37, No. 7. July 2025. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1204

[8] Burak, Elisabeth Wright. "Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)." Center for Children and Families, Georgetown University Health Policy Institute. October 2018. Available at: https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf

[9] Osorio, Aubrianna. Alker, Joan, "Gaps in Coverage: A Look at Child Health Insurance Trends", Center for Children & Families (CCF) of the Georgetown University Health Policy Institute, November 21, 2021. Gaps in Coverage: A Look at Child Health Insurance Trends – Center For Children and Families (georgetown.edu)

[10] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF

American Lung Association.
Massachusetts

September 7, 2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburn Place, 3rd Floor
Boston, MA 02108

Dear Director Levine:

The American Lung Association appreciates the opportunity to submit comments on the MassHealth 1115 Medicaid Demonstration Amendment Request.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the more than 34 million Americans living with lung diseases, including more than 980,000 Massachusetts residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association is committed to ensuring that Massachusetts' Medicaid program provides quality and affordable healthcare coverage. Our organization appreciates the emphasis on health equity in this waiver and supports the inclusion of retroactive eligibility for all enrollees, continuous eligibility for all adults, pre-release coverage for justice-involved populations, and expanded financial assistance for marketplace coverage. The Lung Association offers the following comments on the MassHealth 1115 Demonstration Amendment Request:

Retroactive Coverage for All Enrollees
The Lung Association supports the proposal to reinstate retroactive coverage for all demonstration populations. Retroactive coverage is an important policy to advance health equity and a safety net for low-income families. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries. Patients with chronic conditions like asthma and COPD may be forced to pay out of pocket for care when this happens or may delay treatment, leading to worse health outcomes.

Retroactive coverage is also important for current Medicaid enrollees. Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[1] Medical debt disproportionately affects families of color in the US[2] and is a predictor of other social drivers of health such as homelessness.[3] Retroactive coverage prevents Medicaid enrollees from facing substantial costs at their doctor's office or pharmacy and subsequent delays in care.

Given the importance of this policy change, the Lung Association urges the state to reinstate retroactive coverage sooner than 2025. Many patients are facing gaps in coverage as a result of procedural disenrollments during the Medicaid unwinding process. The state should reinstate retroactive coverage as soon as possible to protect enrollees from the financial and health risks of a gap in coverage.

Continuous Eligibility for All Adults

The Lung Association supports the proposal to provide 12-month continuous eligibility for all adults, as well as 24-month continuous eligibility for seniors experiencing homelessness. Continuous eligibility promotes health equity,[4] and increases continuity of coverage.

Continuous eligibility protects patients and families from gaps in care. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[5] Gaps in Medicaid coverage have also been shown to increase hospitalizations and negative health outcomes for ambulatory care-sensitive conditions like respiratory diseases and heart disease.[6] The Lung Association supports continuous eligibility as a method to reduce these negative health outcomes for patients.

This policy will also reduce churn within the program and its administrative burden on Medicaid offices. Research shows that 40% of Medicaid enrollees who lose coverage are re-enrolled in the program within a year.[7] One study estimated that the administrative cost of churn was between $400 and $600 per person in the Medicaid program.[8] Continuous eligibility eases the administrative burden that these changes in enrollment status place on the program.

As discussed above, because this policy would be especially impactful during the Medicaid unwinding process, the Lung Association encourages the state to move up the implementation date for this policy from January 2025. Additionally, the Lung Association further urges the state to consider providing multi-year continuous eligibility for young children. Multi-year continuous eligibility would improve access to and continuity of care for children during the critical early years of life[9] while promoting health equity. Studies show that children of color are more likely to be affected by gaps in coverage that continuous eligibility would address, rendering it necessary for improving equitable access to care.[10]

Pre-Release Services for Justice-Involved Populations

The Lung Association supports the proposed coverage for incarcerated individuals who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with the goals of Medicaid and will be an important step in improving the continuity of care. This proposal will help these high-risk populations access critical supports needed to treat physical and behavioral health conditions. For example, studies in Washington and Florida reported that people with severe mental illness and Medicaid coverage at the time of their release were more likely to access community mental health services and had fewer detentions and stayed out of jail longer than those without coverage.[11] Research has also shown that cancer mortality is higher among those who are incarcerated or in the first year after incarceration,[12] further highlighting the necessity of transition services for this population. For those with lung cancer, having consistent coverage to detect and treat lung cancer early is crucial; the five-year survival rate is more than four times greater for cases caught before a tumor spreads.[13]

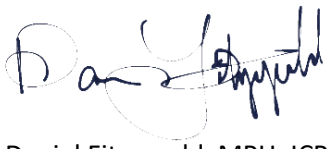
Eligibility Increase for Marketplace Subsidies

The Lung Association supports the expansion of eligibility for ConnectorCare subsidies from 300 percent to 500 percent FPL. This program provides subsidies for premiums and cost-sharing for individuals

determined eligible for up to 100 days while they select, pay, and enroll into a marketplace plan. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[14] Expanding eligibility for the subsidy program would ease the transition from Medicaid to the Marketplace and mitigate gaps in coverage.

Thank you for the opportunity to provide comments.

Sincerely,



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CITYBLOCK HEALTH
495 FLATBUSH AVENUE 5C
BROOKLYN, NY 11225

September 8, 2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
EOHHS Office of Medicaid
One Ashburton Place, 3rd Floor
Boston, MA 02108

Assistant Secretary Levine,

Thank you for the opportunity to comment on the proposed amendment to the MassHealth 1115(a) demonstration.

Please accept the following comments from Cityblock Medical Practice, P.A. (Cityblock) and Cityblock Health, Inc. Cityblock is a provider organization that enters into value-based partners with health plans - including a Massachusetts One Care plan - to deliver integrated physical, behavioral, and social care to Medicaid, dually eligible, and other individuals living in lower-income neighborhoods that have historically had poor access to health care services. The members we serve are clinically and socially vulnerable: 79% are persons of color, 85% have two or more chronic conditions, 47% have an identified behavioral health need, and 62% have an identified acute social need (e.g. transportation, housing). Improving health equity and reducing health disparities are at the core of our care model and mission as an organization.

We recognize and appreciate Massachusetts' longstanding commitment to universal health care coverage, predating - and laying the foundation for - the Affordable Care Act. In turn, we support this proposed amendment, which prioritizes expanding access to health care coverage for underserved populations. In particular, we support:

- **Preserving CommonHealth Members' Ability to Enroll in One Care Plans**. As a provider currently serving One Care members, we fully support this proposal to ensure CommonHealth members are able to maintain their One Care plan enrollment and care from network providers without disruption when One Care transitions from Medicare-Medicaid Plans (MMPs) to dual eligible special needs plans (D-SNPs).

- **Expanding Marketplace Subsidies to Additional Individuals**. The timing of this proposed amendment is especially impactful, as it would take effect at a time when some MassHealth members are involuntarily losing coverage due to resumption of Medicaid redeterminations. Expanding the income limit for individuals to receive assistance with marketplace premiums and

cityblock

cost sharing up to 500% of the federal poverty level would allow more of these individuals to obtain coverage through the Connector.

- **Providing 12 Months of Continuous Eligibility for Adults, and 24 Months for Individuals Ages 65 and Older Experiencing Homelessness**. As a provider, we see the detrimental effects that Medicaid eligibility churn can have on members' health, well-being, and trust in the health care system. We strongly support the Commonwealth's proposal to minimize churn by expanding continuous eligibility to additional populations, with the goal of avoiding gaps in coverage that could result in at-risk members becoming homeless.

- **Including Short-term Post-Hospitalization Housing as an Allowable Health-related Social Need Service.** Safe, stable post-discharge housing is critical to patients' recovery and well-being. We support the Commonwealth's efforts to ensure that MassHealth members experiencing homelessness are discharged from hospitals to a safe space. We also underscore the Commonwealth's position that these types of services can improve flow throughout the hospital system by creating discharge options for members who no longer need a hospital level of care but who do not have safe or appropriate housing to support their needs after discharge. We would encourage the Commonwealth to consider making this service available to additional populations, beyond members aligned to MassHealth Accountable Care Organizations (ACOs).

- **Providing Pre-release MassHealth Services to Individuals in Certain Public Institutions**. We strongly support the proposal to provide pre-release services to individuals in carceral settings. The health disparities and prevalence of behavioral health needs experienced by this population are dramatic, as noted in EOHHS' demonstration amendment request. We applaud EOHHS for pursuing federal flexibility that aligns with April 2023 CMS guidance encouraging states to cover a package of services for up to 90 days pre-release. We are hopeful that this will help to streamline MassHealth members' access to medical and social care upon their return to the community, and provide the opportunity to ensure Medicaid coverage and necessary appointments are in place.

Please do not hesitate to reach out if we can be of any assistance. It would be our pleasure to discuss these comments, and we appreciate the opportunity to share them.

Sincerely,

Toyin Ajayi

CEO, Cityblock Health, Inc.
toyin@cityblock.com

FIMMA
FOOD IS MEDICINE MASSACHUSETTS

September 8, 2023

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

Submitted by email to 1115WaiverComments@mass.gov

Re: MassHealth Section 1115 Demonstration Waiver Amendment

Dear Assistant Secretary Levine,

On behalf of the Food is Medicine Massachusetts coalition (FIMMA), we are grateful for the opportunity to comment on MassHealth's proposed Section 1115 Demonstration waiver amendment released on August 2, 2023.

FIMMA's mission is to build a health care system that reliably identifies people who have food insecurity and health-related nutrition needs, connects them to appropriate nutrition interventions, and supports those interventions via sustainable funding streams. FIMMA is comprised of over 100 organizations representing nutrition programs, patient and advocacy groups, health care providers, health insurers, academics, and professional associations from across the Commonwealth. Many of our nutrition organization members also participate as Social Service Organizations (SSOs) in the Flexible Services Program (FSP) under the 1115 waiver, or aspire to do so in the future.

FIMMA strongly supports the amendment's proposal to increase funding for the SSO Integration Fund in order to account for increased infrastructural needs of SSOs as MassHealth transitions to its new Health Related Social Needs (HRSN) framework. We therefore urge MassHealth to:

- **Move forward with the proposal to increase expenditure authority for the SSO Integration Fund; and**
- **Immediately establish a stakeholder advisory group to inform the transition from the FSP to the new HRSN framework.**

Additional detail on each of these recommendations is provided below.

I. Move forward with the proposal to increase expenditure authority for the SSO Integration Fund.

In late July, FIMMA convened 20 nutrition SSOs from across the Commonwealth participating in the FSP to gather input regarding the upcoming HRSN services glide path process. In this meeting, participants expressed support for MassHealth's proposals to further build out FSP infrastructure, including the potential development of a statewide electronic referral platform. However, participants acknowledged that these infrastructural changes, as well as any policy changes related to billing, workflows, and provider enrollment, would require significant time and investment from SSOs.

Based upon this feedback—and upon the experience of our coalition as whole—we urge MassHealth to move forward with its proposal to increase funding for the SSO Integration Fund to $25m. Access to upfront resources will be critical to SSOs as they make the technological and administrative changes needed to implement the new systems that MassHealth has proposed. We also applaud MassHealth's proposal to provide technical assistance to help guide SSOs as they navigate new requirements (e.g., provider enrollment) to ensure that such processes are as clear and efficient as possible. Many of these changes will be new to SSOs and so technical assistance—as well as clear, direct communication between MassHealth and SSOs—will help ease the learning curve for all involved.

Finally, as MassHealth implements all of these proposals, we encourage MassHealth to proactively consider the timelines involved. Large-scale changes, such as a new referral platform, will take significant lead-time for implementation (e.g., greater than 6 months). Giving SSOs and ACOs adequate time to make these changes will have a strong impact on overall success.

II. Immediately establish a stakeholder advisory group to inform the transition from the FSP to the new HRSN framework.

Many of the changes that MassHealth outlines in the amendment as part of the glide path process will be complex for SSOs, ACOs, and MassHealth alike. We therefore encourage MassHealth to seek direct input from affected stakeholders as part of its planning process. We applaud MassHealth for its recent announcement that it will be establishing a Delivery System Technical Advisory Committee (DSTAC) to provide input on implementation of the 1115 waiver as a whole. We urge MassHealth to build upon this effort by also procuring a separate advisory group focused more specifically on the transition of the FSP program to the new HRSN framework. This transition will be complex and will set a precedent for states across the country as they integrate HRSN services into managed care frameworks. By convening a separate advisory group with meaningful representation from SSOs participating in the FSP, MassHealth can establish a pathway to gather timely feedback on changes that will be occurring under the transition process (e.g., provider enrollment, the

statewide referral system, approaches to pricing, etc.), thereby avoiding potential barriers to implementation down the line.

***

Thank you again for the opportunity to provide feedback on the proposed Section 1115 demonstration waiver amendment. If you have any questions regarding these recommendations, please contact Jean Terranova (JTerranova@servings.org) and Katie Garfield (kgarfield@law.harvard.edu).

Sincerely,

Katie Garfield
Director, Whole Person Care
Center for Health Law and Policy Innovation
Harvard Law School

Jean Terranova
Senior Director of Policy & Research
Community Servings

On behalf of:
Food is Medicine Massachusetts (FIMMA)

Food is Medicine Massachusetts (FIMMA) is a multi-sector coalition comprised of over 100 organizations representing nutrition programs, patient and advocacy groups, health care providers, health insurers, academics, and professional associations. FIMMA's overall mission is to build a health care system that reliably identifies people who have food insecurity and health-related nutrition needs, connects them to appropriate nutrition interventions, and supports those interventions via sustainable funding streams.

FIMMA
FOOD IS MEDICINE MASSACHUSETTS

September 7, 2023

Gary Sing, Senior Director of Strategic Initiatives
Stephanie Buckler, Deputy Director of Social Services Integration
Allison Rich, Senior Program Manager
Ryan Schwarz, Chief, Office of Payment and Care Delivery
MassHealth
Via email

Dear Mr. Sing, Ms. Buckler, Ms. Rich, and Mr. Schwarz,

FIMMA recognizes that we are in a key moment in the 1115 waiver – in two years, MassHealth must integrate the Flexible Services Program (FSP) into managed care delivery systems. This moment presents an important opportunity to offer input to MassHealth for consideration in implementing the health-related social needs (HRSN) services glide path. As such, in late July, we convened 20 nutrition Social Service Organizations (SSOs) from across the Commonwealth participating in the FSP to discuss current experiences with the FSP and to identify opportunities to participate in the glide path process towards managed care, with the ultimate goal of a transition to sustainably funded nutrition services within the new structure.

FIMMA has greatly appreciated MassHealth's willingness to receive our feedback over the years, and we respectfully submit this letter to elevate key takeaways from our July meeting and to offer input for your consideration on specific elements of the glide path implementation plan. We heard from stakeholders that time is of the essence to proactively establish a system that works for nutrition SSOs workflows by the end of the glide path in 2025. To that end, FIMMA recommends that MassHealth consider the following:

1) Establish a stakeholder advisory group that includes SSOs providing HRSN supports in FSP, to facilitate gathering input on the glide path implementation plan.
2) Establish a supportive, transparent transition process from current operations to managed care.
3) Allocate sufficient funds for reimbursement of nutrition services, as well as for infrastructure investments to support data exchange between ACOs and nutrition SSOs, and related needs.
4) Provide flexibility to extend the 6-month enrollment limit on services
5) Develop a comprehensive, inclusive strategy around pricing, budget and payment
6) Upon the transition to managed care, require that ACOs include nutrition support services as a mandatory covered benefit

Below, we've expanded on these considerations in further detail.

1) **Establish a stakeholder advisory group, inclusive of SSOs providing HRSN supports in FSP, to facilitate gathering input on the glide path implementation plan.**

We applaud MassHealth for establishing the Delivery System Technical Advisory Committee (DSTAC) to help guide the broader implementation of the waiver, however, we strongly encourage MassHealth to create a separate and specific advisory group tasked with helping the glide path process and implementation for FSP/HRSN services. We recommend that the advisory group have meaningful representation of the SSOs participating in FSP to best incorporate input specific to their experiences. Additionally, we recommend that MassHealth create a separate working group for FSP beneficiaries only, giving beneficiaries their own forum that is focused their specific experiences A communication channel to share key takeaways and recommendations between these two groups should also be established.

SSOs would particularly like the opportunity to weigh in on the following topics related to the glide path implementation plan: eligibility and types of services provided and duration (to the extent that MassHealth plans to adjust or narrow its approach on these issues during the glide path process), pricing, and approaches to budgeting/payment.

2) **Establish a supportive, transparent transition process from current operations to managed care**

Nutrition SSOs agreed that the transition to the new waiver in April was rushed, which resulted in a serious disruption of services to qualifying members. The April 1 transition was a challenge given limited time for organizations to make changes to their technology, intake, and referral processes. Additionally, reconfiguration of ACOs made it difficult to provide a continuum of care, particularly when patients were carried over under a different contract name. Establishing a transition process that takes these challenges into consideration and creates direct channels of communication between MassHealth and SSOs on key changes is critical. Such a process would ensure that SSOs have time and information needed to implement changes to workflow and technology systems. Nutrition SSOs recommend a six-month transition period from when they are notified of required changes to when those changes need to be implemented. This is necessary to ensure changes can be made without interrupting care for members.

3) **Allocate sufficient funds for reimbursement of services and for infrastructure investments to support data exchange between ACOs and nutrition SSOs**

FIMMA was encouraged to see MassHealth's 1115 waiver amendment which includes an increase in Expenditure Authority for the HRSN integration fund from $8M to up to $25M for infrastructure investment. Our members are optimistic about the potential for a statewide, closed-loop HRSN referral system. The SSO Prep Fund/Integration fund was instrumental in the launch of many programs under the first waiver. Many SSOs shared that

tech limitations and varying technologies can be problematic, impacting their service capacity, and not having a universal technology platform for receiving and responding to referrals is a challenge. Many organizations need to optimize Salesforce or CRMs to meet contract needs, and this requires an investment for each new ACO partner.

SSOs cautioned that development of a statewide platform will require a long lead time (greater than 6 months). SSOs will need resources upfront to take on costly infrastructure upgrades and to mitigate the large learning curve for SSOs to update their current systems, workflows, and compliance. This will be a tremendous undertaking for SSOs. However, they see the value in this investment and look forward to being included in the infrastructure development process to help ensure that the final platform is effective, and also avoids challenges that SSOs have experienced with similar platforms in other states.

Nutrition SSOs are also very pleased with the ability to provide meals at the household level to reach the pediatric population – there is real excitement to expand services to address pediatric and maternal health. However, SSOs noted that the current budget allocations are inadequate to meet the demand for services and highlighted that very few ACO partners are requesting the provision of services at the household level, given the budget constraints. This is particularly concerning given the research goals of the waiver, as it may be difficult to evaluate the impact of scaling to the household level without increased uptake of this important new option.

4) **Provide flexibility with 6-month enrollment limit on services**

We heard that the 6-month limit is a significant challenge. Most importantly, SSOs are concerned that the 6-month enrollment limit hinders the ability of nutrition programs to create the healthcare value necessary to improve patient outcomes and reduce costs. It hampers our ability to evaluate our work, refine our program models, and inform best practices in the Commonwealth and nationwide.

SSOs feel strongly that patients should be able to continue a program beyond 6-months when necessary and appropriate to the health needs of the beneficiary. SSOs therefore urge MassHealth to provide greater flexibility for enrollment—such as by allowing reauthorization of services at 6 months—and not predetermine program duration for beneficiaries. Like other medical interventions, continuation of nutrition services should be allowed at the discretion of the beneficiary's medical care team. Some beneficiaries will need support for only a few months, while others will require interventions for duration longer than 6-months. The length of support should be based on the needs of the individual, rather than predetermined writ large.

5) **Pricing, Budgets and Payment**

SSOs expressed concern that the transition to managed care could pose a potential funding challenge and raised questions about pricing and budgets. Regarding pricing, SSOs would like to discuss whether pricing will be a fixed price or a range of prices for services, and to understand if there will be pricing guidance or a required fee schedule. SSOs would like

bundled pricing to still be allowed and would also like to provide input to MassHealth on how program components and services are parsed out. Furthermore, many SSOs would like to see pricing that is reflective of the actual costs of food interventions (e.g., local foods versus other models).

SSOs have appreciated payment flexibility. For example, some ACOs do not require individual invoicing and allow aggregate level invoicing each month while other ACOs allow for forward payments. Questions remain on whether the glide path implementation plan will address allowance of pre-payments versus reimbursement. Questions were raised on whether a claims based "portal" would be integrated into the statewide referral platform and recognize that integration would require significant time and resources. SSOs also have questions about newly established ACOs budgets and whether they will have budget to cover HRSN services since budgets are based on past spending and number of members.

6) **Upon the transition to managed care, require that ACOs include nutrition support services as a mandatory covered benefit**

SSOs strongly feel that upon transition to managed care, ACOs should be required to continue to provide nutrition support services as a mandatory covered benefit. Requiring nutrition support services provides an opportunity for sustainable funding of nutrition services for the long term. Additionally, preliminary utilization trends suggest that the nutrition services provided through FSP have had positive impact on health outcomes. For example, one ACO found that members who received both nutrition and housing supports in the first half of 2020 saw an improvement in diabetes management. This improvement resulted in an increase from 74.8% to 79.7% of members with hemoglobin A1c levels below 9%, and a decrease in average A1c levels from 7.7 to 7.3, demonstrating important improvements in diabetes control.[1]

Conclusion

Thank you, as always, for your consideration of our requests. We will continue to convene the nutrition SSOs to collaborate on the next evolution of the FSP and will bring recommendations forward to MassHealth as helpful and appropriate. In the meantime, please do not hesitate to contact us if you have any questions or concerns.

