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September 17, 2021

The Honorable Marylou Sudders, Secretary
Executive Office of Health and Human Services
Commonwealth of Massachusetts
One Ashburton Place, 11th Floor
Boston, MA 02108

Executive Office of Health and Human Services Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Comments on 1115 Demonstration Extension Request

Dear Secretary Sudders:

AARP Massachusetts would like to thank the Executive Office of Health and Human Services' Office of Medicaid for the opportunity to submit our comments to your Section 1115 Waiver Demonstration Project and Amendment Request. AARP is a nonprofit, non-partisan membership organization for people 50 and over. We have nearly 38 million members nationwide and 760,000 members in the Commonwealth. We know the Commonwealth provides essential services for the older population – services that keep people healthy and living with dignity. It is critical that adequate funding remain for these programs and services.

As you know, MassHealth provides health coverage to more than 2 million Massachusetts residents, representing approximately 30% of the Commonwealth's population, including some of the most vulnerable residents - 32% of which are non-disabled children, 44% are low-income non-disabled adults, and 24% are people with disabilities and/or seniors.

We are encouraged by the goals you have set for this demonstration extension request, namely to:

- continue the path of restructuring and re-affirming accountable, value-based care – increasing expectations for how Accountable Care Organizations (ACOs) improve care and trend management, and refining the model;
- reform and investment in primary care, behavioral health and pediatric care that expands access and moves the delivery system away from siloed, fee-for-service health care;
- improve the integration of physical, behavioral, and long-term services;

- advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals;
- sustainably support the Commonwealth’s safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care; and
- maintain near-universal coverage including updates to eligibility policies to support coverage and equity.

We appreciate the process you established to engage and receive input from stakeholders, and the statewide investments made during the current waiver period and the successes that have ensued. This proposal represents a continuation of an ambitious undertaking and one that merits close attention and extension. AARP Massachusetts believes that many components of the waiver align with AARP principles and policies.

AARP believes federal and state governments must ensure adequate protections for beneficiaries with disabilities, older adults needing long-term services and supports (LTSS), and people with mental illness or other complex health needs. This includes adequate provider networks, not imposing nominal cost sharing that restricts access, or benefit changes that deny access to needed care.

As a result of the current waiver more than 80% of eligible MassHealth members have now been enrolled in ACOs – health care organizations that take on accountability for improved population-level health outcomes, lower cost, and improved member experience. AARP lauds the Commonwealth’s efforts to create the Behavioral Health and Long-Term Services and Supports Community Partners (CP) program in partnership with the ACOs. These community-based organizations are providing wrap-around expertise and support for members with complex behavioral health and LTSS needs further enabling MassHealth to improve the provision of whole-person, integrated, and member-centric care for its members.

AARP understands the existing waiver intended to have ACOs and Managed Care Organizations (MCOs) gradually assume expanded responsibility in the delivery and coordination of LTSS to vulnerable older adults, with key objectives being to improve quality, outcomes and the consumer experience. As the state seeks an extension, AARP asks that the state takes steps to put financial risk mitigation strategies in place in order to ensure the solvency of these entities and sustain adequate access to services for beneficiaries.

In the proposed extension, MassHealth seeks to improve the provision of whole-person, integrated, and member-centric care. AARP strongly supports the establishment of seamless, person-centered care coordination for consumers who have complex LTSS and social needs. We believe that care coordination is best served when interdisciplinary care teams are formed, and that both community-based LTSS providers and family caregivers are included as members of these teams. Family caregivers often play an essential role in the health and well-being of members and should be a key component and partner when they are willing and able to help. In further developing the MassHealth program, we urge the state to ensure that:

- Family caregivers are broadly defined, so that friends or family members, as requested by the beneficiary, have the opportunity to be actively involved in assessment of need of their loved one and development of the beneficiary's service plan;
- Family caregivers receive an independent assessment to determine how the ACO or MCO can work with the caregiver and support the caregiver's own needs;
- ACOs and MCOs train their case managers on how to communicate and work with family caregivers;
- ACOs and MCOs offer caregiver training to family caregivers that covers both effective caregiving techniques and stress reduction practices; and
- ACOs and MCOs provide respite support for family caregivers on a regular basis.

A person-centered approach should emphasize keeping individuals who need LTSS in the community rather than institutional settings. In the existing waiver, ACOs have explicit requirements to partner with community-based behavioral health (BH) and LTSS providers to serve members with complex BH, LTSS and co-occurring needs. We commend MassHealth's commitment to ensuring that ACOs, other providers and MCOs deliver care in a culturally competent manner that is appropriate to the cultural and linguistic needs of consumers. In addition, the Commonwealth must ensure access and equity by directing public and private policies and practices to eliminate disparities and promote health.

The extension of the demonstration provides a critical opportunity to maintain the gains Massachusetts has made and make further progress to improve care delivery and outcomes for MassHealth members.

We look forward to working with you as this demonstration progresses and would be happy to assist you in any way possible. Please do not hesitate to contact Jessica Costantino, Director of Advocacy, at 617.305.0538 or jcostantino@aarp.org, if you have questions or concerns or need additional information.

Very truly yours,



Michael E. Festa
State Director



Sandra Harris
State President

Dear EOHHS,

I strongly support the extension of MassHealth (Medicaid) coverage to persons who are incarcerated in our state prisons and county houses of correction and to persons who have been recently released from incarceration.

Massachusetts has made great strides in recent years in the effort to provide universal health insurance coverage to state residents. Prisoners and people making the transition from prison back into their local communities remain a major gap in coverage which we could eliminate by making them eligible for MassHealth coverage. The federal/state funding of the Medicaid program would also reduce the cost to Massachusetts taxpayers.

I hope you will take this major step forward.

John E. Bowman, Jr.
Access to Justice Fellow
10 Still Street
Brookline, MA 02446



September 20, 2021

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email

Re: 1115 MassHealth Demonstration ("Waiver") Extension Request

Dear EOHHS,

Thank you for the opportunity to submit comments in strong support of the *1115 MassHealth Demonstration ("Waiver") Extension Request*. The proposal to increase access to doula care through reimbursement shares many goals with Accompany Doula Care's mission to improve expand access to doula care for pregnant individuals and families on MassHealth.

Massachusetts has made great strides in improving health outcomes and controlling costs using Accountable Care Organizations (ACOs). Under ACOs, there is an opportunity to both improve outcomes and reduce healthcare costs. Strengthening health care services and outcomes for pregnant folks and their families remains an area where MassHealth can make a difference—particularly for families and birthing people of color.

Accompany Doula Care was established in 2016 to offer doula care to families who could most benefit but receiving it yet face barriers to access. Accompany currently partners with two Accountable Care Organizations in Massachusetts to provide doula support free-of-charge to MassHealth ACO members, while striving to pay a living wage to more than 20 community-based doulas who comprise

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[@accompanydoulas](https://twitter.com/accompanydoulas)

diversity in race, ethnicity, culture, primary language spoken, and geography. Collectively, Accompany doulas speak over 10 languages. Our work focuses on improving birth outcomes, especially where inequities and disparities are highest. From our launch of services in April 2019, we have served over 100 families, through 52 births, providing 1,020 hours of support, at no cost to them.

Accompany doulas see firsthand what it means to expand access to perinatal doula care to birthing clients who need it. Our community doula model addresses specific disparities in maternal health, serving low-income clients in over 10 languages. Equally important is that with a culturally competent doula, education and support increases while the number of interventions decreases. The result is that birthing people feel respected, empowered, and satisfied with their care.

Accompany doulas see up close the very real mental and physical challenges new parents face. Prenatal education and advocacy, birth support, and postpartum care are shown to reduce maternal morbidity and mortality. This is particularly critical when trying to address the very real racial disparities in maternal health. According to the CDC, for every pregnancy-related death, another 70 people suffer from severe physical illness or disability, including behavioral health conditions.^{1,2} Further, pregnant people enrolled in Medicaid are more likely than those with private coverage to have chronic health conditions, preterm births, or low birthweight babies, putting them at higher risk for poor maternal outcomes.³ Extending doula coverage to more pregnant people would help doula care, an evidence-based and community-driven intervention, reduce these disparities.

¹ Centers for Disease Control and Prevention. (2019, May 7). *Pregnancy-related deaths*. Centers for Disease Control and Prevention. <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>.

² Katherine Ellison, N. M. (n.d.). *Severe complications for women during childbirth are skyrocketing - and could often be prevented*. ProPublica. <https://www.propublica.org/article/severe-complications-for-women-during-childbirth-are-skyrocketing-and-could-often-be-prevented>.

³ MACPAC. (2018, November). *Access in Brief: Pregnant Women and Medicaid*. <https://www.macpac.gov/wp-content/uploads/2018/11/Pregnant-Women-and-Medicaid.pdf>.



We, at Accompany Doula Care, believe that supporting community doula models is integral to addressing perinatal disparities and improving the health of families in the Commonwealth.