Sincerely,

Food Is Medicine Massachusetts (FIMMA)

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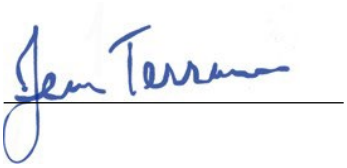
1.Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. Section 1115 Demonstration Project Extension Request. (August 2021)



Jean Terranova, FIMMA Co-convener
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MLRI MASSACHUSETTS LAW REFORM INSTITUTE

September 9, 2023

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

Submitted by email to 1115WaiverComments@mass.gov

Re: Comments on MassHealth 1115 Demonstration Amendment Request

Dear Assistant Secretary Levine,

Thank you for the opportunity to submit comments on MassHealth's proposed Section 1115 waiver amendment released for public comment on August 2, 2023. These comments are submitted on behalf of the Massachusetts Law Reform Institute, on behalf of our clients.

We strongly support MassHealth's waiver amendment requests, which will expand coverage and services, and improve continuity of care. We make the following additional recommendations in furtherance of those shared goals.

1. **Preserve CommonHealth Members' Ability to Enroll in One Care Plans**

We appreciate the agency's foresight in using 1115 authority now to facilitate the transition of One Care to a Medicare + Medicaid plan that will be operating under a different legal authority in January 2026. MLRI has endorsed the comments of Health Care for All concerning the 1115 amendments including its recommendation to allow for more flexibility for One Care beneficiaries to remain enrolled in One Care after age 65 than currently proposed. We look forward to continuing to work with the agency along with others in the disability community to identify what other uses of 1115 authority may be needed to preserve successful features of the One Care program in 2026.

2. **Expand Marketplace (Health Connector) Subsidies to Additional Individuals**

We support the state's efforts to expand affordable coverage to more people through the ConnectorCare program. However, we hope EOHHS and the Health Connector will also revisit the burden of cost-sharing at the lower end of the income scale in ConnectorCare where someone with income $1 over 100% FPL or $1 over 200% FPL now faces a steep increase in out of pocket costs relative to income. The burden of cost-sharing on the low end of the income scale deters enrollment in ConnectorCare and, for those who do enroll, studies show even modest cost sharing at low-income levels deters the use of needed services.

3. **Increase income limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard to the State Statutory Limit**.

The Medicare Saving Program (MSP) is an important benefit for Medicare-eligible beneficiaries who do not qualify for full Medicaid coverage as well as those who do. We support the agency amending the demonstration to raise the MSP income limits to the statutory standards as proposed but urge it to go further as discussed in more detail below.

The current demonstration authorizes MassHealth to provide MSP to people eligible for Standard (without an asset test) but only up to 133% FPL for QMB and 165% FPL for SLMB/QI. Effective January 1, 2023, the state statutory limit for MSP raised the income standard to 190% FPL for QMB and 225% for SLMB/QI. Because MSP has been subject to an asset test, 1115 authority has been needed to extend MSP to certain individuals eligible for MassHealth Standard without an asset test without also obtaining asset information not needed under the MAGI rules. However, there is no reason why the 2023 MSP standards need to await an amendment to the demonstration to be applied to people on MassHealth Standard who *do* have an asset test and who are eligible for MSP, and we urge the agency to implement the 2023 MSP income limits for all non-MAGI individuals eligible for MassHealth Standard.[1]

<u>The agency should also request demonstration authority to increase the MSP benefits to people on CommonHealth to the state statutory limit</u>.

We were disappointed that EOHHS has not taken this opportunity to address MSP for people enrolled in CommonHealth and urge it to do so. In June 2021 EOHHS requested an amendment to provide MSP to individuals in both Standard and CommonHealth with income up to 165% FPL. CMS approved the request for Standard but took no action with respect to the request for CommonHealth. In September 2022 when CMS approved a 5-year extension of the waiver, this is what it said about the MSP waiver for people on CommonHealth:

> For CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth may pay the cost of the monthly Medicare Part B premium until June 30, 2026 ….Effective July 1, 2026, the Commonwealth must either discontinue the program, or have submitted and received approval of an amendment to the demonstration for a Part B premium subsidy design that is consistent with all applicable federal legal requirements.

According to the Medicaid director, the federal legal requirement CMS referred to was Section 1843 of the Social Security Act, (42 U.S.C. 1395v). This section authorizes states and the Secretary of HHS to enter into "buy in " agreements whereby "eligible individuals" may be enrolled in Medicare by the state and for whom the state may pay Medicare premium. Section

[1] MassHealth Standard members with an asset test are currently eligible for MSP with income up to 210% FPL. To be eligible at the QI income level of 210-225% FPL, individuals cannot also be eligible for a state plan benefit like MassHealth Standard. The current demonstration waives this QI limitation for people receiving a state plan benefit with income up to 165% FPL. Therefore, implementation of the 2023 standards for people eligible for Standard will not be able to include people at the new QI level at 210-225% FPL until an amendment of the waiver is granted.

1843 defines eligible individuals via specific cross-references to certain Medicaid eligibility categories but then gives states a broad option to include as eligible individuals anyone eligible under the Medicaid state plan or as "qualified Medicare beneficiaries" under MSP. CommonHealth is not an eligibility category described in the Massachusetts state plan (although it is related to an optional federal program for covering working people with disabilities).[2] Rather, it is a program operating under the 1115 "expenditure" authority. We assume CMS is taking the view that an "eligible individual" under 1843 cannot include an individual in a coverage group that is only under the 1115 expenditure authority and not in the state plan.

We urge the agency to take up CMS's invitation to submit an amendment for a Part B premium subsidy design consistent with all legal requirements. If we are right about the basis for CMS's 2022 objections, we offer three ideas for a Part B premium subsidy design consistent with Section 1843 that we urge the agency to consider and to include in its amendment request:

1). Section 1843 does recognize that individuals eligible under 1115 authority may be "eligible individuals" defined through a series of cross-references. CMS was taking too narrow a view of who may be an "eligible individual" for purposes of Section 1843 in September 2022 particularly in light of the federal regulatory update which took effect in January 2023.

a. Section 1843 defines "eligible individuals" who states may include in a "buy-in" agreement with the Secretary as including "qualified Medicare beneficiaries" and it cross-references to both Sections 1905p and 1902(a)(10)(E) to further define "qualified Medicare beneficiaries."[3] The section of 1902 cross-referenced in 1843(h) includes a further cross-reference to 1905p.[4] The cross-reference to 1905p (4) includes this provision which brings in eligible groups under an 1115 demonstration:

> In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the

[2] See. 42 U.S.C. § § 1396a (a)(10)(A)(ii)(XV), (XVI); 1396o (g).

[3] Section 1843(h) provides in pertinent part:

> (1) The Secretary shall, at the request of a State … enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include (A) individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX, or (B) qualified Medicare beneficiaries (as defined in section 1905(p)(1))….
>
> (3) In this subsection, the term "qualified Medicare beneficiary" also includes an individual described in section 1902(a)(10)(E)(iii).

[4] Section 1902(a)(10)(E)(iii) cross-referenced in 1843(h)(3) above provides in pertinent part:

> (iii) for making medical assistance available for Medicare cost sharing described in section 1905(p)(3)(A)(ii) ***subject to section 1905(p)(4)***, for individuals who would be qualified Medicare beneficiaries described in section 1905(p)(1) … (emphasis supplied).

same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

Thus, Section 1902(a)(10)(E) requires state plans to make assistance available for Medicare cost sharing for "qualified Medicare beneficiaries" under QMB, SLMB and QI as defined in 1905(p). In order to meet this requirement "in the same manner as if the State had in effect an approved state plan" the statute must be giving states authority to include people eligible under the 1115 expenditure authority as "eligible individuals" for purposes of Section 1843.

b. Recently effective federal regulations also support this reading of Section 1843 as giving a state the option to include all state Medicaid beneficiaries not just those in its state plan in its buy in agreement with the Secretary. Final rules modernizing Medicaid payment of Medicare premiums took effect on Jan. 1, 2023.[5] The regulations now provide for three groups of individuals eligible to be included in a state's buy-in agreement: Group 1 includes individuals who are categorically eligible for Medicaid and receive or are deemed to receive cash assistance; Group 2 includes individuals described in Group 1 and the three MSP eligibility groups (QMB, SLMB, and QI), and, in "Group 3: All Medicaid Eligibility Groups: This buy-in group includes all individuals eligible for Medicaid." 42 CFR 407.42. This definition of Group 3 is consistent with reading Section 1843 as including people eligible under an 1115 in addition to those eligible under the state plan as "eligible individuals" under Section 1843.

2). If CMS does not agree with that reading of the statute, there is another approach that may not require an 1115 amendment. Instead, the MassHealth agency simply needs to determine eligibility for MSP based on the MSP eligibility rules and allow individuals who are eligible for both CommonHealth and MSP to receive both. For dually eligible individuals under 65 on CommonHealth this would require supplementing the ACA-3 application with questions about assets.[6] For people 65 and older, the SACA-2 already asks for asset information and uses it in ruling out eligibility for Standard which is one of the eligibility criteria for CommonHealth.

Currently, MassHealth takes the position that disabled individuals enrolled in CommonHealth who demonstrate their eligibility for MSP by also completing the separate MSP application and supplying asset information or who are 65 or older and have supplied asset information as part of their CommonHealth application must choose between the two programs but cannot have both unless their income is under 135% FPL and they are covered under the current demonstration. However, CMS

[5] 87 Fed. Reg. 66454 (Nov. 3, 2022).

[6] This is consistent with the requirement of 42 CFR 435.911(c)(2) that the agency collect such additional information as may be needed to determine whether an individual is eligible for Medicaid on any basis other than the applicable modified adjusted gross income standard and furnish Medicaid on such basis.

guidance to states is clear that if individuals qualify for full Medicaid and for MSP, they should receive both:

> Individuals eligible as a QMB may also meet the separate requirements for another Medicaid eligibility group. In such cases, the individual is eligible for both groups, and therefore eligible for coverage of Medicare cost-sharing and any other state plan services available under the non-QMB group. [7]

MassHealth representatives have told us that despite this CMS guidance, they think CMS prohibits them from taking this approach. The 1115 amendment process is an opportunity for the state to clarify the applicable federal requirements for providing both benefits and seek a waiver if CMS deems it necessary. Clearly, there will be no problem with Section 1843 for CommonHealth members who have separately demonstrated their eligibility for MSP and are therefore unquestionably "eligible individuals" under that section of the Social Security Act.

3). Finally, the 2024 GAA directs the agency to disregard all assets in determining eligibility for MSP subject to federal approval. Section 47, Ch. 28, Act of 2023. Assuming the agency submits its request for a state plan amendment promptly, CMS is likely to approve it long before it acts on the 1115 amendment request. Once this amendment has been approved, there should be no impediment to individuals who qualify for CommonHealth without an asset test, as well as those who qualify for MassHealth Standard without an asset test, to also qualify for MSP. To the extent there is any doubt about that or if additional 1115 authority would facilitate system changes needed to implement the expansion, the agency should expressly ask for any 1115 amendment that it will need when there is no longer an asset test for MSP.

4. Remove the Waiver of Three Months Retroactive Eligibility

We applaud MassHealth's choice to come into alignment with almost all other states by ending its decades-long waiver of three-month retroactive eligibility. We understand that MassHealth plans to wait until a long-term system upgrade before implementing this change. We agree that it is better to have a full system upgrade than to rely on manual processing as a long term strategy. However, while the system upgrade is in development, we urge MassHealth to fill in the gap by implementing this change now as a manual process.

MassHealth has three years of experience implementing three-month retroactive coverage during the COVID public health emergency. Thus, MassHealth enrollment workers are already familiar with how to apply three months retroactive coverage manually. In terms of the CMS authority required to reinstate retroactive coverage, the other lesson from that period is that the state simply needed to notify CMS that it was not choosing to use its waiver authority, it did not need CMS to authorize it to refrain from waiving federal law.

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[7] CMS, Medicaid Program Implementation Guide, Qualified Medicare Beneficiaries, p. 2 (Jan 2020) https://www.hhs.gov/guidance/document/implementation-guide-qualified-medicare-medicare-beneficiaries

The benefits of restoring three-month retroactive eligibility are too great to delay implementation. It reduces the number of months that households are uninsured. It also reduces the burden of medical debt suffered by the poor. The existence of medical debt often deters patients from seeking follow-up care and contributes to a cascade of financial problems that adversely affect health. Retroactive coverage also fairly compensates safety net providers that provide care to patients uninsured at the time of their visit and accommodates the practical barriers that may interfere with the ability of individuals dealing with many other pressing problems or limitations that delay completion of an application.

In addition to urging MassHealth to implement three-month retroactive coverage without delay, we also welcome the opportunity to learn more about how MassHealth intends to program three-month retroactive coverage into the system long-term. Ideally, the coverage date will be based on information gathered upon application and renewal (if the renewal is establishing new Medicaid eligibility), and the system will apply three months retroactive coverage without requiring further action by the applicant or MEC worker.

5. **Provide 12 months Continuous Eligibility to Adults and 24 months Continuous Eligibility for Members Experiencing Homelessness who are 65 and over.**

We strongly support MassHealth's request to expand 12-month continuous eligibility to all age groups, and to expand 24-month continuous eligibility for members experiencing homelessness to members 65 and over. This is a momentous policy improvement that will significantly reduce churn, improving continuity of care and health outcomes for MassHealth members, reducing medical debt, and relieving MassHealth's administrative costs.

When implementing this change, we urge MassHealth to carefully consider how these new continuous coverage benefits will work in combination with existing 12-month continuous coverage for the justice-involved and postpartum populations. When 12-month continuous eligibility for all adults is implemented, and 24-month continuous eligibility for the homeless is implemented (late this year for under 65, and pending CMS approval for over 65), it will be important to assure that an individual eligible for more than one of the continuous eligibility provisions has the benefit of the longest available period of continuous eligibility.

We look forward to working with the agency further on other ways that continuous eligibility can relieve member burdens and make coverage easier for members to use and understand. For example, continuous coverage for all members may be an opportunity to make better use of MassHealth member cards. With continuous coverage, there will be more certainty about the member's coverage dates and coverage type- this may make it practical to issue annual MassHealth member cards. Members are often confused about their MassHealth coverage and rarely know what type of coverage they have. This would reduce member confusion and also serve as a reminder of when their continuous coverage period ends, and they need to renew. It would also help members verify their MassHealth coverage to prove their eligibility for other

programs such as fee waivers, utility discounts, and categorical eligibility for other means-tested programs.

6. Include Short-Term Post Hospitalization Housing as an Allowable Health-Related Social Needs Service

We welcome MassHealth's proposal to support and expand medical respite/short term post hospitalization housing (STPHH) services for homeless individuals through the 1115 amendment. This is a much-needed service that requires a more stable funding source. However, a more broadly defined benefit will better meet the needs of these MassHealth beneficiaries and achieve the goals of STPHH to advance health equity, promote better health outcomes and permanent housing, and reduce total costs of care.

The proposal limits eligibility for medical respite services to MassHealth members enrolled in one of the MassHealth Accountable Care Organizations (ACOs). This excludes disabled and homeless individuals who are not eligible for ACOs because they are dually eligible for MassHealth and Medicare, as well as disabled homeless individuals who may be enrolled in other forms of mandatory managed care that are not ACOs such as the PCC Plan or the MCOs. This appears to exclude a sizable portion of the homeless population with complex medical needs that most need the services. It also excludes any homeless individual age 65 or older.

We understand that the STPHH will be funded as a Health-Related Social Need (HRSN) under the existing demonstration authority as described in Expenditure Authority 22 and Section 15 of the Special Terms and Conditions. However, neither of those two sections appear to limit HRSN to ACOs. In fact, STC 15.7 describes the delivery systems for HRSN as including the fee for service delivery system as well as managed care. Even the general exclusion of the elderly from the demonstration has exceptions for certain services such as diversionary behavioral health services and perhaps could also include an exception for medical respite. See, STC 4.9 Eligibility Exclusions.

A second proposed eligibility criteria for the medical respite benefit that seems far too narrow is the requirement that a MassHealth member is "[b]being discharged from a hospital after an inpatient stay or from an emergency department visit." A clinical criterion less narrowly focused on a recent hospital stay or ED visit would better address the varied circumstances of unhoused people with complex medical and behavioral conditions and be more consistent with the recently approved waivers in California and Washington state.

CMS approved the renewal of Washington State's waiver in July and it included new programs of Recuperative Care and Short-Term Post Hospitalization Housing. See, STC 15.3. The terms are defined differently. Recuperative care is for a shorter period of 90 days but does not appear to be limited to one episode and is not limited to a recent discharge from a hospital or other institutional setting. It requires a medical assessment that the individual is at risk of needing covered services. Short-Term Post Hospitalization Housing is related to a discharge from an

institution, can be for a longer term of up to 6 months but only for one 6-month period. Similarly, California's waiver also includes different definitions for what it calls Short Term Post Hospitalization Housing and Medical Respite. The former is for up to 6 months after being discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care. Medical Respite is for unhoused people who need to heal from an illness or injury.

We urge MassHealth to take a closer look at the scope of the STPHH limitations and define the eligibility criteria more broadly with respect to ACO membership, and the need for a hospital discharge or ED visit and other limitations in the proposed criteria in order to create a more robust and flexible service to meet the needs of unhoused people with complex medical needs.

7. **Increase the Expenditure Authority for the Social Service Organization Integration Fund**. We support this provision.

8. **Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions**.

We strongly support this initiative and, along with the Center for Health Law and Policy Innovation and other organizations have submitted separate comments addressing it. In these separate comments we make five recommendations intended to improve and strengthen the agency's proposal on pre-release services and the successful implementation of this important reform.

****

Thank you for the opportunity to submit these comments. If you have further questions, please contact Vicky Pulos at vpulos@mlri.org or 617-357-0700 ext. 318, or Kate Symmonds at ksymmonds@mlri.org or 617-357-0700 ext. 349.

Yours truly,

Vicky Pulos
Senior Health Law Attorney

Kate Symmonds
Health Law Attorney

FISHING PARTNERSHIP
SUPPORT SERVICES

September 8, 2023

To: 1115 Amendment Comments
EOHHS Office of Medicaid
One Ashburton Place, 3rd Floor
Boston, MA 02108
1115WaiverComments@mass.gov

To Whom It May Concern:

Fishing Partnership Support Services (FPSS) is a nonprofit organization dedicated to improving the health, safety, and economic security of commercial fishermen, their families, and their communities. Since its founding in 1997, FPSS has employed a community-based, holistic public health model to meet this charge and address the social determinants of health. With funding from EOHHS, FPSS currently employs 27 employees to run four offices in port towns in Massachusetts. Our port offices are staffed by highly trained Community Health Workers called Navigators, most of whom are fishermen's wives, partners, or fishermen themselves. Navigators know what fishing families need, and they are experts in delivering care to meet those needs.

FPSS programs and services respond directly to needs of the fishing community in key areas, including health-related education, outreach, and health insurance enrollment; preventive health care interventions; safety and survival training; professional development; and workshops designed to enhance economic security. In FY22, FPSS Navigators assisted 1,481 Massachusetts consumers with health insurance, including 226 new applications and 1,165 enrollments. FPSS shapes its programming to meet the changing demands of this population, having added courses and programs to address stress and behavioral health issues over the past several years, such as the opioid education and naloxone distribution training; we offered to 547 participants in FY22. Through this multi-faceted approach, we aim to reduce Health Safety Net costs.

FPSS supports the Healey-Driscoll administration's proposal to amend Massachusetts' Section 1115 Demonstration ("1115 Demonstration"). In particular, FPSS believes that certain elements of the proposed amendment will positively benefit the populations we serve: fishermen, fishing families, and fishing communities in and around our port offices in Gloucester, Plymouth, New Bedford, and Chatham.

The amendment would address several issues FPSS' Navigators have highlighted:

(1) **Provide 12 Months Continuous Eligibility for Adults**. Fishermen often have variable and inconsistent income, based on the fishing season and accompanying fluctuations in catch and income – and thus their eligibility for different programs and subsidies. Navigator Morgan reports that, "this amendment will allow fishing families to focus on providing for their families and not about whether they will have insurance when they walk in the PCP's office."
(2) **Expansion Marketplace (Health Connector) Subsidies to Additional Individuals**. Similarly, a permanent expansion of the Marketplace ConnectorCare subsidies to 500% FPL would expand coverage to the populations we serve. In turn, this would help fishing families maintain continuous and affordable coverage and improve health equity by supporting the provision of consistent and trusted medical care.

(3) **Implement Three Months' Retroactive Eligibility.** FPSS Navigators currently allocate significant time and limited resources helping individuals address past medical bills. Retroactive eligibility prior to MassHealth enrollment would positively impact fishermen and fishing families who received medical services prior to their enrollment. This would allow members to immediately and proactively address health concerns while completing their MassHealth applications and eliminate a significant source of financial strain.

Thank you for your consideration of FPSS' comments on the proposed amendment.

Sincerely,

John (J.J.) Bartlett
President / Business Official
Fishing Partnership Support Services

September 7, 2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburn Place, 3rd Floor
Boston, MA 02108

Dear Director Levine:

The New England Hemophilia Association, New England Bleeding Disorders Advocacy Coalition, Hemophilia Federation of America, and National Bleeding Disorders Foundation appreciate the opportunity to submit comments on the MassHealth 1115 Medicaid Demonstration Amendment Request.

NEHA and NEBDAC provide education and advocacy about bleeding disorders in all six New England states. HFA and NBDF are national non-profit organizations that represent individuals affected by bleeding disorders across the United States. Our missions are to ensure that individuals affected by hemophilia and other inheritable bleeding disorders have timely access to quality medical care, therapies, and services, regardless of financial circumstances or place of residence.