Best regards,

A handwritten signature in black ink that reads "Christina Gebel". The signature is written in a cursive, flowing style.

Christina Gebel
Co-Founder, Accompany Doula Care

+

The Accompany Doula Care Team



September 20, 2021

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108.

RE: Written Comments from ADDP/MHC on 1115 Demonstration Extension Request

To Whom It May Concern,

The Association of Development Disabilities Providers (ADDP) and Mass Home Care (MHC) appreciate the opportunity to again provide written comments in response to the 1115 MassHealth Demonstration “Waiver” Extension Request submitted by the Executive Office of Health and Human Services (EOHHS) to the Centers for Medicare and Medicaid Services (CMS) on August 18, 2021.

ADDP and MHC are grateful for the forums MassHealth has provided to date to ensure that our stakeholder community’s feedback has been heard. We greatly value the information that MassHealth has shared which indicates that many of the suggestions made by our organizations through our collaborative conversations have been incorporated into the extension proposal submitted to CMS. ADDP and MHC also look forward to continuing to work collaboratively with MassHealth, and the broader stakeholder community, to further shape the Long-Term Services and Supports (LTSS) Community Partners (CP) System and its relationships with Accountable Care Organizations (ACOs).

We clearly recognize that this critically needed program will be successful if the new system provides a framework which affords CP providers the opportunity to partner with ACOs in arrangements which provide standards in practices and results across all entities, ensuring that participants in the system have opportunities for service access and outcomes which are equitable across all ACO and CP systems. To achieve these goals, it will important for MassHealth to develop benchmarks for practices and outcomes supported by payment models which account for potential differences in the economic, social, and medical risks of populations served across ACOs. We are very interested in opportunities to work collaboratively with ACOs and MassHealth to address any issues to ensure the new system is designed to achieve these goals. We would be very interested in MassHealth arranging for a joint ACO-CP planning process.

Specifically, we would like to note our agreement and support of the following concepts embedded in the proposal:

- We strongly support increasing the scope of the LTSS CP model to include care coordination across all medical/physical health, cognitive and behavioral, social determinants of health (SDOH), and long-term services and support domains.
 - We are pleased to see that the proposal establishes the LTSS CP as an option for participants as the primary care coordinator and provides the LTSS CP with the capacity to complete Comprehensive Assessments
 - Due to the complex needs of individuals requiring Long-Term Services and Supports, we also strongly agree that the qualifications and reimbursement rates for LTSS CPs should be comparable to those of the Behavioral Health (BH) CP service delivery model
- Based on their established community relationships, experience delivering and engaging SDOH supports and educational systems, and decades of experience in coordinating services, LTSS CPs are best equipped to navigate community resources for the majority of children and their families, currently being successfully served through the LTSS CP model. We are pleased that the proposed model will continue to allow LTSS CPs to serve the larger pediatric base while offering the top 1-2 percent of children enrolled in the program with complex medical needs direct care coordination through their ACO.
- We are also pleased that MassHealth is considering expanding the list of qualifying activities that could be incentivized for the LTSS CPs.
 - In addition to completion of the participation form, completion of the comprehensive assessment and care plan, and follow-up after discharge from the hospital, we would like to propose MassHealth consider expanding this list to include additional “high-value” activities such as: completion of an Interdisciplinary Care Team meeting, assisting an enrollee who has not been engaged in their care for a specified period of time to attend a Primary Care visit, assisting the enrollee to complete and submit MassHealth redetermination paperwork, and graduation from the program by an enrollee that has met all identified care plan goals.

We are in conceptual agreement on several other components, for which we have recommendations on how to successfully develop detailed processes and standards for implementation. We believe the following recommendations will improve the potential of achieving the Waiver’s goals:

- It will be extremely important for MassHealth to develop specific standards and requirements, to be embedded into their contract with the ACOs in order to ensure full collaboration and partnership with LTSS CPs and enable LTSS CPs to provide the scope of care and supports needed by participants.
 - Given the limited financial resources of CP programs, we recommend that panel-based regular payments need to support the basic CP operation prior to; downside risks should be limited in size.
 - While accepting the concept that incentives such as withholds or payments for achieving priority objectives must depend on ACO-CP partnerships, we recommend that MassHealth consider mechanisms to ensure that CPs are not penalized for below-benchmark performance due to ACO practices which adversely impact performance. This would possibly involve MassHealth

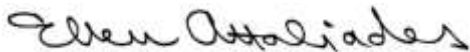
monitoring ACO reports which separate performance metrics for the ACO vs CP roles in selected processes (such as care plan completion dates) and ascribing portions of withholds or incentive payments to ACOs and CPs based on their respective performance to produce the aggregate result. We recognize this would involve MassHealth engaging representatives of ACOs and CPs to establish these guardrails.

- Adequate data trends should be considered before allocating funds from total revenue into risk sharing opportunities and incentives, based on collection of data for a period and risk-adjusting data benchmarks by populations served. It is not yet clear to our members as to whether an additional period of data collection is needed to develop data which would be useful for this purpose.
- If CPs are willing, ACOs and CPs should be allowed to negotiate risk sharing agreements within specifications to be set for the pay for performance and limited downside risks for CPs. MassHealth should consider specifications within ACO contracts as to how this might be planned, documented, monitored, and/or approved by MassHealth.
- We agree that the ACOs and CPs should be held accountable to nationally recognized quality measures when assessing outcomes and performance by the LTSS CP model.
- We support the proposal that MassHealth set consistent standards and benchmarks across all of the ACOs as withholds and incentive payments are considered. However, as evident in data published by Mathematica, the total cost of care for CPs varies significantly across ACO-CP partnerships.
- We look forward to continued conversations with MassHealth regarding what to consider as “high value” qualifying activities that could be incentivized for the LTSS CPs.
- MassHealth has developed robust risk adjustment methodology that takes into account medical conditions, disability, neighborhood stress score, and key social determinants of health factors. We recommend that benchmarks be risk adjusted to the extent that it is possible and meaningful. For example, cost and utilization measures could be risk adjusted. Process measures and screenings may be more appropriately applied across the board without risk adjustment. We recommend that MassHealth convene a workgroup of LTSS CPs and ACOs to provide specific input into the design of the benchmarks, payment models and incentives included in the LTSS CP RFP.
- We recommend that MassHealth includes detailed language within the Contract Management section of their formal agreement with ACOs that establishes specific requirements to ensure full and active participation in the LTSS CP delivery model and timely payment to providers.
 - Language outlined in the contracts EOHHS signs with both Senior Care Options (SCO) and One Care entities outlines specific Contract Management responsibilities maintained by EOHHS to ensure that the administration, performance and evaluation of the program aligns with all aspects of model design. Although MassHealth has proposed to delegate management of the model to the ACOs under this waiver extension, we recommend that MassHealth consider adding these specific contract requirements and continue to play an active role in the oversight of the model to ensure program fidelity and continued success.

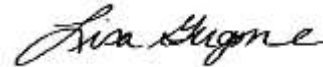
- To remain financially viable and provide the level of care coordination required to delivered quality outcomes, CPs need reasonable volume. ACOs should be required to provide a targeted amount of CP referrals and/or engagement representing a reasonable percentage of their eligible population. A proposed amount of 2% appears reasonable.
- While we understand that ACOs and MassHealth want to reduce the number of CPs with which an ACO must contract, ACOs should offer a minimum of 2 in each geography to provide choice. If an ACO should determine that a selected CP partner is non-performing, the ACO should be required to select a replacement to continue to offer choice to interested individuals or families.

Thank you for your consideration of this feedback, and for the collaborative engagement of our members in this planning process. We look forward to continuing to work with you in the next evolution of the LTSS CP Program.

Sincerely yours,



Ellen Attaliades
ADDP President / CEO



Lisa Gurgone
MHC Executive Director



September 17, 2021

Marylou Sudders, MSW, ACSW
Secretary, Health and Human Services
Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Asburton Place, 11th Floor
Boston, MA 02108

Re: 1115 Demonstration Extension Request

Dear Secretary Sudders:

On behalf of the American Heart Association (AHA), I would like to thank you for the opportunity to provide written comments on the Massachusetts 1115 Demonstration Extension Request for the MassHealth program. As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, we are pleased to see that the state continues to be committed to providing affordable healthcare coverage to all.

The AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care. Nationally, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease. Medicaid provides critical access to prevention, treatment, disease management, and care coordination services for these individuals. Because low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid serves as the coverage backbone for the healthcare services these individuals need.

We applaud Massachusetts' focus on health equity in this proposal and offering twelve-month and twenty-four-month continuous eligibility for incarcerated individuals and individuals experiencing homelessness, respectively, will improve continuity of care for individuals with the serious and chronic health conditions. However, the AHA remains concerned with the continued elimination of retroactive coverage for all non-pregnant adults as this does not meet the objectives of the Medicaid program and will instead continue to create administrative barriers that jeopardize access to healthcare for patients with serious and chronic diseases.