Our organizations are committed to ensuring that Massachusetts' Medicaid program provides quality and affordable healthcare coverage. We applaud the Commonwealth's emphasis on health equity in this waiver and support the inclusion of retroactive eligibility for all enrollees, continuous eligibility for all adults, pre-release coverage for justice-involved populations, and expanded financial assistance for marketplace coverage. NEHA, NEBDAC, HFA, and NBDF offer the following comments on the MassHealth 1115 Demonstration Amendment Request:

Retroactive Coverage for All Enrollees
Our organizations support the proposal to reinstate retroactive coverage for all demonstration populations. Retroactive coverage is an important policy to advance health equity and a safety net for low-income families. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Retroactive coverage is also important for current Medicaid enrollees. Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[1] Medical debt disproportionately affects families of color in the US[2] and is a predictor of other social drivers of health such as homelessness.[3] Retroactive coverage prevents Medicaid enrollees from facing substantial costs at their doctor's office or pharmacy and subsequent delays in care.

Given the importance of this policy change, NEHA, NEBDAC, HFA, and NBDF urge the Commonwealth to reinstate retroactive coverage sooner than 2025. Many patients are facing gaps in coverage as a result of procedural disenrollments during the Medicaid unwinding process. Massachusetts should reinstate retroactive coverage as soon as possible to protect enrollees from the financial and health risks of a gap in coverage.

Continuous Eligibility for All Adults

Our organizations support the proposal to provide 12-month continuous eligibility for all adults, as well as 24-month continuous eligibility for seniors experiencing homelessness. Continuous eligibility promotes health equity,[4] and increases continuity of coverage.

Continuous eligibility protects patients and families from gaps in care. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[5] For individuals living with a bleeding disorder, an inability to continue on therapy and/or promptly treat acute bleeds can result in permanent joint damage or (in the case of head bleeds) even death. Consequently, our organizations support continuous eligibility as a means to prevent gaps in care and prevent/reduce devastating health outcomes for patients.

This policy will also reduce churn within the program and its administrative burden on Medicaid offices. Research shows that 40% of Medicaid enrollees who lose coverage are re-enrolled in the program within a year.[6] One study estimated that the administrative cost of churn was between $400 and $600 per person in the Medicaid program.[7] Continuous eligibility eases the administrative burden that these changes in enrollment status place on the program.

As discussed above, because this policy would be especially impactful during the Medicaid unwinding process, our organizations encourage the Commonwealth to move up the implementation date for this policy from January 2025. Additionally, we further urge the Commonwealth to consider providing multi-year continuous eligibility for young children. Multi-year continuous eligibility would improve access to and continuity of care for children during the critical early years of life[8] while promoting health equity. Studies show that children of color are more likely to be affected by gaps in coverage that continuous eligibility would address, rendering it necessary for improving equitable access to care.[9]

Pre-Release Services for Justice-Involved Populations

NEHA, NEBDAC, HFA, and NBDF support the proposed coverage for incarcerated individuals who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with the goals of Medicaid and will be an important step in improving the continuity of care. This proposal will help these high-risk populations access critical supports needed to treat physical and behavioral health conditions.

Eligibility Increase for Marketplace Subsidies

Our organizations support expanding eligibility for ConnectorCare subsidies from 300 percent to 500 percent FPL. This program provides subsidies for premiums and cost-sharing for individuals determined eligible for up to 100 days while they select, pay, and enroll into a marketplace plan. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[10] This problem is particularly acute for people with bleeding disorders, since their health care costs are so high[11] and their need for care

continues year-after-year throughout their entire lives. Expanding eligibility for the subsidy program would protect additional individuals and families with bleeding disorders from financial toxicity and would mitigate gaps in coverage.

Thank you for the opportunity to provide comments.

Sincerely,

Nathan Schaefer, MSW
Vice President, Public Policy & Access
National Bleeding Disorders Foundation

Miriam Goldstein
Acting Vice President of Public Affairs
Hemophilia Federation of America

Richard Pezzillo
Executive Director
New England Hemophilia Association

Joe Zamboni
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New England Bleeding Disorders Advocacy Coalition

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Lynn Health Task Force
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LYNN HEALTH TASK FORCE
COMMENTS ON EOHHS PROPOSED AMENDMENT TO 1115 WAIVER
(Short-Term Post Hospitalization Housing)
September 9, 2023

INTRODUCTION

These comments are submitted on behalf of the Lynn Health Task Force, a grassroots health advocacy organization focused on Lynn and the North Shore. For over 25 years, the Task Force has been a leader in advocating for accessible, quality, affordable health care in the City of Lynn. We focus on issues of health access for underserved groups including low-income people, immigrants, the elderly and the uninsured. Our membership includes community leaders, social service providers, senior citizens, union activists and representatives of newcomer communities. As a consumer health advocacy organization, we have participated in multiple regulatory proceedings related to health access in our community, including as a ten-taxpayer part in Department of Public Health Determination of Need (DoN) matters and Essential Services proceedings.

We are deeply appreciative of recent steps taken by EOHHS to support and expand Medical Respite capacity in the Commonwealth, including the proposed amendment to the 1115 Waiver for Short-Term Post Hospitalization Housing (STPHH). The Lynn Health Task Force has a particular interest in the formation, funding and support of Respite Services. Respite care in Lynn was a long-time goal of the Task Force, which ultimately led to the establishment of the Deborah Smith Walsh Recuperative Care Center in 2017. Loosely modeled on the Barbara McInnis House and the Stacy Kirkpatrick House, both operated by Boston Health Care for the Homeless, we believe the Lynn respite program is the only respite program operating in Massachusetts outside of Boston. We have found that the combination of health care with a healthy, safe, and stable residential program leads to dramatic changes in patients' health outcomes and in their quality of life. Our experience demonstrates the necessity for recognition of Respite as a distinct and essential component of the health care delivery system with commensurate funding mechanisms for **both** the medical care and the 24-7 residential services.

For many years, the Lynn Health Task Force advocated for the creation of a respite program; however, there were no sources of funding for capital or operations. When North Shore Medical Center (part of what is now Mass General Brigham) filed a Determination of Need (DoN) application with the Department of Public Health for a major expenditure and expansion of its campus in Salem, we saw an opportunity for seed funding. The Salem expansion was necessitated by MGB's decision to close Union Hospital, the only hospital in Lynn, a city of roughly 100,000 people. While the closure of Lynn's only hospital was devastating for our community, the "silver lining" was that the DoN application required the commitment of funds for community needs. This enabled us to obtain much of the needed capital to establish a facility for a local respite program. Were it not for that funding, we would not have a respite program in Lynn. Even with the capital funds in hand, there were multiple challenges to the creation of the Lynn Respite. It was a challenge to find accessible space to house a 24-hour program, a receptive and appropriate landlord, funds to pay for the initial staffing, and to find a partner to provide the residential component to complement the medical care provided by Lynn Community Health Center.

And since the Lynn Respite opened its doors in 2017, it has been a constant challenge to cobble together funding to keep it operating. While the medical visits (only one per day) provided to patients can be billed to insurance (primarily MassHealth), there is no funding source for the wrap-around services such as case and milieu management, and no compensation for the 24-7 residential staffing. For the last five years, we have scrambled to identify a variety of funding sources, many of which are one-time funds. These include federal and state grants, hospital financial support, in-kind food donations, and City of Lynn ESG-CV funds. Every year we face the very real possibility of being unable to sustain the Respite because we lack stable funding. While the care being delivered is remarkable, the financing is unreliable, insufficient and an impediment to any long-term planning.

Despite these challenges, the Lynn Respite has achieved remarkable progress with many of its patients, including a high success rate of discharge to stable housing. Some examples include an elderly man with COPD who was in and out of the hospital with exacerbations but who could not use his oxygen tank outside of his rooming house unit because he was on the third floor and could not carry it down the stairs, a brittle diabetic who'd had multiple ED visits for diabetic ketoacidosis whose blood sugars were controlled with Continuous Glucose Monitoring while staying at the Respite and is now housed and working out daily at the YMCA, and a homeless paraplegic woman who was able to regain her strength and stability and exit to housing.

We are therefore extremely heartened and relieved to see that EOHHS has recognized the importance of respite care and the need for stable funding for these crucial services for our community's most vulnerable patients. Additionally, the life expectancy for a

homeless person in Massachusetts is 53 years[1], compared to over 80 years[2] for housed residents of the Commonwealth. National data is consistent with our experience in Lynn: Respite care leads to reduced need for inpatient care, fewer ED visits and fewer readmissions. Without the Respite program, vital care provided to homeless patients would either not be provided at all or would be provided in much more expensive settings. Our experience over the last five years is that Respite has filled an indispensable niche in our care delivery system. We have reviewed the 1115 Amendment materials on the state's website, and offer the following concerns based on our experiences over the past 5 years with Lynn's Deborah Smith Walsh Recuperative Care Center.

MASSACHUSETTS PROPOSED 1115 AMENDMENT – SPECIFIC ISSUES/CONCERNS

As noted above, the Lynn Health Task Force has been instrumental in the creation and sustainment of the Deborah Smith Walsh Recuperative Care Center. We therefore reviewed the summary of the proposed 1115 Waiver with special interest. We note the following concerns about the proposal as it appears on the Mass.gov website.

1. <u>The 1115 Waiver for Short-Term Post Hospitalization Housing Benefits Should Include Non-ACO Patients</u>

The Lynn Health Task Force urges MassHealth to include non-ACO patients in the Short-Term Post Hospitalization Housing benefit. The benefits of respite care are clear across populations, including people over age 65. The homeless population of Lynn includes many people over age 65, and they are often among the most frail and medically needy within that population. The Lynn Respite has had significant success managing patients over age 65. Their Respite patients have also had success remaining stable in housing following discharge from the Respite. The fundamentals which presumably are leading the Commonwealth to propose the STPHH benefit - facilitating hospital discharges, stabilizing patients whose needs make congregate shelter or unhoused settings especially damaging, establishing discharge plans with stable housing and ongoing support - apply to people over age 65 as often as those under age 65; most likely even more. By limiting the STPHH benefit to ACO patients, the benefit will not include people over age 65. We urge the state to broaden the eligibility to include non-ACO patients.

[1] Mortality Among Unsheltered Homeless Adults in Boston, https://ncbi.nlm.nih.gov/pmc/articles/PMC6142967/
[2] Centers for Disease Control and Prevention, National Center for Health Statistics, Life Expectancy at Birth by State https://www.cdc.gov/nchs/pressroom/sosmap/life_expectancy/life_expectancy.htm

2. The 1115 Waiver for Short-Term Post Hospitalization Housing Benefits Should Not Be Limited to Patients Discharged From Hospitals

The summary of the proposed 1115 Waiver indicates that the STPHH benefit will be limited to patients who are being discharged from an inpatient stay or an Emergency Department visit. We urge EOHHS to include a broader definition of clinical eligibility. Our experience in Lynn has been that while many patients are admitted to the Lynn Respite from hospital stays or ED visits, many others are admitted from shelters or the streets. Admissions are based on risk factors and clinical presentation, not on the patient's setting immediately prior to admission. Indeed, our current approach reduces unnecessary hospital utilization, by treating patients in the community and caring for them before a hospitalization becomes necessary. If the Respite can only accept patients from the hospital, homeless community-based patients will have to wait for an emergency department visit or hospitalization, leading to overuse of the hospital and reducing the efficacy of preventive outreach care.

3. The Short-Term Post Hospitalization Housing Benefit Should Not Be Limited to Six Months.

Our final recommendation is that the STPHH benefit should not be limited to six months. Our experience has been that there is a wide range in the lengths of Respite stays. Some are much shorter than six months, while some stays are longer. The length of stay is determined based on clinical needs, which often indicate that discharge is appropriate within six months of admission, but not always. Lynn has had terminal patients who were able to remain at the Respite until their final days. The Respite stays gave them a community life they lacked elsewhere and gave them the dignity they deserved, but an arbitrary time limit would have precluded that. Similarly, Lynn Respite admitted a patient following amputation of both of her lower limbs. She was stabilized during her Respite stay, but it took longer than six months to arrange a safe discharge for her. While the number of stays over six months is small, these are often the most vulnerable and challenging patients, and the Task Force urges EOHHS to ensure that they will be able to remain for the time period needed, determined on an individualized clinical basis.

CONCLUSION

As noted above, the Lynn Health Task Force is very appreciative of EOHHS's interest in formalizing Medical Respite services in Massachusetts, and we are grateful for this opportunity to share our experiences and the issues we have identified from review of the proposed Amendment. We see this as an opportunity to stabilize the Lynn Respite, which offers a vital service but has struggled to survive fiscally, and to encourage the establishment of similar programs in other parts of the Commonwealth to offer this life-saving service to residents of other communities. At the same time, we urge EOHHS to revise its current plan to ensure that all MassHealth patients, not just ACO patients, have access to Respite care, as well as to broaden the admission criteria beyond hospital discharges, and to eliminate the six-month cap on Respite admissions. Once again, we thank EOHHS for its efforts and for the comment period. We would be happy to respond to any questions or to share further information from our experience in Lynn.

LEUKEMIA & LYMPHOMA SOCIETY®

9/7/2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburn Place, 3rd Floor
Boston, MA 02108

Dear Director Levine:

The Leukemia and Lymphoma Society (LLS) appreciates the opportunity to submit comments on the MassHealth 1115 Medicaid Demonstration Amendment Request.

LLS's mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. We advance that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare, regardless of the source of their coverage.

LLS is committed to ensuring that Massachusetts' Medicaid program provides quality and affordable healthcare coverage. Our organization appreciates the emphasis on health equity in this waiver and supports the inclusion of retroactive eligibility for all enrollees, continuous eligibility for all adults, pre-release coverage for justice-involved populations, and expanded financial assistance for marketplace coverage. LLS offers the following comments on the MassHealth 1115 Demonstration Amendment Request:

Retroactive Coverage for All Enrollees
LLS supports the proposal to reinstate retroactive coverage for all demonstration populations. Retroactive coverage is an important policy to advance health equity and a safety net for low-income families. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Blood cancer patients face significant treatment costs, and these costs are particularly acute during the first few months following a diagnosis.[i] Even with coverage, it is common for blood cancer patients to incur significant medical debt. LLS, in partnership with the organization Dollar For, assists blood cancer patients who have medical debt or medical bills with applications for hospital financial assistance programs: those patients who have been approved for financial assistance have seen an average of $5,371 in bills waived. Providing retroactive coverage will ease or eliminate this burden for individuals who may only apply for coverage as a result of a new cancer diagnosis.

Retroactive coverage is also important for current Medicaid enrollees. Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[ii] Medical debt disproportionately affects families of color in the US[iii] and is a predictor of other social drivers of health such as homelessness.[iv] Retroactive coverage prevents Medicaid enrollees from facing substantial costs at their doctor's office or pharmacy and subsequent delays in care.

Given the importance of this policy change, LLS urges the state to reinstate retroactive coverage sooner than 2025. Many patients are facing gaps in coverage as a result of procedural disenrollments during the Medicaid unwinding process. The state should reinstate retroactive coverage as soon as possible to protect enrollees from the financial and health risks of a gap in coverage.

Continuous Eligibility for All Adults

LLS supports the proposal to provide 12-month continuous eligibility for all adults, as well as 24-month continuous eligibility for seniors experiencing homelessness. Continuous eligibility promotes health equity,[v] and increases continuity of coverage.

Continuous eligibility protects patients and families from gaps in care. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[vi] Blood cancers are complex diseases that often require significant, sustained, and carefully coordinated care across multiple providers and care settings: any disruption or delay in a treatment plan can have devastating consequences for a patient. LLS supports continuous eligibility as a method to reduce these negative health outcomes for patients.

This policy will also reduce churn within the program and its administrative burden on Medicaid offices. Research shows that 40% of Medicaid enrollees who lose coverage are re-enrolled in the program within a year.[vii] One study estimated that the administrative cost of churn was between $400 and $600 per person in the Medicaid program.[viii] Continuous eligibility eases the administrative burden that these changes in enrollment status place on the program.

As discussed above, because this policy would be especially impactful during the Medicaid unwinding process, LLS encourages the state to move up the implementation date for this policy from January 2025. Additionally, LLS further urges the state to consider providing multi-year continuous eligibility for young children. Multi-year continuous eligibility would improve access to and continuity of care for children during the critical early years of life[ix] while promoting health equity. Studies show that children of color are more likely to be affected by

gaps in coverage that continuous eligibility would address, rendering it necessary for improving equitable access to care.[x]

Pre-Release Services for Justice-Involved Populations
LLS supports the proposed coverage for incarcerated individuals who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with the goals of Medicaid and will be an important step in improving the continuity of care. This proposal will help these high-risk populations access critical supports needed to treat physical and behavioral health conditions.

Eligibility Increase for Marketplace Subsidies
LLS supports the expansion of eligibility for ConnectorCare subsidies from 300 percent to 500 percent FPL. This program provides subsidies for premiums and cost-sharing for individuals determined eligible for up to 100 days while they select, pay, and enroll into a marketplace plan. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[xi] Expanding eligibility for the subsidy program would ease the transition from Medicaid to the Marketplace and mitigate gaps in coverage.

Thank you for the opportunity to provide comments.

Sincerely,

Ernie Davis, Director of State Government Affairs
The Leukemia & Lymphoma Society

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[i] Dieguez G, Ferro C, Rotter D. The Cost Burden of Blood Cancer Care. October 2018. Available at: https://www.lls.org/sites/default/files/Milliman%20study%20cost%20burden%20of%20blood%20cancer%20care.pdf

[ii] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

[iii] Bennett, Neil et al. "Who Had Medical Debt in the United States?" U.S. Census Bureau. April 7, 2021. Available at: https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html

[iv] Bielenberg JE, Futrell M, Stover B, Hagopian A. Presence of Any Medical Debt Associated With Two Additional Years of Homelessness in a Seattle Sample. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. 2020;57. doi:10.1177/0046958020923535

[v] Chomilo, Nathan. Building Racial Equity into the Walls of Minnesota Medicaid. Minnesota Department of Human Services. February 2022. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG

[vi] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of

Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[vii] Corallo, Bradley et al. "What Happens After People Lose Medicaid Coverage?" Kaiser Family Foundation. January 25, 2023. Available at: https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/

[viii] Swartz, Katherine et al. "Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End Of Calendar Year Is Most Effective." Health Affairs, Vol 37, No. 7. July 2025. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1204

[ix] Burak, Elisabeth Wright. "Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)." Center for Children and Families, Georgetown University Health Policy Institute. October 2018. Available at: https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf

[x] Osorio, Aubrianna. Alker, Joan, "Gaps in Coverage: A Look at Child Health Insurance Trends", Center for Children & Families (CCF) of the Georgetown University Health Policy Institute, November 21, 2021. Gaps in Coverage: A Look at Child Health Insurance Trends – Center For Children and Families (georgetown.edu)

[xi] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF

Planned Parenthood
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September 9, 2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02108

Submitted electronically via 1115WaiverComments@mass.gov

RE: Massachusetts' Draft MassHealth Section 1115 Demonstration Amendment Request

Dear Assistant Secretary Levine,

Planned Parenthood League of Massachusetts (Planned Parenthood) is pleased to submit these comments in response to the Executive Office of Health and Human Services's (EOHHS) draft MassHealth amendment request to continue its commitment to universal health care coverage and addressing health equity in the state.

In recent years, Planned Parenthood's four health centers in the state have provided health care and educational services to over 40,000 individuals each year. These services include the full range of sexual and reproductive health (SRH) care, including services known to contribute to healthier pregnancies, such as lifesaving cancer screenings, birth control, abortion, and testing and treatment for sexually transmitted infections (STIs) and HIV/AIDS, and HIV prevention. Collectively, women comprise 89 percent of our patients, and nearly 40 percent of our patients are people of color. More than a third of our patients have incomes below 150 percent of the federal poverty level (FPL), which would qualify them for essential public benefits through the state's Medicaid program. People across our state trust Planned Parenthood to provide them with quality, expert care in a confidential and non-judgmental setting. Planned Parenthood believes it is important that each person be able to access the medical care they need from the providers they trust.

Medicaid is a vital part of the health care system and plays a major role in ensuring access to essential primary and preventive care services for women, men, and young people. Medicaid is critical to improving the health and well-being of women and families with low incomes across Massachusetts and the rest of the nation. In particular, as the largest payer of reproductive health care coverage in the

country,[1] Medicaid is a crucial program for women of reproductive age, enabling them to access necessary SRH services, including maternal health services. Approximately 1 in 5 women of reproductive age use Medicaid,[2] and roughly two-thirds of adult women enrolled in Medicaid are in their reproductive years.[3] For nearly half of women giving birth, Medicaid is the source of coverage for essential care, including prenatal and delivery care; recent data found that in 21 states 40 percent or more of births are covered by Medicaid.[4] Furthermore, Medicaid pays for 75 percent of family planning services.[5]

Because women make up the majority of Medicaid enrollees, they will be particularly impacted by implementation of EOHHS's draft application. Importantly, Medicaid coverage of family planning services and supplies improves women's health, lives, educational success, and economic empowerment. Moreover, due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population and will particularly benefit from the draft application; 31 percent of Black women and 27 percent of Hispanic women are enrolled in Medicaid, compared to 16 percent of white women.[6]

Finally, Medicaid is essential in narrowing health disparities and improving access to care for communities of color. Indeed, research shows that Medicaid expansion has contributed to reductions in racial disparities in health coverage, in particular for Black and Hispanic individuals,[7] and decreased disparities in some health outcomes, including in infant and maternal health.[8]

As one of the state's leading safety net health care providers and advocates for SRH care, Planned Parenthood is uniquely situated to provide input on policy proposals that affect the health of people

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[1] Usha Ranji, "Medicaid and Family Planning: Background and Implications of the ACA," Kaiser Family Foundation (Feb. 3, 2016), available at https://www.kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/.

[2] Adam Sonfield, "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health," Guttmacher Institute (Mar. 9, 2017), available at https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health.

[3] "Medicaid's Role for Women," Kaiser Family Foundation (Mar. 28, 2019), available at https://www.kff.org/medicaid/fact-sheet/medicaids-role-for-women/.

[4] In Massachusetts, Medicaid covers 29 percent of births, see Births Financed by Medicaid, Kaiser Family Foundation, available at https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=.

[5] Adam Sonfield et al., "Public funding for family planning, sterilization and abortion services, FY 1980–2006," Occasional Report, New York: Guttmacher Institute, No. 38. (Jan. 2008), available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/2008/01/28/or38.pdf.

[6] *Supra,* note 2.

[7] Madeline Guth, et al., "Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care," Kaiser Family Foundation (Sep. 30, 2020), available at https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/.

[8] *Id.*

and the communities Planned Parenthood serves in Massachusetts. Accordingly, this letter focuses on supporting the state in proceeding with its goal to address health equity and reduce disparities with the following requests: (1) reinstatement of 3-months retroactive coverage for all remaining MassHealth enrollees; and (2) provide 12-months continuous eligibility to all adults age 19 and older. Planned Parenthood fully supports these requests and urges EOHHS to proceed forward with them.

I. Planned Parenthood recommends EOHHS to proceed forward with the draft proposal to reinstate retroactive coverage for all eligible MassHealth enrollees. We also urge EOHHS to consider reinstating retroactive coverage at a sooner effective date to help reduce gaps in coverage for individuals disenrolled during the unwinding process.

Retroactive coverage is a federal law and policy that requires states to pay for covered services provided to individuals during the three month period prior to the date of applying for Medicaid coverage, provided that the individual would have been eligible during that period.[9] States are required to provide retroactive coverage to Medicaid enrollees, and this provision helps safeguard enrollees' continuous access to care when there are delays in determining eligibility. Planned Parenthood notes that retroactive coverage has been a requirement of the Medicaid program since 1972; waivers of retroactive coverage are a departure from this long-standing requirement that state Medicaid programs should be required to adhere to.

EOHHS's draft application proposes to build on its most recent MassHealth extension that reinstated retroactive coverage for pregnant individuals and children up to age 19[10] and fully withdraw its waiver of retroactive coverage from MassHealth. By doing so, EOHHS is proposing to reinstate retroactive coverage for all remaining MassHealth enrollees. Planned Parenthood enthusiastically supports this proposal and recommends EOHHS to proceed with it.

A. Retroactive coverage is vital for enrollees to access cost-effective and timely care, including SRH care.

Retroactive coverage is critical to reducing individuals' medical debt, as well as financial strain on the health care system that stems from uncompensated care. When individuals have coverage, they are more likely to be able to receive the care they need in a timely manner, which enables the health care system to treat conditions before they become more serious and more costly. For example, in New Hampshire, in one 16-month period, 4,567 Medicaid expansion individuals benefited from the policy, which paid more than $5 million for their medical expenses.[11]

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[9] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914.
[10] *See* MassHealth Extension Approval, Centers for Medicare & Medicaid Services (Sep. 28, 2022), available at https://www.medicaid.gov/sites/default/files/2022-09/ma-masshealth-ca1.pdf.
[11] Conditionally Approved Waiver of Retroactive Coverage, NHDHHS (Dec. 21, 2015), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf.

In addition, the absence of retroactive coverage has increased financial burdens for people with low incomes, as well as safety net providers that serve those individuals. For instance, after retroactive coverage was waived in Indiana, individuals eligible as parents and caretakers incurred medical costs averaging $1,561 per person.[12] These costs would have been paid for by Medicaid if retroactive coverage was in place.[13] On top of this, 16 percent of providers in Indiana experienced increases in the provision of uncompensated care after retroactive coverage was waived.[14]

Timely access to care is particularly relevant in the context of family planning, as only a few days without contraception can result in an unintended pregnancy. Moreover, STIs that go untested and untreated can spread throughout communities and cause lifelong problems, including infertility and pelvic inflammatory disease.[15] Urinary tract infections are one of the most common infections women experience and are easily treatable, but without treatment, can require in emergency room care, which can cost a state nearly $1,500 per patient.[16]

Finally, Planned Parenthood underscores the importance of retroactive coverage after the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization (Dobbs).* The *Dobbs* decision significantly increased demand for timely SRH services. Specifically on June 24, 2022 (the day *Dobbs* was decided), Planned Parenthood health centers across the country saw enormous growth in scheduling various SRH appointments: (1) a more than 150% increase in the number of birth control appointments; (2) a 48% increase in the number of emergency contraception appointments; and (3) a more than 375% increase for intrauterine devices (IUDs) appointments.[17] Ensuring access to timely SRH care for Medicaid enrollees is more important than it has ever been.

B. Retroactive coverage is a necessary component of building a robust provider network.

Retroactive coverage also bolsters critical provider participation in the Medicaid program as providers know in advance that they will be adequately compensated, which means that patients are better able to meaningfully access care. Medicaid programs are already faced with provider shortages, with more

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[12] Letter to Director McGuffee, CMS (Jul. 29, 2016), available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[13] *Id.*

[14] Harris Meyer, "New Medicaid Barrier: Waivers ending retrospective eligibility shift costs to providers, patients," Modern Healthcare (Feb. 9, 2019), available at https://www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

[15] Chlamydia: Fact Sheet, Centers for Disease Control and Prevention (Apr. 12, 2022), available at https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm.

[16] Nolan Caldwell, et al., "'How Much Will I Get Charged for This?' Patient Charges Top Ten Diagnoses in the Emergency Department,"Plos One Journal (Feb. 27, 2013), available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491.

[17] "By the Numbers: One Month in a Post-Roe America," Planned Parenthood Federation of America, available at https://www.plannedparenthood.org/uploads/filer_public/d0/87/d087f64c-f1a7-4a2d-b5b8-08089a4c7346/by_the_numbers__one_month_in_to_a_post_roe_america.pdf.

than two-thirds of states reporting difficulty in ensuring provider participation in Medicaid.[18] SRH provider shortages are particularly acute, as states are especially challenged in recruiting OB/GYNs. A report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) found that Medicaid managed care plans had extreme provider shortages, with only 42 percent of in-network OB/GYN providers able to offer appointments.[19] The *Dobbs* decision exacerbated these existing shortages, with SRH provider shortages at record levels across the country.[20] In particular, SRH providers are contending with the pressures of a rapidly changing legal landscape and continued attacks in hostile states on SRH care access, including to abortion, gender-affirming care, and birth control.

Yet, despite these shortages of OB/GYN providers, women often rely on their OB/GYN providers as their main source of care.[21] Any policy, including the current lack of retroactive coverage for all MassHealth enrollees, that reduces the availability of women's health providers in the Medicaid program can cause longer wait times for appointments and delays in accessing critical women's health care. Due to the unique way women experience the health care system, delays in access to OB/GYNs and other women's health care providers can also impact women's access to the broader health care system and result in women lacking access to other essential primary and preventive care. Sufficient provider participation is essential to ensure Massachusetts's success in MassHealth. Indeed, health care coverage is meaningless if patients are unable to receive care from quality providers in a timely manner.

C. The elimination of retroactive coverage has a disproportionate impact on people of color.

Finally, Planned Parenthood emphasizes that retroactive coverage waivers have a disproportionate impact on people of color. Medical debt disproportionately impacts people of color in the U.S. Nationally, 15% of people in communities of color have medical debt in collections, compared to 11% of people in white communities.[22] This racial disparity persists in Massachusetts: 6% of people in communities of color have medical debt in collections compared to 4% of people in white communities.[23] Furthermore, people in communities of color in Massachusetts have a higher median amount of medical debt in collections ($451) compared to people in white communities ($385).[24] Retroactive coverage waivers

[18] "States Made Multiple Program Changes, and Beneficiaries Generally Access Comparable to Private Insurance," Government Accountability Office (Nov. 2012), available at http://www.gao.gov/assets/650/649788.pdf; "Access to Care: Provider Availability in Medicaid Managed Care," Department of Health and Human Services, Office of the Inspector General (Dec. 2014), available at http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.
[19] *Id.*
[20] "What Will Happen to the Reproductive Healthcare Workforce? Early warning signs suggest shortages in many states," Relias Media (Jan. 1, 2023), available at https://www.reliasmedia.com/articles/what-will-happen-to-the-reproductive-healthcare-workforce.
[21] "What Will Happen to the Reproductive Healthcare Workforce? Early warning signs suggest shortages in many states," Relias Media (Jan. 1, 2023), available at https://www.reliasmedia.com/articles/what-will-happen-to-the-reproductive-healthcare-workforce.
[22] "Debt in America: An Interactive Map – Share with medical debt in collections," Urban Institute (Jun. 23, 2022), available at https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=medcoll.
[23] *Id.*
[24] *Id.*

expose more people of color to medical debt, which only decreases access to timely care and worsens health equity for these communities.

D. Given the current MassHealth unwinding process, EOHHS should reinstate the retroactive coverage as soon as possible.

In the draft application, EOHHS is seeking an effective date of January 1, 2025 to eliminate the waiver of retroactive coverage. Planned Parenthood notes that this is an unnecessarily long time to eliminate the waiver and reinstate this coverage for the remaining MassHealth enrollees. Therefore, EOHHS should consider a sooner effective date to help reduce gaps in coverage for individuals disenrolled during the unwinding.

Massachusetts began its MassHealth unwinding process on April 1, 2023. As of September 5, 2023 at least 5,677,000 Medicaid enrollees have been disenrolled from state Medicaid programs in 48 states and the District of Columbia.[25] In Massachusetts, approximately 127,000 individuals have been disenrolled so far,[26] although an estimated 400,000 individuals are expected to lose their MassHealth coverage because they no longer qualify, and even more are expected to lose coverage due to procedural reasons.[27]

Individuals who lose their MassHealth coverage as a result of this process will experience a disruption in their continuity of care, even if they are able to enroll in another insurance option like a Marketplace plan. To minimize this disruption, Planned Parenthood strongly urges EOHHS reinstate retroactive coverage to the remaining MassHealth enrollees as soon as possible.

II. Planned Parenthood recommends EOHHS to proceed forward with the draft proposal to provide continuous eligibility for adults 19 and older.

EOHHS's draft application proposes to provide continuous eligibility to all MassHealth adults age 19 and older. Planned Parenthood strongly supports this proposal for the reasons set forth in this section and recommends EOHHS to proceed forward with it.

Continuous eligibility is vital to ensuring that Medicaid coverage, such as MassHealth coverage, is stable, continuous, and accessible for eligible individuals. Continuous eligibility keeps people enrolled in Medicaid for a specific period of time regardless of changes in income. This policy has been shown time and again to reduce the likelihood that Medicaid enrollees will lose their affordable health insurance coverage due to small fluctuations in income or burdensome administrative

[25] "Medicaid Enrollment and Unwinding Tracker," Kaiser Family Foundation (Sep. 5, 2023), available at https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/.
[26] *Id.*
[27] Nik DeCosta-Klipa, "New rules and blue envelopes: What MassHealth members need to know to keep their coverage," WBUR (Mar. 16, 2023), available at https://www.wbur.org/news/2023/03/16/masshealth-medicaid-changes-mbta-zoning-law-march-madness-isobel-cup-newsletter.

requirements.[28] For example, a variety of Montana stakeholders, including health care providers and the state's Medicaid agency, have noted the benefits of this feature, which include: (1) stabilizing coverage, especially for seasonal workers; (2) improving continuity of care, particularly for preventive care services; and (3) saving on Medicaid administrative costs.[29]

Notably, the income of individuals served by Medicaid coverage is uniquely variable. Many tend to receive an hourly wage rather than a salary. This makes their income vary by seasonal, market, or other workplace changes. Further, hourly wage workers are more likely to experience periodic layoffs. Indeed, throughout the course of the pandemic, an individual's income may have fluctuated several times, with many individuals enrolled in Medicaid being employed in industries particularly at risk for income or job loss, such as food and other service industries.[30] Given the frequency of movement in their jobs, it is not uncommon for Medicaid enrollees to experience income fluctuations that may raise their incomes above the Medicaid threshold for short periods of time. In fact, a study by the U.S. Financial Diaries found that households with low incomes experienced substantial income swings month to month: on average, they experienced 2.5 months when income fell more than 25 percent below the average, and 2.6 months when income was more than 25 percent above average.[31] Along with families with low incomes, Planned Parenthood underscores that income volatility is more prevalent among Black, Hispanic, and Indigenous individuals and families.[32] Requiring individuals to report each time their income changes is not only administratively burdensome, but causes people, including disproportionately people of color, to lose their Medicaid coverage and disrupts their continuity of care.

In addition, continuous eligibility is a necessary tool in tackling existing health disparities among women, in particular Black women. As Planned Parenthood noted earlier, women, including women of color, are disproportionately enrolled in Medicaid. Additionally, women of color, in particular Black women, experience worse health outcomes on several measures: shorter life expectancies, chronic conditions such as anemia and cardiovascular disease, and obesity, among others.[33] Continuous

[28] Jennifer Wagner and Judith Solomon, "Continuous Eligibility Keeps People Insured and Reduces Costs," Center on Budget and Policy Priorities (May 4, 2021), available at https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-costs.
[29] Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report, Social & Scientific Systems: Prepared for CMS (Jul. 22, 2019), available at https://www.medicaid.gov/medicaid/downloads/mt-fed-eval-draft-interim-eval-rpt.pdf.
[30] Rachel Garfield, et al., "Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements," Kaiser Family Foundation (Feb. 11, 2021), available at https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/.
[31] Anthony Hannagan and Jonathan Morduch, "Income Gains and Month-to Month Income Volatility: Household evidence from the US Financial Diaries," US Financial Diaries (Mar. 16, 2015), available at https://www.usfinancialdiaries.org/paper-1/.
[32] Tricia Brooks and Allexa Gardner, "Continuous Coverage in Medicaid and CHIP," Georgetown University Health Policy Institute: Center for Children and Families (Jul. 2021), available at https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf.
[33] Juanita J. Chinn, et al, "Health Equity Among Black Women in the United States," Journal of Women's Health (Feb. 2, 2021), available at https://www.liebertpub.com/doi/10.1089/jwh.2020.8868.

eligibility ensures that these women are able to have continuous access to their health care coverage and critical health services that can positively impact their health outcomes.

III. Planned Parenthood recommends EOHHS proceeds forward with the draft proposals that address critical populations' access to care and health-related social needs (HRSN).

EOHHS has included several requests and changes in the draft application to advance health equity. In addition to the proposals discussed at length in this letter, Planned Parenthood notes its support for the following proposals that increase access to care and address HRSN for critical populations:

- Pending the Massachusetts Legislature's proposed statutory changes, expanding ConnectorCare[34] premiums and cost sharing assistance to individuals up to 500% of the FPL;
- Providing 24-months continuous eligibility to MassHealth enrollees experiencing homelessness who are 65 and older;
- Providing pre-release MassHealth services to individuals detailed in the application that are excluded from the federal Medicaid Inmate Exclusion Policy; and
- Providing Short-Term Post Hospitalization Housing (STPHH, also called Medical Respite) to MassHealth enrollees currently experiencing homelessness that 1) are discharged from a hospital after an inpatient stay or from an emergency department visit, and 2) have primary acute medical issues that have not resolved but do not require hospital level of care.

Taken together with the other program features discussed in detail in this letter, these features provide a strong foundation to meaningfully make progress on health equity for people in Massachusetts. Planned Parenthood recommends EOHHS proceed forward with these requests.

Conclusion

Planned Parenthood is pleased to submit these comments in full support of Massachusetts EOHHS's draft waiver amendment request and applauds the state for pursuing the requests discussed in this letter. The draft proposals will help MassHealth enrollees to better access timely and necessary care that will positively affect their health outcomes. All of these initiatives will help address existing racial disparities, in particular for Black and brown people and women of color.

Planned Parenthood thanks EOHHS for consideration of our previous MassHealth comments, which included requests for the state to reinstate retroactive coverage and provide 12-months continuous eligibility for all MassHealth enrollees. We appreciate EOHHS reviewing those recommendations and

[34] ConnectorCare (originally established in 2006 as Commonwealth Care) is a program for uninsured individuals who are not eligible for employer sponsored insurance, Medicare or Medicaid. ConnectorCare members enroll in certain Qualified Health Plans administered by the Health Connector, the Commonwealth's health insurance marketplace, and receive state subsidized assistance with plan premiums and cost sharing, in addition to receiving federal tax credits towards the purchase of the insurance. Through the 1115 demonstration, the state has expenditure authority for these marketplace state subsidies for premiums and cost sharing and for gap coverage for individuals up to 300% FPL who are determined eligible for Qualified Health Plan coverage through the Connector, for up to 100 days while they select, pay and enroll into a health plan.

incorporating them in this draft proposal.

Planned Parenthood urges EOHSS to proceed forward with all the proposals discussed in this letter, and recommends EOHHS consider a sooner effective date for eliminating the waiver of retroactive coverage to minimize gaps in coverage many individuals are experiencing as a result of the unwinding process.

If you have any questions about the issues raised in this letter, please contact Sheila Ramirez, Director of Health Policy and Government Relations, at sramirez@pplm.org or (978) 332-4829.

Sincerely,

Nate Horwitz-Willis, MPA, MPH, DrPH
Executive Director
Planned Parenthood Advocacy Fund of Massachusetts

MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

September 11, 2023

Michael Levine, Assistant Secretary
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: MassHealth's Requested 1115 Demonstration Amendment

Dear Assistant Secretary Levine:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 15 member health plans and 2 behavioral health organizations that provide coverage to nearly 3 million Massachusetts residents, I am writing to offer our support for the state's proposed 1115 Demonstration Waiver Amendment (Amendment), released on August 2, 2023.

MAHP member plans that participate in the MassHealth program, including the five Medicaid Managed Care Organizations (MCOs) partnered with Accountable Care Organizations (ACOs), three One Care plans and six Senior Care Options (SCO) plans are deeply committed to the MassHealth program and to the communities that they serve. The MCOs have been long-standing partners with the state, providing high quality, innovative, and affordable coverage for MassHealth, working closely with their provider partners and community partners to implement the ACO, SCO, and One Care programs. MAHP and our member plans remain committed to this close partnership, as we work together to protect coverage for Medicaid eligible members and those transitioning to other forms of state subsidized or employer sponsored coverage following the federal government's decision to end the continuous coverage requirements and to resume the standard annual eligibility renewal process. This will require our shared collaboration and prioritization to ensure our state's residents retain coverage.

The reforms included in the proposed Amendment are important to ensuring that the gains that the state made in universal coverage through health reform are preserved. MAHP is supportive of the Administration's request, and we discuss some of the provisions in greater detail below.

Providing 12-Months of Continuous Eligibility

MAHP and our member health plans support the proposed Amendment's expansion of the 12-month continuous eligibility policy to all adults aged 19 and over and 24 months for members who are under age 65 and experiencing homelessness. MassHealth already has continuous eligibility for children under age 19 scheduled to take effect on January 2024. We support this proposed expansion as it would protect coverage for vulnerable populations. The proposal is also consistent with the principles of the MassHealth ACO program, as it would provide continuity of care and protect the enrollee's relationship with their MCO or ACO. MCOs and their ACO partners provide their enrollees with access to care coordination services, care management programs, and community partners. The existing 1115 Waiver and ACO program prioritizes primary care through

implementing a primary care subcapitation program, incentivizing transformation of primary care. Continuous enrollment provides predictability for primary care patient panels, funding calculations, and helps retain the enrollee's relationship with their primary care practice.

Expand Marketplace (Health Connector) Subsidies to Additional Individuals
The proposed Amendment is requesting an expansion of the state's existing 1115 Demonstration expenditure authority for marketplace subsidies for ConnectorCare premiums to expand eligibility to individuals up to 500% of the Federal Poverty Level (FPL). The state's FY 24 state budget included a 2-year pilot program to expand eligibility to individuals up to 500 % FPL from 300% FPL. This expansion pilot program will provide a coverage bridge to help retain coverage while the state implements Medicaid eligibility redeterminations. MAHP and our member health plans are working closely with the Health Connector to implement the expansion.

Increase Expenditure Authority for Health-Related Social Needs Integration Fund
The proposed Amendment would increase the expenditure authority for Health-Related Social Needs. The current 1115 Waiver includes the Social Service Organization (SSO) Integration Fund, which is an $8M program that allows SSOs to receive funding to support infrastructure needs associated with the implementation of the Flexible Service Programs. The proposed Amendment would allow MassHealth to allocate additional funding up to $25M for infrastructure investment. The posted amendment aims to advance health equity by expanding coverage and further addressing members' health-related social needs.

The Delivery System Reform Incentive Program (DSRIP) enabled the MCOs and ACOs to address the needs of members and their families by providing connections to housing, food, and other social and economic supports to help members better focus on their health. For these reasons, we support the proposed Amendment.

Preserve CommonHealth Members' Ability to Enroll in One Care Plans
With the One Care program transitioning from a Medicare Medicaid Plan (MMP) platform to a Dual Eligible Special Needs Plan (D-SNP) platform, as required by the Centers for Medicare & Medicaid Services (CMS) effective January 1, 2026, the proposed Amendment will ensure that CommonHealth members are able to continue to be enrolled in One Care as their Medicaid managed care plan. This preserves access to the One Care program for CommonHealth members, ensuring continued choice for the disabled population.

We thank you for the opportunity to provide these comments and we look forward to working collaboratively with you and your staff on these important issues.

Sincerely,

Sarah Chiaramida, Esq.
Senior Vice President and General
Massachusetts Association of Health Plans

Massachusetts Sheriffs' Association

44 School Street, Suite 300
Boston, Massachusetts 02111

September 8th, 2023

Mike Levine
Assistant Secretary for MassHealth
Medicaid Director
1115-Comments@mass.gov
(Sent VIA EMAIL ONLY)
Re: MassHealth Section 1115 Demonstration Amendment Request

Dear Assistant Secretary Levine,

On behalf of the Massachusetts Sheriffs' Association (MSA) and the fourteen duly elected Sheriffs of the Commonwealth, we write in unequivocal and overwhelming support of the Executive Office of Health and Human Services (EOHHS) *1115 Demonstration Amendment Request: Seeking Authority to Provide MassHealth to Individuals Experiencing Incarceration.*

In partnership with the Executive Office of Health and Human Services, Executive Office of Public Safety and Security, the MSA and other strategic partners in the state, have come together to propose an innovative and sustainable proposal: to expand Medicaid eligibility to all individuals in the Commonwealth experiencing incarceration.