The American Heart Association would like to offer the following comments on the 1115 Demonstration Extension Request for the MassHealth Program.

Continuous Eligibility for Justice-Involved Individuals and Individuals Experiencing Homelessness

The AHA strongly supports the proposal to provide twelve-month continuous eligibility to individuals upon release from incarceration to facilitate re-entry transition, as well as offer continuous eligibility of twenty-four months for individuals with confirmed status of homelessness for a specific amount of time. This proposal will help these high-risk populations access critical supports needed to treat physical and behavioral health conditions. For example, studies in Florida and Washington 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.¹ This policy change will improve continuity of care for individuals with the serious and chronic health conditions. Continuous eligibility will reduce administrative burdens and promote health equity.

Retroactive Eligibility

Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. 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, such as cardiovascular disease, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

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 Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care because of the waiver.ⁱⁱⁱ Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs.

The American Heart Association is supportive of the reinstatement of 3-month retroactive coverage for pregnant women and children, however, the continued elimination of retroactive coverage for most other Medicaid beneficiaries does not promote the objectives of the Medicaid program and we request that MassHealth strongly consider reinstating 3-month retroactive coverage for all Medicaid beneficiaries.

The AHA applauds MassHealth for seeking to improve access to care by providing continuous eligibility for targeted adult populations, including the justice-involved and homeless population. Unfortunately, the continuance of eliminating retroactive eligibility for all non-pregnant adults does not advance the objectives of the state's Medicaid program and will continue to make care unaffordable or inaccessible to Medicaid patients. Therefore, we request that the State of Massachusetts extend retroactive eligibility coverage for all non-pregnant adults to three months. We stand ready to partner with you to further expand care for Medicaid recipients and offer our continued guidance and support as you review ways to implement additional actions to protect vulnerable populations. If you have questions or would like to discuss further, please contact **Alllyson Perron Drag, Massachusetts Director of Government Relations** at Alllyson.Perron@heart.org or 857-540-9686.

Sincerely,
Alllyson Perron Drag

ⁱ Joseph Morrissey et al. Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness. *Psychiatric Services* 57, no. 6 (June 2006): 809-815. DOI: 10.1176/ps.2006.57.6.809, and Joseph Morrissey et al. The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness. *Psychiatric Services* 58, no. 6 (June 2007): 794-801. DOI: 10.1176/ps.2007.58.6.794.

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 Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", *Modern Healthcare*, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

September 20, 2021

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108
submitted via email to 1115-Comments@mass.gov

To Whom It May Concern:

Please accept these comments on the proposed 1115 waiver extension on behalf of the Alliance for Community Health Integration (ACHI). ACHI is a coalition of public health, consumer advocacy, and social service organizations working together to harness the power of health care to improve social determinants of health and health-related social needs. We appreciate the partnership with MassHealth over the last three years as social needs screening, referral, navigation, and service efforts have been developed.

Models developed during this waiver period, such as the Flexible Services Program, provide great promise for improving the social needs of members and reducing health inequities in the coming years. With continued investment in Flex Services and the appropriate flexibility, we expect to see short, medium, and long term impacts. In other areas - such as demographic data collection and stratification - we have witnessed earnest efforts, but disappointing results and progress on critical infrastructure that is moving at an unacceptable pace.

The waiver extension provides an important opportunity to build on the successes of the current waiver, while bringing additional resources and attention to areas that need improvement.

Waiver Extension Proposal Puts Health Equity at the Center

We are extremely pleased with the focus on health equity embedded throughout the waiver extension proposal, including:

- The inclusion of health equity, with a focus on addressing health-related social needs, as one of five core goals of the waiver proposal.
- A strong commitment to the Flexible Services Program (FSP), including an investment of \$40 million/year¹ to address housing and nutrition needs of members.
- Increased access to FSP for pregnant and postpartum women, children, and families, including inclusion of childcare coverage to facilitate access to services.
- Coverage for family-level nutrition supports under FSP. This is one of the simplest but perhaps most important reforms in the waiver extension proposal. Evidence strongly suggests that food supports provided to one member are likely shared with the entire household, diminishing the

¹ According to "MassHealth 1115 Demonstration: Strategy for 2022 Extension" Slides, July 2021.

effectiveness of these supports to address food insecurity for any one member or household². Allowing family level nutrition support is a more effective and more humane approach, and is likely to lead to increased household food security and concomitant health benefits.