We would like to propose one addition to the current 1115 Demonstration Amendment which was was included in California's1115 MIEP Demonstration. The language, approved by CMS for California, included the following:

> By allowing early interventions to occur in the full 90-day period immediately prior to expected release, such as for certain behavioral health conditions and including stabilizing medications like long-acting injectable anti-psychotics and medications for addiction treatment for SUDs, California expects that it will be able to reduce decompensation, suicide-related death, overdose, and overdose-related deaths in the near-term post-release.

In our shared priority surrounding the expanded provision of behavioral health care, the inclusion of the language proposed and adopted by CMS for California aligns with the Commonwealth's shared priority and would be a powerful addition to the MassHealth Section 1115 Demonstration Amendment Request.

Prior to the COVID-19 Pandemic, approximately 11 million individuals were admitted yearly into our nation's jails with a daily population hovering around 740,000. The U.S. Department of Justice found that the local jail population has a higher prevalence of chronic health conditions than the general population. In fact, our nation's jails have become the largest de facto behavioral health treatment facilities for those impacted by substance use and mental health disorders. It is estimated that over 75% of our incarcerated individuals here in the Commonwealth have a substance use,

mental health and/or cooccuring disorder. We are experiencing a crisis that together we must address to prevent gaps in health care and to improve health outcomes for those returning to our communities.

Responding to and addressing crisis is what our Sheriffs excel at. There are barriers that must be remedied to address the inequities and disparities of the current provision of the Social Security Act which prohibits incarcerated individuals, regardless of their status, from receiving the federal health care benefits, otherwise known as the Medicaid Inmate Exclusion Policy (MIEP), they are entitled to (with the exception of hospital stays over 24 hours). But for the fact they are incarcerated, these women, men and youthful offenders would be eligible for federal assistance. The inequities place an undue strain on our law enforcement, public safety, public health, our communities at large and most importantly, the individuals themselves. The Sheriffs have been advocating for years for the need to eliminate the MIEP. Expanding the health coverage for eligible incarcerated individuals can and will change lives.

This is a heavy lift and we have been and will continue to prepare . For the past three and ½ years, we have been meeting and working in collaboration on the MIEP 1115 Demonstration and now the Amended Request. Together, we can be the state to lead and guide others as we navigate this extraordinary proposition to improve health outcomes and address health disparities of the current MIEP.

Thank you for your commitment to improving health disparities and inequities for all incarcerated individuals in the Commonwealth. We stand united and in full support of the MassHealth Section 1115 Amended Demonstration Request.

Please do not hesitate to contact me if you have any questions.

Respectfully,

Carrie Hill, Executive Director

Cc: Secretary Kate Walsh
Secretary Terrence Reidy
Undersecretary Andrew Peck
Commissioner Carol Mici
Sheriff Nicholas Cocchi, President
Sheriff Patrick McDermott, Vice President
Scott Taberner

Mass General Brigham

399 Revolution Drive
Somerville, MA 02145
617-278-1085

Michael Levine
Assistant Secretary for Medicaid
1 Ashburton Place, 11th floor
Boston, MA 02108
September 1, 2023

Dear Mr. Levine,

Mass General Brigham, Inc. is the largest health care system in the Commonwealth of Massachusetts and has enjoyed a long-standing, positive relationship with the Massachusetts Medicaid program, MassHealth. We share a commitment to expand equity, access, and high quality care to all. It is in this spirit that we write this letter of support for MassHealth's August 2, 2023 intent to submit an amendment (Amendment 1) to the FY23-27 1115 Waiver.

The Commonwealth has led the way on expanded coverage, empowering patients and allowing providers to care for patients in the right place for the right reason. Amendment 1 continues this important path by expanding coverage in the following critical manners, which Mass General Brigham strongly supports:

- **12-month continuous eligibility for adults.** The COVID 19 pandemic demonstrated the importance of providing stable coverage for individuals that are categorically eligible for Medicaid. Mass General Brigham strongly supports this proposal for adults to have 12 months continued eligibility, along with children, starting in 2024.

- **Three-month retroactive eligibility.** This provision will allow greater billing and scheduling stability, easing administrative burden.

- **Expanded income thresholds for marketplace plans.** Expanded eligibility for subsidized health plans through the Massachusetts healthcare exchange, The Connector, will alleviate the increased burden of health care costs on individuals and families. In addition, this provision would increase opportunities for coverage and sustained relationships with patients and their providers that could otherwise be disrupted due to churn or coverage loss.

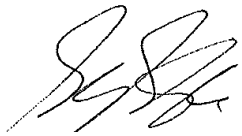
- **Short-term post-hospitalization housing (STPHH).** Mass General Brigham strongly supports the proposal to stand up and support stable housing for individuals experiencing homelessness. This initiative will alleviate the burden on hospitals to maintain individuals within the hospital due to their unhoused status, despite their no longer requiring acute-level care. The proposed STPHH setting is a more appropriate environment for patients. It will also allow hospitals to make better use of its limited space to provide acute care for those that require it.

Mass General Brigham greatly values its partnership with the MassHealth program and the innovation that the 1115 waiver initiatives have provided to its patients and community partners. We stand in support of

this proposed amendment. If you have any questions, please contact Kelly Driscoll, Director of Government Payer Policy, kdriscoll12@mgb.org.

Sincerely,

Niyum Gandhi
Chief Financial Officer and Treasurer



Gregg Meyer, MD, MSc
President, Community Division
Executive Vice President, Value Based Care

MASSACHUSETTS Health & Hospital ASSOCIATION

September 8, 2023

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

Dear Mr. Levine:

On behalf of our member hospitals and health systems, the Massachusetts Health & Hospital Association (MHA) enthusiastically endorses the 1115 MassHealth waiver amendment proposals put forward by the Executive Office of Health and Human Services (EOHHS) on August 2, 2023. The proposals further cement Massachusetts as the leader in health equity and coverage. We commend EOHHS for advancing these new MassHealth and subsidized insurance benefits that will eliminate coverage gaps while also increasing access to affordable health insurance for more Massachusetts residents.

MHA strongly supports all the provisions EOHHS proposed. Of note, we particularly appreciate the following provisions:

- **12 Months Continuous Eligibility for Adults and 24 Months' Continuous Eligibility for Members Experiencing Homelessness Who Are 65 and Over**
  EOHHS proposes to seek approval for 12 months of continuous MassHealth eligibility for all adults, which is in alignment with a recent federal law that will provide this same continuous coverage timeline for children effective January 1, 2024. Continuous coverage for 12 months provides needed stability for low-income residents whose income and other eligibility circumstances may fluctuate and cause them to be ineligible. With this proposal, MassHealth will achieve alignment for all enrollees so that that they are covered for at least one year even if their eligibility circumstances change during the year, allowing individuals and families to receive consistent care as needed.

- **Three Months Retroactive Eligibility**
  MHA is grateful that EOHHS will pursue a long-standing request of MHA by no longer limiting retroactive coverage for any low-income residents that apply and become eligible for MassHealth. Adequate retroactive coverage is necessary to cover low-income uninsured patients who receive medically necessary services but only apply for Medicaid coverage thereafter. We appreciate that the most recent 1115 waiver extension implemented last year ensured that children and pregnant women with the three-month federal Medicaid standard for this lookback coverage. This provision

will ensure MassHealth coverage protects all low-income Medicaid applicants eligible for initial medical services preceding their application submission, thereby reducing medical debt and supporting safety net providers.

- **Expanded Marketplace (Health Connector) Subsidies to Additional Individuals**
  The proposed waiver amendment seeks additional federal support for expanded subsidized coverage offered through the Health Connector for those with incomes up to 500% of the federal poverty level. Currently, individuals up to 300% received enhanced state and waiver-funded subsidized insurance. This support will help to reduce premium and out-of-pocket expenses for many middle-income individuals and families purchasing health insurance through the Health Connector. The expansion is estimated to increase Connector Care subsidized coverage by 47,000 to 70,000[1]**.** This waiver provision is in alignment with the FY2024 state budget that provides state support for this expanded category through a two-year pilot program, which could be further supported through the waiver, thereby ensuring greater financial stability for this expanded coverage.

- **Short-Term Post Hospitalization Housing (STPHH) and Support Services**
  To help address hospital throughput challenges and to ensure adequate support for those recovering from hospital care, MassHealth is proposing coverage for up to six months of Short-Term Post-Hospital Housing (medical respite) as a Health-Related Social Needs service. As it has been well documented, delays in patient discharges to post-acute care settings have become a growing challenge for hospitals and post-acute care providers[2]. MHA's most recent survey of its member hospitals shows 722 patients across the state awaiting discharge from an inpatient bed to either an inpatient rehabilitation facility, long-term acute care hospital, skilled nursing facility (SNF), or home care service. And in our May Throughput survey, there were 18 housing unstable patients waiting discharge to shelter (nine of whom had been waiting discharge for more than seven days, and 11 of whom had behavioral health and/or substance use disorder diagnoses).[3] As fall approaches, the numbers are expected to rise for a variety of reasons, including the resurgence of flu and an uptick in COVID-19. Addressing transition delays and optimizing the flow of patients throughout their healthcare journey is a priority for MHA, its members, the post-acute care community, and state government. The short-term post hospitalization housing and support coverage will help to alleviate this pressure on our healthcare system. It will also provide numerous MassHealth members, including those experiencing homelessness, with the appropriate community support they need to transition to better health.

[1] https://www.statehousenews.com/email/a/2023540?key=f4e0ff
[2] July_2023_Throughput_Survey_Report.pdf (informz.net)
[3] https://mhalink.informz.net/mhalink/data/images/May2023ThroughputSurveyReport.pdf

- **Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard to the State Statutory Limit**
  The proposed amendment seeks to further expand eligibility rules for the Medicare Savings/Buy-in program, which provides state and federal assistance for low-income Medicare beneficiaries. MHA strongly supports this. In the past, some related prior expansions assumed funding transfers from the Health Safety Net Trust Fund to the MassHealth program. MHA believes the Health Safety Net Fund should not be further depleted given the current estimated funding shortfall of $124 million and its negative implications for hospitals, many of which are experiencing significant financial challenges.

- **Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions**
  EOHHS is proposing to provide certain MassHealth-covered services to otherwise eligible individuals for up to 90 days prior to release, including youth in Department of Youth Services (DYS) facilities, who are also involved in the criminal justice system. Covered services would include physical and behavioral health clinical consultation services, medications and medication administration, as well as pre-release case management, post-release treatment plan, and discharge planning. MHA strongly supports these coverage expansions that will enable low-income and Medicaid eligible individuals to transition their healthcare services more seamlessly from correctional facilities to the community. With the same coverage and healthcare providers, medical and behavioral care needs will be better identified, managed, and coordinated during the transition. This would not only improve the Medicaid beneficiary's experience and health outcomes, but we believe it will also yield healthcare cost savings to state and federal governments and provide other societal benefits.

MHA appreciates the opportunity to offer these comments as EOHHS looks to soon put forward the state's 1115 Medicaid waiver amendment request. We believe these proposals will bolster MassHealth coverage and subsidized health insurance programs, as well as the delivery system reforms and health equity goals currently being pursued under the 1115 waiver. MHA appreciates the strong collaboration with EOHHS in continuing to build upon the tremendous progress to improve the health experience of MassHealth members and support for healthcare providers who care for them. If you have any questions regarding these comments, please do not hesitate to contact me at dmchale@mhalink.org.

Sincerely,

Daniel J. McHale
Vice President, Healthcare Finance & Policy
Massachusetts Health & Hospital Association

1115 Amendment Comments

Submitted by Joyce Tavon, Chief Executive Officer
Massachusetts Housing & Shelter Alliance (MHSA)

September 8, 2023

Introduction

On behalf of the Massachusetts Housing & Shelter Alliance (MHSA), thank you for the opportunity to submit comments on MassHealth's proposed Amendment to the Section 1115 Demonstration.

MassHealth deserves congratulations for its construction of this Amendment. The Amendment clearly highlights Massachusetts' focus on universal healthcare, with progressive proposals that take important steps toward providing health care for all. These proposals demonstrate progressive management of Medicaid toward more efficient and less costly implementation of care, especially for some of the neediest populations in the Commonwealth. Thank you for all the work and research that went into developing this document.

At the same time, for those of us focused on providing housing and services for unaccompanied adults experiencing homelessness, larger state systemic problems continue to prevent the most effective utilization of Medicaid. Ultimately, if we do not break down the siloes that exist within state government and address the key issue of homelessness – housing – there will continue to be inefficient and costly utilization of health care resources. While the Housing First movement began as a reform of service delivery systems, the challenge now is to create sufficient housing for a population often living with physical and behavioral disabilities.

Therefore, our comments are divided into two parts. The first section relates to the specific proposals of the Amendment. The second section will outline the various systemic issues related to the delivery of services and care for those experiencing homelessness and steps we believe are necessary to reduce reliance on costly emergency and acute resources. While we recognize, understanding the CMS process, that these may not necessarily be helpful in the waiver amendment process, they may help to inform MassHealth's own discussion with the Executive Office of Health and Human Services and the Executive Office of Housing and Livable Communities. We are convinced that this is the only way to move beyond the need for massive investment in emergency resources.

I. Amendment-specific Comments

1. **Preserve CommonHealth Members' Ability to Enroll in One Care Plans:** MHSA unreservedly supports.

2. **Expand Marketplace (Health Connector) Subsidies to Additional Individuals:** MHSA unreservedly supports.

3. **Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard to the State Statutory Limit**: MHSA unreservedly supports.

4. **Remove the Waiver of Three Months Retroactive Eligibility:** MHSA unreservedly supports.

5. **Provide 12 Months Continuous Eligibility to Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness who are 65 and Over:** MHSA unreservedly supports this proposal. Extending continuous eligibility to include adults ages 65 and older who are experiencing homelessness is important given the instability of this population. MHSA is hearing from providers about increasing numbers of older adults falling into homelessness for the first time – often purely for economic reasons – as well as the aging of the long-term/chronically homeless population. Sustaining eligibility will be critical in ensuring these individuals have access to needed medical and behavioral health services, including housing search and tenancy sustaining supports.

6. **Include Short-Term Post Hospitalization Housing as an allowable Health-Related Social Needs Service:** This is perhaps the most important proposal in the Amendment as it relates to those experiencing homelessness. This proposal will most likely not only reduce the emergency and acute care utilization for a population experiencing homelessness, but it will also:

    a. Dramatically reduce the health costs of such populations;

    b. Reduce the flow of individuals entering shelter or living in encampments or on the streets; and

    c. Give the time for enhanced navigation that may lead to permanent housing.

    There are some questions that remain for us related to this much-need innovation:

    a. Page 11: Statement #3 related to risk-based and clinical criteria states: “Has a primary acute **medical** (emphasis added) issue that is not yet resolved, but no longer requires or does not require hospital level of care and does not meet skilled nursing facility level of care.” We wish to clarify the meaning of the world “medical.” Does this word include those suffering from behavioral health-related illnesses, as is the MassHealth stated intent in other documents related to “integrated care?” A significant challenge in addressing homelessness is serving those who constantly cycle in and out of private psychiatric hospitals into homelessness. We believe that the extended stay offered here would dramatically improve their chance for housing and eventual stabilization.

    b. Page 11: Statement related to robust housing navigation resources: “In addition to medical services, these programs will have robust housing navigation services available to assist members with the goal of identifying permanent housing options once they have recuperated.”

While MHSA certainly supports "robust housing navigation resources," will the services being offered be culturally appropriate to be successful in housing these individuals? MHSA believes there are behavioral health entities and some health care entities who are very qualified to work with populations experiencing homelessness; however, not all stepdown facilities will have this expertise. MHSA recommends that MassHealth focus on contracting with those entities who have the capacity to expand and have already proven themselves in measurable outcomes as successful in housing this population. The Amendment is unclear as to where such resources will come from. At a minimum, Short-Term Post-Hospitalization Housing (STPHH) providers that provide such "housing navigation" themselves should be able to demonstrate outcome-based competence in this area.

7. **Increase the Expenditure Authority for the Social Service Organization Integration Fund:** MHSA is generally supportive of this proposal, and we particularly support the expansion of the funds to Specialized CSP providers. However, we do have some concerns:

    a. We strongly encourage MassHealth to implement outcome-based metrics to measure the successful expenditure of SSO Integration Fund, with a nexus to actual successful resolution of homelessness.

    b. There is some ambiguity related to the following on page 12: "These exciting changes require HRSN providers, including Specialized CSP providers, to take on additional projects." What is not clear is whether this is an antecedent condition to being an HRSN provider or a justification for the increase in the Expenditure Authority for the SSO Integration Fund. This meaning of this statement is not clear to MHSA and we feel it needs to be better defined.

8. **Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions:** For all the reasons stated in the Waiver Amendment we support this amendment. We would only qualify with the following questions/comments:
    a. On the Reinvestment Plan stated on page 23: "Funds will be reinvested into critical activities and initiatives that strengthen access and quality of health care services for individuals who are incarcerated or were recently released from incarceration, or for health-related social services that help divert people from critical justice involvement."
        1) Given the incredible amounts of money proven to be saved by addressing the needs of people with disabilities experiencing chronic and long-term homelessness, to what extent are funds resulting from federal match being invested in innovations to provide housing and services to this population?
        2) We do not fully understand CMS's total ban on utilizing Medicaid resources for actual housing. Does this apply to reinvestment of match? Such resources would be valuable in supporting innovations including enhanced navigation and sponsor-based housing. If this were allowed, it would be a very effective tool for both reentry and addressing chronic homelessness.

b. MHSA strongly recommends utilizing Correction Officers (COs) outside the walls to build relationships with community-based agencies to develop resources necessary for reentry. This would engage COs in the process of reentry to ensure an integrated mission with the correctional system. MHSA helped inspire a reentry program in the 1990s that employed COs working with resources in the community to ensure successful landings for those coming out after completing their sentences in prison. This program was eliminated during the Romney Administration for a post-sentencing program that never came to fruition. Reentry resources were instituted wholly outside the prison system. We strongly encourage a plan that also utilizes COs in the process of reentry.

II. Systemic Issues Associated with Housing and the Integration of Care

Assisted Living

MHSA has heard concern from our membership about a gap that is impacting vulnerable older adults in the Commonwealth. Currently older adults on the frail elder waiver who qualify for services may only choose between home care or a nursing home setting. For some older adults, the services that can be provided through home care are not sufficient to meet their needs, but moving to a nursing home setting would lead to a level of institutionalization and expense beyond what their daily needs require. We support requests to amend the waiver to include Assisted Living and the services provided therein for the purpose of allowing individuals qualifying for MassHealth to reside in a certified Assisted Living Residence.

Need for a Coordinated State Strategy to Address Homelessness

It is impossible to believe there will ever be wholly effective care, no matter the MassHealth enrollment rate, if people are experiencing homelessness. This should be a grave concern as the number of people experiencing homelessness in encampments and public spaces continues to grow from Pittsfield to Cape Cod. While MassHealth effectively provides new tools and ways of responding to those without insurance, the Commonwealth lacks any unified plan to address the growing problem of homelessness. We need more housing. While the various Housing First initiatives developed by MHSA have been focused on service delivery systems, the lack of housing now has us focused on housing development, especially for the vulnerable, mostly insured population with serious life-limiting disabilities who cannot succeed in mainstream, compliance-based housing.

It is critical that MassHealth, given the progressive nature of its reform, bring the Executive Office of Housing and Livable Communities to the table to develop a plan to address the lack of housing for this population. This plan needs to state the number of people experiencing homelessness to be housed, cross matching MassHealth and HMIS data and including some predictive model to estimate and address the number of those who will fall into chronic homelessness. It is a plan that needs to move beyond the current system where homeless service providers are engaging people experiencing homelessness at the apex of their care. A reformed system needs a housing intervention prior to this point in order to truly reduce the significant costs associated with this population.

MassHealth is to be praised for its progressive programs and its attempt to use Medicaid resources in the fullest possible and most effective way. But MassHealth cannot solve these challenges alone, and if

the housing issue is not addressed, the Commonwealth will only see these vulnerable populations grow. What is necessary is to reform the system for developing housing in Massachusetts. We need an integrated plan to address this problem, and we hope MassHealth will take the lead in developing such a plan.

Thank you for your time and consideration. Please do not hesitate to reach out to me with any questions at jtavon@mhsa.net or 617-367-6447 x27, or to Caitlin Golden, MHSA Director of Public Policy, at cgolden@mhsa.net or 617-367-6447 x28.

Massachusetts League
of Community Health Centers

September 8, 2023

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

[Submitted via email to 1115WaiverComments@mass.gov]

Re: MassHealth Section 1115 Demonstration Waiver Amendment

Dear Assistant Secretary Levine,

On behalf of the Massachusetts League of Community Health Centers (the League), we are pleased to offer these comments regarding the August 2nd, 2023, MassHealth 1115 Waiver Amendment Request.

The League is Massachusetts' Primary Care Association, representing and serving the state's 52 health center organizations. Annually, our health center members provide high-quality health care to more than one million state residents of all ages, representing a wide range of racial and ethnic backgrounds, and serving 96% of the Commonwealth's zip codes.

Since their inception in Massachusetts in 1965, health centers have approached the notion of health care for all from a holistic perspective. We believe that a strong, integrated approach to primary care that addresses the whole person and, in many cases the whole family, is critical to improving health and reducing costs. Over the last decade, including through MassHealth's 1115 Waivers, we have worked to further advance that integrated model which includes medical, behavioral health, dental, vision, pharmacy and substance use disorder (SUD) care; as well as enabling (non-clinical) and other support services, which often focus on social drivers of health. Multiple studies over decades have demonstrated the quality outcomes and cost savings that this model produces, including a multi-state study of Federally-Qualified Health Center (FQHC) Medicaid patients that demonstrated a 24% reduction in total cost of care[1].

Health centers serve as the largest safety net provider network for primary care in the Commonwealth, caring for 1 in 7 Massachusetts residents, with virtually all health centers also providing significant co-located and/or integrated behavioral health services. Because by mission (and law, in the case of FQHCs), health centers serve all who walk through their doors, the patient population at health centers looks very different than that of other providers. We are 15% uninsured, 49% Medicaid, and 10% Medicare, while overall in the Commonwealth only 2% of residents are uninsured and approximately 20% are covered by Medicaid. Given 50% of the average Massachusetts health center's revenue comes from MassHealth, everything related to this vital program is significant to Massachusetts health centers, including the current 1115 Waiver.

[1] Richard, Ku, Dor, et al. *Cost Savings Associated With the Use of Community Health Cen... :* The Journal of Ambulatory Care Management, January/March 2012 - Volume 35 - Issue 1 - p 50-59

Throughout the development of the current 1115 Waiver, we have appreciated MassHealth's enhanced focus on health equity, access to care, and health-related social needs (HRSN), and these proposed flexibilities continue to demonstrate that commitment. **The Mass League is supportive of all proposed flexibilities in the amendment, which align with our priority areas of expanded access, continuity of care, and health equity.** Below we offer additional comments about the amendments:

1. **Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions**
   We are supportive of this proposal, and it builds off work MassHealth and other state agencies have implemented to increase access to care for justice-involved individuals. We look forward to partnering with the state and other community-based organizations/providers on providing critical care and a medical home for individuals during the precarious post-release (re-entry) period, with a particular focus on continuity of care, access to HRSN services, behavioral health, and SUD needs for this population.
2. **Provide 12 Months Continuous Eligibility for Adults and 24 Months' Continuous Eligibility for Members Experiencing Homelessness Who Are 65 and Over**
   We are very supportive of these policy changes, which will help reduce "churn" on and off Medicaid coverage for administrative/paperwork reasons and to promote continuity of care. We and health centers look forward to our continued work with MassHealth to implement these policies.
3. **Implement Three Months Retroactive Eligibility**
   We are very supportive of this proposal, which will have a positive effect on both promoting access to care and reducing medical debt and will especially benefit individuals with limited English proficiency, members experiencing homelessness, and other vulnerable patient populations who may experience additional barriers to applying for and effectuating coverage.
4. **Expand Marketplace (Health Connector) Subsidies to Additional Individuals**
   This proposal to continue the current pilot program by requesting expenditure authority from CMS to expand ConnectorCare eligibility up to 500% FPL (from 300% FPL) is an exciting and important step in helping more Massachusetts residents access more affordable health coverage, which is foundational to be able to engage in care and improve health outcomes.
5. **Include Short-Term Post Hospitalization Housing (STPHH) and Support Services as an Allowable Health Related Social Needs Service**
6. **Increase the Expenditure Authority for the Health-Related Social Needs Integration Fund**
   We know that health centers have valued Flexible Services partnerships and programs, which address health-related nutrition and housing needs of some of their most vulnerable patients. This increased investment in the Social Service Organization Integration Fund will help provide infrastructure investments, sustain, and grow these important partnerships.
7. **Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard to the State Statutory Limit**
8. **Preserve CommonHealth Members' Ability to Enroll in One Care Plans**

We appreciate the opportunity to provide comments on these amendments and, as close working partners, we look forward to continuing to work with MassHealth on these important policies.

Respectfully,

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September 7, 2023

1115 Amendment Comments
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Sent by Email: 1115WaiverComments@mass.gov

To Whom It May Concern:

MLPB is pleased to submit these comments to the proposal Massachusetts intends to submit to CMS amending the MassHealth Section 1115 Demonstration.

MLPB is a pathbreaking organization and is credited as the first medical-legal partnership nation-wide. Originally based in the Pediatrics Department at Boston Medical Center in 1993, MLPB spun off from BMC in 2012 and is now an independent program serving partners throughout Massachusetts and Rhode Island. MLPB currently operates under the fiscal sponsorship of TSNE.

MLPB equips medical and social service communities of care with legal education and problem-solving insights that foster prevention, health equity, and human-centered system change. Through training, consultation and technical assistance – our team-facing legal partnering framework – MLPB helps health care workforce members and organizations better connect patients and populations to the legal resources and protections they seek. MLPB empowers care team members to become strengths-based, role-aligned partners in legal problem solving. MLPB consults on more than 1,000 questions from care teams about health-related social needs of their patients, and delivers more than 70 trainings each year.

At a household level, our capacity-building expertise focuses on addressing immediate health related social needs for patients. MLPB seeks to disrupt the trajectory where social, economic or environmental factors transform into a legal and health crisis. At a population level, our work encourages communities of care to engage in systemic and policy change work.

MLPB has signed onto the comments to be submitted by Health Care for All regarding the proposed changes to the Section 1115 Demonstration. In general, MLPB applauds the proposals that expand care coverage, simplify systems, and reduce costs to the insured. MLPB is submitting this letter to provide additional comments regarding Proposed Amendment #7, which would increase the expenditure authority for the Social Service Organization and Integration Fund.

MLPB's Massachusetts-based partners include three Accountable Care Organizations. As a contractor paid through the Flexible Services Program, MLPB understands well that health care systems are ideal hubs for social care as well as physical care. In general, we believe any effort that increases the ability of Medicaid providers to integrate services to address health related social needs are vital in the effort to achieve health and health equity. We are supportive of the request to expand funding for social care infrastructure needs from $8 million to $25 million. We are mindful that technological solutions require investment in workforce knowledge of SDOH, HRSN, benefits eligibility and resource navigation.

If this proposed funding increase is granted, we hope that MassHealth will consider the below principles in determining how to allocate the increase. Ideally, an expansion of the Social Service Organization Integration Fund would accomplish the following objectives:

- Allow for FSPs and CSPs to saturate their practices more deeply to engage and coordinate more meaningfully with existing social care entities;
- Encourage the creation of new ventures to address health related social needs that don't currently exist;
- Prioritize building the capacity of the health care workforce to be able to understand how systemic structures interfere with health, and what actions they can take to address and remove structural barriers;
- Support training and technical assistance efforts that help health care workforce engage in HRSN issue detection and response;
- Encourage the building of systems that are flexible and responsive to patient need; and
- Account for the ongoing human capital investment that is required to implement any technology-based strategies, like a statewide referral platform, successfully.

Thank you for the opportunity to submit comments to the proposed amendments to the MassHealth Section 1115 Waiver Demonstration.

Sincerely,

Amy Copperman
Executive Director

MLRI MASSACHUSETTS LAW REFORM INSTITUTE

CHLPI CENTER for HEALTH LAW and POLICY INNOVATION HARVARD LAW SCHOOL

September 9, 2023 (as revised with 30 co-signers)

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

Submitted by email to 1115WaiverComments@mass.gov

Re: Comments on MassHealth 1115 Demonstration Amendment Request

Dear Assistant Secretary Levine,

On behalf of the undersigned organizations, thank you for the opportunity to submit comments on MassHealth's Section 1115 Demonstration waiver amendment released for public comment on August 2, 2023. These comments address just one of the eight proposed amendments: No. 8 "Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions." Several of the undersigned organizations have submitted or endorsed comments that also address one or more of the other proposed amendments.

We strongly support MassHealth's amended proposal to provide pre-release services to MassHealth eligible individuals in carceral settings. We appreciate that the agency is committed to extending services as broadly as possible in light of the April guidance from CMS and the waivers CMS has already approved for California and Washington. We make the following comments and recommendations in furtherance of that shared goal.

1. We urge the agency to include a provision for an advisory council composed of a broader group of stakeholders, particularly prioritizing people with lived experience.

There are many important decisions to come in developing, implementing, and monitoring the demonstration. In depth discussions about the current MassHealth initiative have been limited to MassHealth and its interagency Coordinating Council, largely made up of state correctional agencies.

We strongly urge MassHealth to expand the interagency Coordinating Council with which it has been working since 2021 to encompass a broader group of stakeholders, including individuals with personal experience of justice involvement and the community providers that are often directly responsible for their care. While correctional partners play an integral part of providing care during and after incarceration, these other stakeholders have invaluable perspectives that are not currently being considered.

Current Stakeholders Involved in Massachusetts' 1115 Proposal

Since January 2021, MassHealth has convened an interagency Coordinating Council to inform the development of its 1115 proposal on providing pre-release services in Massachusetts's carceral settings.[1] The Coordinating Council includes representatives from the Department of Corrections (DOC), the Massachusetts Sheriffs' Association, the fourteen Massachusetts Sheriffs' Offices (of which thirteen have correctional facilities), Department of Youth Services (DYS), Parole and Probation Units, and the state Executive Office of Public Safety and Security (EOPSS).[2] These members are exclusively from Massachusetts's correctional agencies and do not reflect any representation of individuals currently or formerly incarcerated in the system, nor does it include other advocates and community health partners that would inevitably play a role in designing care transition plans.

Federal Guidance To Include Stakeholders with Lived Experience

In 2021, the Medicaid Reentry Stakeholder Group, established under Section 5032 of the SUPPORT Act, met to identify strategies for improving care transitions for individuals being released from incarceration.[3] In January 2023, the group's recommendations were published in a Report to Congress. Of its recommendations, the significance of stakeholder representation and their continued engagement in the decision-making process was apparent. The report specifically noted the value of bringing in individuals with personal experience of justice involvement as well as the individuals from communities historically overrepresented in carceral facilities. The value of doing so "from the onset of demonstration design and engaging them throughout the process, to ensure that the opportunity is person-centered and well-tailored to the needs of [the justice-involved population]" is stressed repeatedly by the Stakeholder Group.[4]

Influenced by the findings of this Stakeholder Group, CMS concluded that it "strongly encourages states contemplating submitting a demonstration application to engage individuals with lived experience who were formerly incarcerated in both the design and implementation of a state's Section 1115 Reentry Demonstration proposal."[5] By engaging individuals with lived experience within this system, in addition to soliciting input from care providers with specialized experience working with the justice-involved population, CMS highlights the importance of this group's inclusion to identify the specific and unique challenges encountered by an individual in their transition from incarceration to the community. Attempting to make such decisions without the participation of the people who will be most directly impacted by its implementation would negate the federal guidance directed by the Medicaid Reentry Stakeholder Group and CMS.

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[1] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*

[2] Ibid.

[3] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Medicaid Reentry Stakeholder Group, 2023. *Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group*.

[4] Medicaid Reentry Stakeholder Group, 33.

[5] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.

Lessons from California and Washington

California and Washington are currently the only states with 1115 waivers approved for financing pre-release services with Medicaid funds. Both states' waivers specify the inclusion of justice-involved stakeholders and would serve as excellent models for MassHealth in its efforts to expand its stakeholder reach to justice-impacted individuals and the advocates and organizations working with them directly.

California, the first state to receive CMS approval for its 1115 request, has included justice-involved individuals since the initial phases of designing its proposal. To supplement its efforts in expanding Medicaid services to the states' incarcerated population, CalAIM has regularly convened the CalAIM Justice-Involved Advisory Group since October 2021.[6] This advisory group reports to CalAIM on all policy matters related to the state's Justice-Involved Initiative, including its 1115 amendment request. The Advisory Group is made up of a diverse range of stakeholders involved in the California criminal justice system, including the state's correctional partners as well as community health providers, health plans and MCOs, other community-based organizations involved in reentry, and CalAIM members with lived experience in the justice system.[7] Their meetings are scheduled in advance, held regularly, and open to the public.

Similarly, Washington's approved 1115 waiver detailed an advisory process that emphasized diverse stakeholder engagement, including consulting with groups outside of the solely correctional scope. In the state's approved waiver request, Washington stated its commitment to convene key stakeholders in planning the waiver's implementation, including "state agencies responsible for Medicaid managed care, benefits and eligibility, corrections, juvenile justice, and behavioral health; correctional facilities; behavioral health providers; MCOs; counties; tribal health programs; community-based organizations; people with lived experience; and Tribal representatives."[8]

Both California and Washigton's approved 1115 amendments provide for more stakeholder engagement of people with lived experience and their advocates than MassHealth's current interagency Coordinating Council. We strongly encourage MassHealth to use both states as a model for stakeholder participation in the Massachusetts demonstration.

Importance of Including Stakeholders with Lived Experience

As MassHealth acknowledged in their proposal:

> Individuals leaving carceral settings tend to experience difficulties accessing the care they need, largely due to challenges in establishing or reestablishing Medicaid coverage, making appointments before coverage is established, and planning around uncertain

[6] California Department of Health Care Services, 2023. *California Advancing and Innovating Medi-Cal (CalAIM) Justice-Impacted Advisory Group: Update on CalAIM Justice-Impacted Waiver Approval.* https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Adivsory-Group-Feb-2023.pdf.
[7] Ibid.
[8] Washington State Health Care Authority, 2022. *Medicaid Transformation Project (MTP) Waiver Renewal Application*. https://www.hca.wa.gov/assets/program/wa-mtp-renewal-application.pdf, 43.

release dates. They are also more likely to lack health insurance. Other barriers include trouble navigating the health care system, lack of transportation, interruption in medication, and unmet health-related social needs (HRSN) such as food insecurity or homelessness.[9]

The people described above, who stand to benefit the most from this demonstration— and to suffer the resulting harm if policy or administrative decisions do not meet their needs— are being left out of the conversation. The inclusion of MassHealth members with lived experience must be a priority for this 1115 demonstration if MassHealth seeks to provide equitable access to care.

Since the health and health-related social needs faced by incarcerated populations are unique and often traumatic, it is essential that the perspectives of individuals with lived experience are taken into consideration at all steps of decision-making in the 1115 waiver process. In this way, their participation should not only be valued but considered as a requirement for working with this population. In addition, the stakeholder group should include the community-based organizations that will be providing services to returning citizens after their release.

One example of an area where community engagement will be useful is in determining what additional services are needed to serve young people in carceral settings. The facilities under the Department of Youth Services (DYS) differ from the adult carceral setting in many key ways, including its modalities of health care and treatment for detained juveniles. It will be important to maintain and support the protections that have already been put in place for detained juveniles within DYS systems and extend those protections to juveniles in other carceral settings. Feedback will be particularly helpful for determining what gaps currently exist that can be addressed through enhanced pre-release or transitional services.

To date, meaningful stakeholder engagement has not included community-based providers, managed care plans, or people with lived experience despite the fact that a key purpose of these waivers is to improve access to care and services in the community and smooth the transition from the carceral setting to the community. The goals of the 1115 waiver for pre-release coverage generally and MassHealth specifically cannot be achieved without the agency engaging a broader group of stakeholders from the community to advise on the development of the proposal, including people with lived experience. It is crucial to engage a broader group early and in all remaining stages of the process: now, before submission, during negotiations with CMS, in the 120 days after approval when MassHealth will be finalizing the implementation plan and reinvestment plan, and on an ongoing basis as the program is being implemented over time. We urge the agency to make this commitment and include it in its proposal to CMS.

2. **We urge the agency to include more incentives to involve managed care plans, community-based health care providers, and other community-based organizations in providing case management, health care and reentry services prior to release.**

[9] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*

The success of MassHealth's proposal, which seeks to improve care transitions and health outcomes after reentry, requires the participation of community-based providers as early in the pre-release process as possible. We urge MassHealth to do more to involve the individuals and organizations who will be providing services in the community in providing services during the pre-release period as well. Of course, the mix will vary among facilities—for example, DYS facilities already contract with community-based providers such as Boston Children's Hospitals. However, the current proposal leaves the mix of facility-based service providers and community-based providers entirely to the discretion of the facility. We urge MassHealth to build in incentives to affirmatively encourage the involvement of community-based providers in providing health care and case management services to patients prior to release.

Many of the same community-based stakeholders who should be involved in developing the demonstration should also be involved in the delivery of pre-release services under the demonstration. This includes the MassHealth managed care plans. For most MassHealth members who are returning citizens, their health care services in the community will be delivered by managed care plans. Yet the proposal indicates that pre-release services will be provided exclusively on a fee-for-service basis. This raises a variety of administrative concerns, including that providers who participate in MassHealth managed care plans but not fee-for-service *will not* be able to provide services prior to a patient's release. Further, there are already successful models of how to engage managed care plans in pre-release services, and we urge the agency to consider them as it develops its proposal.

In MLRI's discussions of barriers to arranging services at reentry with community-based organizations, CPCS social workers, and people with lived experience, the two most common problems identified were: (1) problems scheduling appointments on release when providers cannot confirm an individual's eligibility for anything but inpatient-only services, and (2), that on release, when full coverage is activated, "it's the wrong kind of MassHealth." When we inquired further in one-on-one interviews,[10] we learned what makes it the "wrong kind of MassHealth" is that it is fee-for-service. In Massachusetts, the fee-for-service system has not kept pace with managed care, particularly in terms of participating behavioral health providers. Thanks to the Behavioral Health Roadmap, MassHealth recently expanded the types of licensed behavioral health providers it will allow to participate in the fee-for-service system. However, the managed care plans still offer greater access to participating providers other than hospitals and community health centers than the MassHealth fee-for-service system.

The Report to Congress describes successful models other states have developed for Medicaid managed care organizations to be involved in pre-release discharge planning, even without an MIE waiver and federal reimbursement. This includes New Mexico, where care coordinators provide education about Medicaid benefits and help develop a care plan for returning community members, and Ohio, where all Medicaid MCOs are required to deliver pre-release care coordination services including social worker and nurse-led care management as well as Peer-to-Peer Medicaid Guides.[11]

[10] Massachusetts Law Reform Institute interviews with MassHealth members who self-identify as justice-involved or a returning citizen, 2022.

[11] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Medicaid Reentry Stakeholder Group, 2023. *Health Care Transitions for Individuals Returning to the Community*

More importantly, CMS expectations for the Reentry Section 1115 Demonstration Opportunity highlight the importance of involving the community organizations that will be providing services after release *during the pre-release period*. The goals CMS identifies for the demonstration notably include to:

- Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry,
- Improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers,
- Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs (HRSN); and
- Develop a plan for organizational level engagement, coordination, and communica,ion between the corrections systems, community supervision entities, health care providers and provider organizations, state Medicaid agencies, and supported employment and supported housing agencies or organizations.[12]

The Report to Congress also emphasizes the importance of community-based in-reach services. "In-reach occurs when community-based professionals--such as case managers, social workers, or other supportive personnel--come into correctional facilities and provide in-person assistance such as care coordination, discharge planning, and/or cross-sector coordination. Cross-sector coordination integrates support across multiple sectors including health, housing, and employment. In this collaborative effort, in-reach staff inform community-based staff of the needs of soon-to-be-released individuals. In-reach care coordinators undergo necessary training to be awarded the security clearance to work in jails and prisons. In some states, including New York and Rhode Island, peer navigators with histories of justice system involvement participate in the in-reach process and assist with pre-release discharge planning. Compared to remote care coordination and cross-sector coordination, in-reach is associated with greater engagement in care following release."[13]

Greater involvement of community-based providers is also evident, not only in the planning of California's 1115 waiver demonstration but in its implementation. For example, California's definition of "case management" in its 1115 waiver includes:[14]

- "Providing warm linkages with designated managed care plan care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) which includes sharing discharge/reentry care plans with managed care plans upon reentry"

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from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, p. 18. Also, see the discussion of data sharing at pages 20-21 and the MIE waiver proposals of some states to initially provide services on a fee for service basis and transition to managed care 30 days prior to release at page 30.

[12] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*, p. 11, 33.

[13] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Medicaid Reentry Stakeholder Group, 2023. *Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group*, 17.

[14] California Department of Health Care Services, 2023. *Reentry Demonstration Initiative Amendment Approval*. https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf, 48-50.

- "Ensuring that, as allowed under federal and state laws and through consent with the member, data are shared with managed care plans, and, as relevant to physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs"
- "Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups."

Also specifically included in its definition of "pre-release services" are services provided by community health workers with lived experience.[15]

We urge MassHealth, in consultation with the relevant stakeholders, to build in a greater role for community-based health care providers, managed care plans, and other community-based organizations pre-release, which will facilitate successful reentry into the community.

3. We urge MassHealth to more explicitly leverage the pre-release coverage proposal to combat Hepatitis C among the justice-involved population.

We strongly support MassHealth's commitment to remedying health disparities for people who are incarcerated, and we encourage MassHealth to make a clear, explicit commitment to screening for and treating the hepatitis C virus (HCV) in furtherance of this goal. Hepatitis C is disproportionately concentrated among people who experience incarceration. Experts believe that at least 2.4 million people in the United States are living with hepatitis C,[16] and up to 30% of these individuals spend time in a carceral facility in any given year.[17] The main mode of transmission of HCV is the use of contaminated needles for injection drug use, and high incidences of housing instability along with stigma against people who use drugs further complicate the facilitation of access to HCV treatment. Periods of incarceration present a crucial opportunity to address these issues and reduce rates of HCV transmission. Thus, we urge MassHealth to prioritize HCV treatment in the design and implementation of the new pre-release coverage program.

CMS has also made clear that waivers for pre-release Medicaid coverage should be used to promote access to treatment of HCV. The CMS guidance specifically states, "we recognize that there may be other important physical and behavioral health services that states request to cover on a pre-release basis, such as… treatment for Hepatitis C." Moreover, in considering activities related to coordinated care, the CMS guidance again points to HCV as a condition for which

[15] Ibid, 11.

[16] *See* State of Medicaid Access, Center for Health Law and Policy Innovation, Harvard Law School & National Viral Hepatitis Roundtable (June 2023), https://stateofhepc.org/; *See also* Brian R. Edlin, et al., *Toward a more accurate estimate of the prevalence of hepatitis C in the United States*, 62 HEPATOLOGY 1353 (2015), https://pubmed.ncbi.nlm.nih.gov/26171595/ (indicating that estimates of Hepatitis C prevalence are likely even higher than reports suggest).

[17] Tessa Bialek & Matthew J. Akiyama, 2023. *Policies for Expanding Hepatitis C Testing and Treatment in United States Prisons and Jails*. https://www.globalhep.org/sites/default/files/content/resource/files/2023-04/Clearinghouse WhitePaper2_Hepatitis_C_Testing_and_Treatment_in_US_Jails_and_Prisons.pdf.

states will want to ensure the "ability to bi-directionally share data with public health entities and community providers."[18]

We applaud the work that MassHealth has done thus far to enable facilities to use the pre-release coverage waiver to combat HCV and write here to highlight further opportunities that MassHealth should incorporate. Foremost, MassHealth should identify HCV treatment as a priority for pre-release services, make clear that testing and treatment will be covered benefits under the demonstration, and encourage facilities to regularly offer opt-out screening for HCV.[19] Doing so will encourage stakeholders to develop and implement best practices that reduce the incidence and spread of HCV. Additionally, we support MassHealth's decision to request the authority to provide 90 days of medication post-release as clinically appropriate. Since HCV regimens can be completed in as little as 56 days,[20] specifically including HCV treatment among those for which up to 90 days of medication can be provided would enable people leaving incarceration with a recent HCV diagnosis to be discharged with a full course of medications. Inclusion of HCV treatment in both pre- and post-release services that may be covered under the proposed waiver would drastically increase the ability of incarcerated people to receive and adhere to HCV treatment, especially those that are in facilities for only short stays.

We also recommend that MassHealth utilize this demonstration to support and encourage better data sharing for purposes of inter-agency coordination and more effective collaboration with community-based providers and organizations. As noted above, CMS has recognized and emphasized to states that data sharing is important for effective HCV care, especially given the significant role that the Department of Public Health plays in controlling and responding to infectious disease. MassHealth should ensure that carceral facilities are prepared to gather and monitor the appropriate data, and that the necessary infrastructure exists to support readily sharing health information with relevant providers.

Lastly, we encourage MassHealth to provide resources to all demonstration stakeholders that will directly participate in the care of patients. Stigma and bias play a significant role in the ability of people with HCV who are incarcerated to access and adhere to treatment.[21] All stakeholders should be provided support to understand how to provide non-stigmatizing and culturally responsive services. Moreover, providers and other relevant stakeholders should receive ongoing

[18] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.
[19] The Infectious Diseases Society of America and the American Association for the Study of Liver Diseases promote universal screening as a crucial piece of HCV treatment strategies. *See* Debika Bhattacharya, et. al., *Hepatitis C Guidance 2023 Update*, https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciad319/7179952.
[20] Ibid.
[21] *See e.g.*, Alysse G. Wurcel, et al., *"I'm not gonna be able to do anything about it, then what's the point?": A broad group of stakeholders identify barriers and facilitators to HCV testing in a Massachusetts jail*, https://pubmed.ncbi.nlm.nih.gov/34038430/.

support to understand whether and to what extent HCV treatment is covered under the demonstration, including any future policy changes.

4. We urge MassHealth to include in the reinvestment plan services that prevent incarceration and to adopt program accountability and oversight measures.

We appreciate MassHealth's thoughtful framing of the future reinvestment plan into four core pillars. However, we encourage MassHealth to expand beyond these four core pillars and include the opportunity for reinvestment in services that are likely to prevent incarceration altogether. While the four listed categories are broad and potentially inclusive of such services, stakeholders should be made aware of the opportunity to use reinvestment funds for new or innovative approaches to reducing incarceration. In the proposed amendment, MassHealth itself states, "funds will be reinvested into critical activities and initiatives... for health-related social services that help divert people from criminal justice involvement."[22] The creation of a fifth pillar would simply solidify this priority as in-line with the others and make clear the opportunity for investment in pre-incarceration services.

Utilizing reinvestment funds to reduce incarceration rates and related health inequities closely aligns with the goals of the Massachusetts demonstration. The U.S. Department of Health and Human Services, as part of their Healthy People 2030 campaign, identified incarceration as a social determinant of health, articulating that incarceration itself has negative impacts on the wellbeing of people who are incarcerated as well as their families and communities.[23] As MassHealth states in the amendment, incarceration also disproportionately affects some racial and ethnic groups. In particular, Black and Latino people are incarcerated at significantly higher rates than white counterparts as well as other racial groups and suffer disparities in health outcomes that further compound the detriments of incarceration. This is also true for many other systemically marginalized identities, including, but not limited to, LGBTQ+ individuals and people with disabilities. These disparities suggest that interventions and programming that prevent or reduce the risk of incarceration would further MassHealth's goals of addressing health inequities for justice-involved populations.

The CMS guidance encourages a broader approach to reinvestment than MassHealth has taken, and specifically allows for investment in services for people who "may be at higher risk of criminal justice involvement."[24] For example, CMS suggests that Medicaid programs could invest in "the addition or expansion of mobile crisis services," or other health services that can help people with complex conditions avoid incarceration. It is therefore clear that CMS is willing

[22] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*
[23] U.S. Department of Health and Human Services, 2020. *Incarceration*. Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration/
[24] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.

to approve the use of reinvestment funds for services that not only support reentry but instead disrupt criminalization, which negatively impacts health. We strongly encourage MassHealth to build upon their current framework and include an additional pillar that specifically supports investment in upstream interventions for those at higher risk of incarceration.

We also strongly encourage MassHealth to consider the importance of developing mechanisms for accountability and oversight as these programs are implemented. Pre-release coverage offers a multitude of opportunities to address the health needs of justice-involved populations. However, CMS has made overwhelmingly clear that demonstrations are not to be used to shift financial responsibility for carceral health care to state Medicaid programs.[25] Therefore, MassHealth should be intentional in working with carceral and community stakeholders to ensure that the reinvestment plan prioritizes currently unmet needs of the justice-involved population first and foremost, and that the availability of pre-release coverage does not create an unintended incentive to delay care until an inmate is within the 90-day pre-release timeframe.

5. We encourage MassHealth to add provisions for improving the suspension process and include any necessary funding.

In its April 2023 letter to State Medicaid Directors, CMS makes clear that suspension, rather than termination, and pre-release eligibility and enrollment support will be a requirement for 1115 approval for all individuals incarcerated in facilities in which the demonstration is operating.[26] This was one of the special terms and conditions in California's approved 1115 demonstration and applied to all incarcerated individuals, not just those who had been screened and found eligible for pre-release service under California's approach.[27]

In its proposal, MassHealth notes that it was one of the first states to suspend coverage, rather than terminate it,[28] and says it will continue its practice of suspending enrollment upon incarceration—implying that there will be no improvements in the current suspension process. However, in Massachusetts, suspension still relies on manual processing by a designated MassHealth office, "workarounds," use of faxes (at some facilities), and little or no public-facing information describing the process.[29] We strongly recommend that MassHealth acknowledge the limitations of its current suspension system and allocate the resources to design and implement a better and more transparent system.

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[25] "…the Reentry Section 1115 Demonstration opportunity is not intended to shift current carceral health care costs to the Medicaid program." *Ibid*.
[26] Ibid, 14.
[27] California Department of Health Care Services, 2023. *Reentry Demonstration Initiative Amendment Approval*. https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf.
[28] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*
[29] See, unpublished July 2023 subregulatory guidance entitled, "MassHealth Policy Updates for Justice-Involved MassHealth Members."

Pursuant to state legislation enacted in 2014, MassHealth first implemented a suspension process in 2015.[30] Since 2015, the MassHealth process has suspended all but an inpatient-only benefit during incarceration.[31] However, the implementation of the suspension process is problematic. For one thing, it has never been reflected in state regulations. The eligibility regulations on residence requirements provide that incarcerated individuals will not receive MassHealth unless they are inpatients in a medical facility.[32] The integrated application form for MassHealth and the Health Connector has a question for the Contact Person completing the application asking if anyone on the application is in prison or jail. If the answer is Yes, the HIX system will issue a denial or termination notice for the incarcerated person. The manual process used for applications from carceral facilities employs a "workaround" by the designated MEC to address this limitation of the HIX system, but no such workaround applies to individuals applying through an authorized representative in the community or on their own.

For example, in at least one county, the Sheriff only allowed applications to be submitted by facility staff for sentenced individuals with a release date. When a CPCS social worker attempted to submit a pre-release application for a client who required an appropriate medical placement as a condition of release, the local MEC told her they accepted such applications only from prisons and jails. This is just one example of both the value of hearing from people in the community and of the need to improve the system.

Another issue not addressed in the current suspension system is how the incarceration of one member of a household affects other household members in the community, such as a family in a MAGI household that will be filing taxes jointly with an incarcerated spouse. This is information both the family who may be completing an application, renewal or update needs to know, as well as information that facility personnel who complete an application or redetermination for an incarcerated person need to know. In MLRI's interviews with returning citizens, most reported meeting with a reentry officer who did not ask questions corresponding to questions on the application and did not supply a copy of either the application or the Member Book, but simply asked the client to sign papers needed for MassHealth after release.

Another factor for consideration that will have a significant effect on returning citizens is implementation of continuous eligibility for 12 months from release. It has been in place since April 1, 2023 for applications or redeterminations submitted by correctional facilities, but there has been no guidance for people applying in the community. When 24-month continuous eligibility for the homeless is implemented later this year and 12-month continuous eligibility for all adults is implemented pursuant to another of the proposed amendments, it will be important

[30] Sec. 227, c. 165, Acts of 2014; Eligibility Operations Memo 15-09 (Dec. 2015).
[31] See, EOM 19-17.
[32] 130 CMR 502.003(H).

to assure that an individual eligible for more than one of the three provisions has the benefit of the longest available period of continuous eligibility.

Relying exclusively on the facilities to identify people released from incarceration and eligible for 12-months continuous eligibility also leaves out people returning to the community after stays too short to trigger suspension. The pre-trial population makes up the largest share of the population cycling in and out of incarceration, and their stays average fewer than 30 days. Under the proposed 1115 amendment they are eligible for pre-release services, however, unlike sentenced individuals, they may have no pre-determined release date. However, they should be identified not only for purposes of obtaining continuous eligibility for 12-months after release but also for purposes of enhanced case management. California, like Massachusetts, continues Medicaid enrollment for short stays, and has also identified a set of services to be offered within 48 or 72 hours of incarceration for these individuals, including reentry planning and coordination.[33]

MassHealth's proposal requests authority to use presumptive eligibility for individuals with short-term stays. CMS in its April 2023 letter recommends that states consider permitting prisons and jails to serve as "qualified entities" able to make presumptive eligibility determinations.[34] There are clear advantages to enabling prisons and jails to immediately authorize an individual to qualify for MassHealth. On the other hand, a presumptive determination is only temporary and coverage will end if an eligible individual does not complete a full application within 45 days. An individual released with only temporary coverage is at risk of losing coverage for this procedural reason alone. In light of this risk, CMS cautions states that it is preferable for a full application to be submitted prior to release if time permits. While MassHealth has implemented Hospital Presumptive Eligibility since it was required by the ACA in 2014, prisons and jails are very different settings, and we are concerned that MassHealth allocate the resources needed to be sure that presumptive eligibility operates as intended within correctional settings.

The proposal should include the suspension process when it identifies funding needs and in its design of accountability systems. In the current proposal, there is no mention of the suspension process in the request for expenditure authority to support capacity building and information technology.[35] Similarly, the accountability systems which will be necessary to monitor delivery of Medicaid-paid services within carceral settings should also include monitoring and support for the suspension and reapplication process. In interviews with returning citizens about their reentry experience, MLRI found that the process operated very differently within different facilities and even among reentry officers within the same facility. The suspension and enrollment process is

[33] See, Table 10, Short Term Model: Key Activities and Timeline Requirements, p. 80 California Draft Policy and Operations Guide (June 2023).
[34] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.
[35] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request,* 23-24.

one of many areas where the contributions of stakeholders will be important to inform and improve the demonstration.

* * *

In closing, we want to express our appreciation for MassHealth's efforts to address the needs of its justice-involved members. We urge you to consider our recommendations to better serve this population through the 1115 demonstration waiver opportunity. We look forward to continuing to work with you on MassHealth's justice-involved initiatives and are eager to see any pending changes to the current 1115 amendment. If you have any questions, please contact Isabel Wanner (iwanner@mlri.org), Victoria Pulos (vpulos@mlri.org), or Johnathon Card (jcard@law.harvard.edu).

Respectfully submitted by the following organizations:

AccessHealth MA (formerly Community Research Initiative)
Actual Justice Task Team of the Southern New England United Church of Christ
Boston Health Care for the Homeless
Center for Health Law and Policy Innovation, Harvard Law School
Central West Justice Center
Citizens for Juvenile Justice
Committee for Public Counsel Services
Community Reentry Program Inc.
Disability Law Center
Gavin Foundation
Greater Boston Legal Services, CORI & Reentry Project
Harvard Law School Safety Net Project
Healing Our Land, Inc.
Health Care For All
Health Law Advocates
Lynn Health Task Force
JRI Health Law Institute
Massachusetts Association for Mental Health
Massachusetts Law Reform Institute
Massachusetts Organization for Addiction Recovery
Metrowest Legal Services
MLPB
New Beginnings Reentry Services, Inc.
Prisoners' Legal Services of Massachusetts
Recovery Homes Collaborative of Massachusetts
Ruth's Way
Temple Sinai

The F8 Foundation
Women and Incarceration Project, Suffolk University

Individuals (affiliations included for identification purposes only)
Gatewood West, LICSW, Greater Boston Reentry Task Force

National
Multiple Sclerosis
Society

9/06/2023

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburn Place, 3rd Floor
Boston, MA 02108

Dear Director Levine:

The National Multiple Sclerosis Society (Society) appreciates the opportunity to submit comments on the MassHealth 1115 Medicaid Demonstration Amendment Request.

Multiple Sclerosis (MS) is an unpredictable, often disabling, disease of the central nervous system, which interrupts the flow of information within the brain and between the brain and the body. Symptoms range from numbness and tingling to blindness and paralysis, often leading to impaired mobility. The progression, severity, and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are moving us closer to a world free of MS. The Society works to cure MS while empowering people affected by MS to live their best lives.

The Society is committed to ensuring that Massachusetts' Medicaid program provides quality and affordable healthcare coverage. Our organization appreciates the emphasis on health equity in this waiver and supports the inclusion of retroactive eligibility for all enrollees, continuous eligibility for all adults, and expanded financial assistance for marketplace coverage. The Society offers the following comments on the MassHealth 1115 Demonstration Amendment Request:

Retroactive Coverage for All Enrollees
The Society supports the proposal to reinstate retroactive coverage for all demonstration populations. Retroactive coverage is an important policy to advance health equity and a safety net for low-income families. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries. MS is a highly expensive disease. The average total cost of living with MS is $88,487 per year[i]. The total estimated cost to the U.S. economy is $85.4 billion per year, and the direct medical cost to live with MS is an average of $65,612 more than a person who does not live with MS[ii].

Retroactive coverage is also important for current Medicaid enrollees. Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs

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Multiple Sclerosis
Society

with the elimination of retroactive eligibility.[iii] Medical debt disproportionately affects families of color in the US[iv] and is a predictor of other social drivers of health such as homelessness.[v] Retroactive coverage prevents Medicaid enrollees from facing substantial costs at their doctor's office or pharmacy and subsequent delays in care.

Given the importance of this policy change, The Society urges the state to reinstate retroactive coverage sooner than 2025. Many patients are facing gaps in coverage as a result of procedural disenrollments during the Medicaid unwinding process. The state should reinstate retroactive coverage as soon as possible to protect enrollees from the financial and health risks of a gap in coverage.

Continuous Eligibility for All Adults

The Society supports the proposal to provide 12-month continuous eligibility for all adults, as well as 24-month continuous eligibility for seniors experiencing homelessness. Continuous eligibility promotes health equity,[vi] and increases continuity of coverage.

Continuous eligibility protects patients and families from gaps in care. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[vii] The Society supports continuous eligibility as a method to reduce these negative health outcomes for patients.

This policy will also reduce churn within the program and its administrative burden on Medicaid offices. Research shows that 40% of Medicaid enrollees who lose coverage are re-enrolled in the program within a year.[viii] One study estimated that the administrative cost of churn was between $400 and $600 per person in the Medicaid program.[ix] Continuous eligibility eases the administrative burden that these changes in enrollment status place on the program.

As discussed above, because this policy would be especially impactful during the Medicaid unwinding process, the Society encourages the state to move up the implementation date for this policy from January 2025. Additionally, The Society further urges the state to consider providing multi-year continuous eligibility for young children. Multi-year continuous eligibility would improve access to and continuity of care for children during the critical early years of life[x] while promoting health equity. Studies show that children of color are more likely to be affected by gaps in coverage that continuous eligibility would address, rendering it necessary for improving equitable access to care.[xi]

Eligibility Increase for Marketplace Subsidies

The Society supports the expansion of eligibility for ConnectorCare subsidies from 300 percent to 500 percent FPL. This program provides subsidies for premiums and cost-sharing for individuals determined eligible for up to 100 days while they select, pay, and enroll into a marketplace plan. Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and

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medical care among low-income populations.[xii] Expanding eligibility for the subsidy program would ease the transition from Medicaid to the Marketplace and mitigate gaps in coverage.

Thank you for the opportunity to provide comments.

Sincerely,

Laura Hoch
Associate Vice President, State Advocacy & Policy
National Multiple Sclerosis Society

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[i] Bebo, Bruce et. al. The Economic Burden of Multiple Sclerosis in the United States: Estimate of Direct and Indirect Costs. Neurology May 2022, 98 (18) e1810-e1817; DOI: 10.1212/WNL.0000000000200150. https://n.neurology.org/content/98/18/e1810 (accessed May 4, 2022).

[ii] Bebo, Bruce et. al. The Economic Burden of Multiple Sclerosis in the United States: Estimate of Direct and Indirect Costs. Neurology May 2022, 98 (18) e1810-e1817; DOI: 10.1212/WNL.0000000000200150. https://n.neurology.org/content/98/18/e1810 (accessed May 4, 2022).

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[iv] Bennett, Neil et al. "Who Had Medical Debt in the United States?" U.S. Census Bureau. April 7, 2021. Available at: https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html

[v] Bielenberg JE, Futrell M, Stover B, Hagopian A. Presence of Any Medical Debt Associated With Two Additional Years of Homelessness in a Seattle Sample. INQUIRY: The Journal of Health Care Organization, Provision, and Financing. 2020;57. doi:10.1177/0046958020923535

[vi] Chomilo, Nathan. Building Racial Equity into the Walls of Minnesota Medicaid. Minnesota Department of Human Services. February 2022. Available at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG

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[viii] Corallo, Bradley et al. "What Happens After People Lose Medicaid Coverage?" Kaiser Family Foundation. January 25, 2023. Available at: https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage/

[ix] Swartz, Katherine et al. "Reducing Medicaid Churning: Extending Eligibility for Twelve Months Or To End Of Calendar Year Is Most Effective." Health Affairs, Vol 37, No. 7. July 2025. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1204

[x] Burak, Elisabeth Wright. "Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)." Center for Children and Families, Georgetown University Health Policy Institute. October 2018. Available at: https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf

[xi] Osorio, Aubrianna. Alker, Joan, "Gaps in Coverage: A Look at Child Health Insurance Trends", Center for Children & Families (CCF) of the Georgetown University Health Policy Institute, November 21, 2021. Gaps in Coverage: A Look at Child Health Insurance Trends – Center For Children and Families (georgetown.edu)

[xii] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings | KFF

Notes from MA 1115 Amendment Listening Session

8/17/2023 2:00-3:00

Ryan Schwarz and Monica Sawhney walked through the slides and provided an overview of the amendment request.

Q&A was moderated by Martha Farlow with Emily Cooper, Ryan, and Monica responding to questions.

Some questions came via the chat box, but most people raised hands and were called on to ask questions.

Q&A

Q. Gargi Cooper (Lynn Community Health Center) Why is the coverage for homeless individuals only for clients who are being discharged from hospitals? We serve a large population of clients who need medical respite care who live on the streets or cannot be managed in our local shelters.

A. Emily - It is a broader population than those just being released from hospital, i.e. someone going for a colonoscopy

Q. Mary Takach (BHCHP) Have a question about STPHH, how is it different from current medical respite programs in MA.

A. Emily - Refer to current procurement for medical respite, which is up to 6 months that would allow someone time to recover from medical issue. Aligned with the CA model that is currently approved by CMS.

Mary - Any plans to expand beyond those facilities that do not fit into the CA model.

Martha - We'll take that back

Q. Brian Doherty (MA Assisted Living Association) Concerned about inclusion of assisted living in Frail Elder Waiver.

A. Emily/Martha - 1115 demo waiver covers folks up to age 64 and is separate from Frail Elder Waiver.

Q. Vicky Pulos (MA Law Reform Institute) Any plans to expand coordinating council to go beyond the DOC, to include community members

A. Monica - We hear that and will plan to reach out to various stakeholders.

Q. What is the cap per year or length of stay for the 6 months. If a client stays for 3 months they can return to respite care for another 3 in a calendar year? Despite best efforts many clients fail housing or placement (sober housing, shelters) and require readmitance to Respite services, which has always played a role as a community safety net.

A. Martha - STPHH is only for MassHealth clients. Still working through the details of implementation.

Q. John Card, (Center for Health Law and Policy Innovation) 90 days of medication coverage post-release, and 90-days of coverage pre-release. Wondering if you have an intention to include HCB during that period.

A. Monica – Take your point and will look into that.

Ryan – Looking into best practices clinically, and other states who are slightly ahead of us in authority

John – Is MA intending to pursue funding programs beyond the 4 pillars,

Monica – We have been thinking about some of those programs falling within the 4 pillars, but will take that back.

Q. Lisa Sheehy (DPH Div CYSHN) Is it expected that the STPHH would be for individuals or would it include medical respite on a family model? Will it include medical respite for minor children ready for hospital/ER discharge whose families are experiencing homelessness or housing instability, using a family housing model? Thank you!

A. (Emily) Right now not for minor children and that is based on coordinating with other state agencies.

Q. Jennifer Honig (MAMH) – Carceral detainees, can you speak more to who that population includes?

A. Monica - Take back and get back with more detail.

Q. Vicky Pulos – Does Medical respite have to be limited to ACO population?

A. Emily – We are using the grant opportunity to better understand who is accessing medical respite, but we need more data and evaluation, to inform the implementation of the STPHH. We are using the 1115 waiver which is based in the ACO world, but we will look at the data to see if there are other populations we should be talking about.

Q. Gargi Cooper – Large population in our medical respite, and this is very narrow if we're only including ACOs. Hoping there will be more discussion and data.

A. Martha – Thank you for that comment.

Q. Kate Symmonds (MLRI) How will continuous eligibility coordinate with post-release and postpartum populations?

A. Monica - Generally yes, the intention is for it to be coordinated, but will follow up as it is implemented.

Ryan also received a direct message question from Sarah Chiaramida: Is the request [Marketplace Subsidies] only for the pilot period or the duration of the waiver? A. We will take it back.

Open Sky
COMMUNITY SERVICES

September 8, 2023

1115 Amendment Comments
EOHHS Office of Medicaid
1 Ashburton Pl
Boston MA 02108

Re: Massachusetts Section 1115 Demonstration Amendment Request

Open Sky Community Services applauds the Executive Office of Health and Human Services, Office of Medicaid's Section 1115 Demonstration Amendment Request. All the waiver requests are important steps to ensure health care for many of the most underserved and underrepresented populations in the Commonwealth.

The amendment to provide pre-release MassHealth Services to individuals up to 90 days prior to release is particularly relevant as Open Sky has had the privilege of participating in the BH-JI/CSP-JI programs since 2019. In this work we have served over 1,300 individuals. Through our work we have seen firsthand the effectiveness of connecting individuals with case management prior to release. These services have been effective in coordinating physical and behavioral health services, ensuring continuity of medication adherence post release, as well as securing housing, employment, nutritious food and other social determinants of health needs. Building a strong and supportive case management relationship and carrying it over into the community is a key factor in successful transition to the community for incarcerated individuals. Positive outcomes that have been a direct result of these services include nearly 50% of enrollees achieving stable housing and over 60% securing employment while in services. In addition enhanced coordination and engagement with health and behavioral health care has reduced acute care needs and we have seen significant success in overdose prevention.

A 90-coverage period prior to release would be particularly helpful in coordination of physical and behavioral health care. With active MassHealth coverage providers will accept referrals and through the use of telehealth initial appointments could be completed prior to release and ensure that appointments are scheduled for soon after release to ensure continuity of care.

We appreciate the opportunity to provide comments on this important amendment.

Sincerely,

David Lambert
Vice President of Business Development

September 8, 2023

Submitted via: 1115WaiverComments@mass.gov

Michael Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services (EOHHS)
EOHHS Office of Medicaid
One Ashburton Place
Boston, MA 02108

RE: MassHealth Section 1115 Demonstration Amendment Request

Dear Mr. Levine:

ViiV Healthcare Company (ViiV), offers the following comments to The Massachusetts Executive Office of Health and Human Services (EOHHS) Office of Medicaid, on its proposed amendment to its current MassHealth Section 1115 Demonstration.[1]

ViiV, a global specialist HIV company established in 2009, is the only company 100 percent dedicated to combating, preventing, and eventually one day curing HIV and AIDS. ViiV specializes in the development of HIV medicines and is devoted exclusively to advancing science into HIV treatment, prevention, and care. From its inception, our company has had a singular focus to improve the health and quality of life for people impacted by HIV, which has transformed the disease from a terminal illness to a manageable chronic condition. ViiV remains committed to developing meaningful scientific advances in HIV, improving access to all HIV medicines, and supporting the HIV community to facilitate enhanced care, prevention, and treatment. We are proud to be a part of the nation's success in reducing the number of new HIV cases and increasing viral suppression rates.[2,3]

ViiV supports the EOHHS' efforts to address health disparities, in particular the waiver's stated goals to reduce health disparities that persist by race, ethnicity, language, disability, sexual orientation, and gender identity. We are pleased to provide the following comments on how the Demonstration's Amendments can address many of these social and healthcare inequities, especially for often marginalized MassHealth enrollees with HIV and those who are not but could benefit from HIV pre-exposure prophylaxis (PrEP).

Provide Pre- and Post- Release MassHealth Services to Individuals in Public Institutions

People with HIV are disproportionately involved in the criminal justice system with sero-positive rates more than three times higher than the general population.[4] Often these individuals face

[1] MassHealth Section 1115 Demonstration Amendment Request. August 2, 2023. https://www.mass.gov/doc/masshealth-section-1115-demonstration-amendment-request-2/download Accessed August 16, 2023
[2] AIDSVu: United States. https://aidsvu.org/local-data/united-states/. Accessed July 20, 2023.
[3] America's HIV Epidemic Analysis Dashboard (AHEAD). Ending the HIV Epidemic in the US. https://ahead.hiv.gov/. Accessed July 20, 2023.
[4] Cheever, Laura. HRSA's Ryan White HIV/AIDS Program Discusses Engaging the Criminal Legal System to End the HIV Epidemic. September 9, 2020. HIV.gov https://www.hiv.gov/blog/hrsa-s-ryan-white-hivaids-program-discusses-engaging-criminal-legal-system-end-hiv-epidemic/. Accessed August 16, 2023.

complex medical, mental health, and substance abuse needs.[5] In 2006, 14% of all people with HIV in the United States, or more than 150,000, passed through a correctional facility and the proportion was closer to 20 percent for black and Hispanics with HIV.[6] Fortunately, the rate of HIV within this population has been falling steadily since 1998,[7] although it was higher in Massachusetts (1.4 percent) than the national average (1.1 percent) between 2017-2021.[8]

Due to the advancement in antiretroviral treatment, people with HIV are often treated successfully while incarcerated resulting in viral suppression, however upon release face multiple challenges in maintaining continuity of care.[9] For these reasons, ViiV encourages transitional services that maintains continued access to antiretroviral treatment and other prescribed medications and linkage to care that includes a scheduled first appointment with an HIV specialist upon release.

Case worker services are especially important during reentry. One study published in the American Journal of Public Health, assessed six-month outcomes for people with HIV released from New York City jails with a transitional care plan found significant improvements in the number of individuals taking antiretroviral medications and adherence to antiretroviral therapy. The study also reported significant reductions in emergency department visits, unstable housing, and food insecurity compared with baseline.[10]

ViiV also recommends that an HIV test be offered to any individual going through the reentry program. While the state's prison system offers HIV testing throughout incarceration it only does so upon request at discharge.[11] For some individuals, this maybe a missed opportunity to identify the HIV virus, initiate antiretroviral treatment, and potentially achieve viral suppression before returning back to the community.

If taken as prescribed, antiretrovirals have the potential to reduce the amount of HIV in the blood to a very low level – below what can be measured by a lab test – which promotes a long and healthy life for a person with HIV.[12] Effective ARV treatment that reduces the amount of HIV in the blood to undetectable levels has a secondary public health benefit of preventing new transmission of HIV to others. This is commonly referred to as Treatment as Prevention,[13] or Undetectable = Untransmissible (U=U).[14] It is estimated that people with HIV who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.[15]

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[5] Westergard et al. HIV among persons incarcerated in the USA: a review of evolving concepts in testing, treatment, and linkage to community care. Curr Opin Infect Dis. 2013 Feb;26(1):10-6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3682655/. Accessed August 16, 2023.

[6] Beckwith, Curt et al. Opportunities to Diagnose, Treat, and Prevent HIV in the Criminal Justice System. Journal of the Acquired Immune Deficiency Syndrome, January 7, 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3017345/. Accessed August 17, 2023.

[7] Maruschak, Laura. HIV in Prisons 2021-Stat Tables. US Department of Justice. https://bjs.ojp.gov/document/hivp21st.pdf. Accessed August 16, 2023.

[8] Maruschak, Laura. HIV in Prisons 2021-Stat Tables (Appendix Table 2) Page 11. US Department of Justice https://bjs.ojp.gov/document/hivp21st.pdf. Accessed August 16, 2023.

[9] Cheever, Laura. HRSA's Ryan White HIV/AIDS Program Discusses Engaging the Criminal Legal System to End the HIV Epidemic. September 9, 2020. HIV.gov https://www.hiv.gov/blog/hrsa-s-ryan-white-hivaids-program-discusses-engaging-criminal-legal-system-end-hiv-epidemic/. Accessed August 17, 2023.

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[11] Maruschak LM. HIV in Prisons 2021-StatisticalTables. US Department of Justice. March 2023. https://bjs.ojp.gov/document/hivp21st.pdf. Accessed August 17, 2023.

[12] HIV.gov. Viral Suppression and Undetectable Viral Load. June 7, 2022. https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression. Accessed August 23, 2023.

[13] Centers for Disease Control and Prevention (CDC). HIV Treatment as Prevention. July 21, 2022. https://www.cdc.gov/hiv/risk/art/index.html. Accessed August 23, 2023.

[14] National Institutes of Health (NIH). HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention. May 21, 2019. https://www.niaid.nih.gov/diseases-conditions/treatment-prevention. Accessed August 23, 2023.

[15] Skarbinski J, Rosenberg E, Paz-Bailey G, et al. Human immunodeficiency virus transmission at each step of the care continuum in the United States. JAMA Intern Med. 2015;175(4):588-596. Accessible at: https://pubmed.ncbi.nlm.nih.gov/25706928/.

For the majority who will not test positive for HIV, we urge EOHHS to include material on how to remain HIV negative including information and potentially initiation of PrEP as part of its reentry protocol. In 2023, the USPSTF assigned a "Grade A" rating to PrEP as a highly effective preventive intervention.[16] PrEP has been shown to reduce the risk of acquiring HIV from sex by 99 percent and reduces risk by 74 percent among those who inject drugs.[17]

While Massachusetts has amongst the highest PrEP coverage rates in the nation (41 percent)[18] it has not been equally accessed by several communities impacted by HIV. In fact, PrEP coverage is inversely proportional to those newly diagnosed with HIV. In 2022, of the 12,990 individuals receiving PrEP in the Commonwealth, 75.5 percent of the uptake was in the white population, compared to 7.2 percent of the Black and 12.5 percent of the Hispanic populations.[19]

ViiV commends the EOHHS for proposing to provide access to certain pre-and-post MassHealth services to individuals in public institutions. Targeted interventions for HIV and other infectious diseases are critical for the reentry population and require coordination between correctional and community health systems.[20] We encourage that these services include HIV testing, access to effective antiretroviral treatment for those who test positive for HIV and education on how to remain HIV negative, with possible initiation of PrEP, for those who test negative for HIV but could otherwise benefit from an HIV preventive drug. Caseworker services provide an effective portal to navigating a complex healthcare system and should also be offered as a re-entry service.

Provide 12 Months Continuous Eligibility to Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness who are 65 and Over

ViiV supports EOHHS's proposal to provide access to quality healthcare for members experiencing homelessness, including 24 months continuous eligibility for members experiencing homelessness who are aged 65 or over.

Elderly patients in general, but in particular those with HIV, often have to navigate many primary healthcare issues, including frailty, being disabled and, cognitive issues that must be addressed early on in order to successfully manage chronic diseases.[21] Often older people with HIV experience age-related comorbidities, such as cardiovascular disease, impaired renal function and neurocognitive function, and neuropathy/distal neuropathic pain at a greater rate and earlier in life than their peers who are HIV negative. This often leads who do not have HIV, which has led to an increase in non-antiretroviral, polypharmacy to treat these comorbidities.[22]

One study found that 65 percent of people with HIV over the age of 60 take at least five-medications to manage their health issues.[23] As a consequence of HIV and comorbid disease burden, polypharmacy and medication-related problems are emerging as an important challenge

[16] US Preventive Services Task Force, Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis. August 22, 2023. https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis. Accessed August 24, 2023.
[17] Centers for Disease Control and Prevention (CDC). HIV Risk and Prevention: PrEP (Pre-Exposure Prophylaxis). July 5, 2022. https://www.cdc.gov/hiv/risk/prep/index.html. Accessed August 24, 2023.
[18] Centers for Disease Control and Prevention (CDC). PrEP Coverage. September 2, 2022. https://www.cdc.gov/hiv/statistics/overview/in-us/prep-coverage.html. Accessed August 24, 2023.
[19] AIDSVu: Massachusetts. https://aidsvu.org/local-data/united-states/northeast/massachusetts/. Accessed August 24, 2023.
[20] Rush EN, Puglisi L, Eber GB, et al. Prison and Jail Reentry and Health. October 28, 2021. https://www.healthaffairs.org/do/10.1377/hpb20210928.343531. Accessed August 25, 2023.
[21] New York State Department of Health AIDS Institute. Guidance: Addressing the Needs of Older Patients in HIV Care. https://www.hivguidelines.org/guideline/hiv-aging/. Accessed August 25, 2023.
[22] Smith L, Letendre S, Erlandson KM, et al. Polypharmacy in older adults with HIV infection: Effects on the brain J Am Geriatr Soc. 2022 Mar;70(3):924-927. Accessible at: https://pubmed.ncbi.nlm.nih.gov/34855982/.
[23] Id

facing HIV-positive older adults resulting in a greater risk of adverse drug events, drug-drug interactions, and poor adherence to medications.[24]

We refer EOHHS to the New York State Guidance: Addressing the Needs of Older Patients in HIV Care[25] as proactive strategies to address the unique needs of older people with HIV, including:

- Screening for frailty or functional decline can enable early identification of at-risk patients.
- Prioritizing treatment plans that help to reduce the potential for polypharmacy in older patients with HIV who are being treated for multiple comorbidities.
- Facilitating and simplifying access to care and services as patients' care needs increase as one strategy to improve overall adherence to and satisfaction with treatment.

ViiV also encourages MassHealth to continue to tackle homelessness in addition to health coverage for this particularly marginalized and transient population. Homelessness and housing instability remain obstacles to effective HIV treatment. Access to stable housing can be a key intervention in stabilizing medical care for many vulnerable populations.

The Housing Opportunities for Persons with AIDS (HOPWA) program,[26] created in 1992 to address the housing needs of people with HIV, provides an example how addressing social determinates of health (SDOH) can have a significant impact on improving health care outcomes for individuals with a complex health condition. We urge EOHHS to work with Massachusetts Ryan White program officials and with HOPWA to address the many healthcare and social complexities as a way to increase positive outcomes for this and other vulnerable populations.

Include Short-Term Post Hospitalization Housing (STPHH) as an allowable Health-Related Social Needs (HRSN) Service

ViiV appreciates EOHHS's proposal to include STPHH as part of the Commonwealth's HRSN services to improve members' health and avert further intensive medical interventions, reduce health disparities, and reduce the total cost of care for members experiencing homelessness.[27] These social determinants of health play an important role in effective care and treatment for people with HIV.

In 2020, it was estimated that 13.9 percent of the state's HIV population were living in unstable housing and 9.2 percent were living with food insecurities.[28] For people with HIV, a lack of stable housing may lead to unnecessary hospitalization, negative clinical outcomes, and worsening of

[24] Greene M, Steinman MA, McNicholl IR, Valcour V. Polypharmacy, Drug–Drug Interactions, and Potentially Inappropriate Medications in Older Adults with Human Immunodeficiency Virus Infection. J Am Geriatr Soc. 2014 Mar;62(3):447-53. Accessible at: https://pubmed.ncbi.nlm.nih.gov/24576251/.
[25] New York State Department of Health AIDS Institute. Guidance: Addressing the Needs of Older Patients in HIV Care. https://www.hivguidelines.org/guideline/hiv-aging/. Accessed August 25, 2023.
[26] Housing and Urban Development HUD. Housing Opportunities for Persons With AIDS. https://www.hudexchange.info/programs/hopwa/. Accessed August 31, 2023.
[27] MassHealth Section 1115 Demonstration Amendment Request. August 2, 2023. https://www.mass.gov/doc/masshealth-section-1115-demonstration-amendment-request-2/download Accessed August 16, 2023.
[28] AIDSVu: Illinois. https://aidsvu.org/local-data/united-states/midwest/illinois/. Accessed August 24, 2023.

chronic conditions as well as contribute to the inability to stay adherent to antiretroviral treatment and become virally suppressed.[29,30,31]

Homelessness and housing instability remain obstacles to effective HIV treatment. Access to stable housing can be a key intervention in stabilizing medical care for many vulnerable populations. A systematic literature review found that 94 percent of studies associated worse HIV medical care outcomes among those who were homeless, unstable, or inadequately housed compared to "housed" people with HIV, and 93 percent found worse rates of adherence to antiretroviral therapy (ART) among those who were homeless or unstably housed.[32] Of the 13 studies that examined emergency room (ER) and inpatient visits among people with HIV, all found higher rates of ER visit or inpatient stays among those who were homeless or unstably housed.[33] Among homeless people with AIDS who received supportive housing, there was an 80 percent reduction in mortality.[34,35] This is not surprising given that people with HIV and stable housing are much more likely to access health services, attend primary care visits, receive ongoing care and receive care that meets clinical practical standards.

According to the National HIV/AIDS Housing Coalition, there is not "a path toward ending the HIV epidemic in the United States without addressing the need for safe, appropriate, & affordable housing for people at high-risk and those living with HIV/AIDS."[36] Additionally, availability of housing assistance services could be co-located with HIV care services to ensure a whole person approach to care. In line with one of STPHH's primary goal of connecting members to more permanent housing upon discharge from the STPHH[37], ViiV encourages EOHHS' Office of Medicaid to work together with state housing program officials to seek coordination and share best practices in addressing homelessness as a way to increase positive outcomes in medical care and treatment for people with HIV.

Conclusion

In 2019, the U.S. Department of Health and Human Services (DHHS) released the "Ending the HIV Epidemic: A Plan for America (EHE)." This plan proposes to use scientific advances in ART to treat people with HIV and expand proven models of effective HIV care and prevention.[38] EHE's ambitious goals are to reduce new HIV infections in the United States 75% by 2025 and 90% by 2030, and advance health equity by scaling up key HIV prevention and treatment strategies.[39]

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[29] Berthaud V, Johnson L, Jennings R et al. The effect of homelessness on viral suppression in an underserved metropolitan
area of middle Tennessee: potential implications for ending the HIV epidemic. BMC Infectious Diseases (2022) 22:144. Accessible at: https://bmcinfectdis.biomedcentral.com/counter/pdf/10.1186/s12879-022-07105-y.pdf

[30] Arum C, Fraser H, Artenie AA et al. Homelessness, unstable housing, and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis. Lancet Public Health. 2021 May;6(5):e309-e323. Accessible at: https://www.thelancet.com/article/S2468-2667(21)00013-X/fulltext

[31] Rajabiun S, Tryon J, Feaster M et al. The Influence of Housing Status on the HIV Continuum of Care: Results From a Multisite Study of Patient Navigation Models to Build a Medical Home for People Living With HIV Experiencing Homelessness. Am J Public Health. 2018 Dec;108(S7):S539-S545. Accessible at: https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304736

[32] Aidala AA, Shubert V. Housing as a Determinant of HIV Health Outcomes: Results from a Systematic Review of Research 1996-2014 & Implications for Policy and Program. The National Center for Innovations in HIV Care. https://targethiv.org/sites/default/files/supporting-files/Housing%20and%20HIV%20Health%20Outcomes%20Final.pdf Accessed August 24, 2023.

[33] Id.

[34] National HIV/AIDS Housing Coalition. Housing is Health Care. http://nationalaidshousing.org/hivhousing/. Accessed June 5, 2023.

[35] Eastwood EA, Nace AJ, Hirshfield S et al. Young Transgender Women of Color: Homelessness, Poverty, Childhood Sexual Abuse and Implications for HIV Care. AIDS Behav 25 (Suppl 1), 96–106 (2021). Accessible at https://link.springer.com/article/10.1007/s10461-019-02753-9

[36] National HIV/AIDS Housing Coalition. National AIDS Housing Coalition Now the National HIV/AIDS Housing Coalition. November 2, 2022. https://nationalaidshousing.org/2022/11/02/nhahc/. Accessed June 5, 2023.

[37] MassHealth Section 1115 Demonstration Amendment Request. August 2, 2023. https://www.mass.gov/doc/masshealth-section-1115-demonstration-amendment-request-2/download Accessed August 16, 2023.

[38] HIV.gov. Ending the HIV Epidemic. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview. Accessed August 24, 2023.

[39] Centers for Disease Control and Prevention (CDC). Ending the HIV Epidemic in the U.S. (EHE). June 9, 2023. https://www.cdc.gov/endhiv/index.html. Accessed August 29, 2023.

Massachusetts has an important role to play in EHE efforts, as Suffolk County is a priority jurisdiction in the EHE plan.[40]

In order to promote the state and federal goals to end the HIV epidemic, it is imperative that state Medicaid programs participate in local and national efforts and promote policies that contribute to HIV public health goals. Therefore, ViiV encourages EOHHS to consider adopting ViiV's recommendations to build upon the Agency's Amendment's proposals and goals to provide a more equitable healthcare program, and advance the goals of the national public health initiative to End the HIV Epidemic in the U.S.

Please feel free to contact me at steve.f.novis@viivhealthcare.com with any questions.

Sincerely,

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[40] HIV.gov. Ending the HIV Epidemic. August 1, 2023. https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview. Accessed August 24, 2023.