- Ambitious goals for demographic data collection (including addition of sexual orientation and gender identity data), stratification, and disparities reduction, including investment of \$190 million/year³ in health equity incentive payments to support these goals.
- Greater support for health-related social needs navigation as a requirement of the new primary care sub-capitation program.
- Expanded access to housing supports through the Community Support Program for individuals experiencing homelessness who do not meet the federal definition for chronically homeless, and those facing eviction related to disability status such as a behavioral health disorder.
- Continuous coverage during incarceration.

Changes Requested to the Waiver Proposal

We request three changes be made to the waiver proposal, which are necessary to fulfil the promise to truly address health equity. These requests address crucial infrastructure necessary to achieve the ambitious goals of the proposal:

1. Downside Risk For Demographic Data Collection and Stratification. Demographic data collection and stratification is at the core of understanding health inequities and tracking progress to close them. Progress in this area has been unacceptably slow and is hindering the ability of ACOs, MassHealth, consumers, and the public to understand and act to improve health equity, while limiting public transparency regarding the impact of public investments. We greatly appreciate the goals and intent of the proposed Health Equity Incentives (pp. 47-52 of the Section 1115 Demonstration Project Extension Request). Using incentive payments (upside risk) to improve demographic data collection and stratification is necessary, but not sufficient to ensure badly-needed system-wide reform. It is crucial that ACOs also bear downside risk for not meeting standards related to subcomponents one (data collection) and two (stratified reporting) no later than year two of the waiver period. We support the use of upside risk for ACOs that meet higher standards and which demonstrate progress in reducing identified inequities (subcomponent three). The exclusive use of upside risk in this program will continue the history of slow and uneven progress, undermining the health equity goals across the waiver proposal. Data collection standards should ensure that ACOs are not penalized for members that refuse to provide demographic information.
2. Improved Transparency and Public Reporting on Health-Related Social Needs. Public transparency of data related to social needs screening, referrals, and connection to social services has been lacking. The waiver renewal proposal includes language regarding public

² White JS, Vasconcelos G, Harding M, Carroll MM, Gardner CD, Basu S, et al. Heterogeneity in the Effects of Food Vouchers on Nutrition Among Low-Income Adults: A Quantile Regression Analysis. *American Journal of Health Promotion*. 2021 Feb;35(2):279-283. doi: 10.1177/0890117120952991. Epub 2020 Sep 3.

³ According to "MassHealth 1115 Demonstration: Strategy for 2022 Extension" Slides, July 2021.

transparency, but should be enhanced with specific commitments for the kinds of data that will be made available to the public during each year of the waiver period. This data is essential to monitor progress, glean lessons learned, and shape ongoing and future policy development. Examples of data that should be publically-available may include the number and percentage of members screened for health-related social needs by ACO, as well the number and percentage of ACOs meeting quality measures for data completeness. Additionally, for members not served by FSP, it will be important to understand potential barriers for ACOs to connect members to social services, including barriers that may be related to specific social needs domains, geographic regions, or subpopulations (e.g., primary language). Data should be made publicly available regarding the number and percent of members who successfully connect to a social service provider, of those who have screened positive for a health-related social need and who request a referral. Across all measures, data should be stratified by demographic factors in public reporting.

3. Participation of Primary Care, including Community Health Centers, in Health Equity Incentives. The current proposal provides incentives for ACOs and hospitals to reduce health inequities, but may not include primary care practices, including community health centers, which provide a crucial connection for a large proportion of MassHealth members to health and social services. Supporting these sites both within and outside of ACOs, including incentivizing additional systems transformation, is crucial to meeting the health equity goals of the waiver. These sites should be included in the Health Equity Incentives program described on pp. 47-52 of the Section 1115 Demonstration Project Extension Request.

These three changes are in alignment with the goals of the waiver extension proposal and would significantly enhance the ability of MassHealth, providers, and consumers to advance health equity.

There are numerous areas in the waiver proposal for which more details are needed and that will require additional policy development outside of the waiver proposal in the months to come. We plan to follow up with you to request additional conversation about several of these elements, and we anticipate offering additional recommendations in the future as more detail is made available through guidance, contracts, and presentations. Some of these areas include using contractual requirements or other mechanisms to set a minimum population and/or spend for each ACO on FSP; FSP evaluation methodology that accounts for medium to long term impact, especially for children; caution on standardization of Flex Services so as not to stifle innovation and experimentation; details on adequacy of primary care sub-capitation payments that support HRSN navigation supports and practice transformation; using contractual requirements or other mechanisms to provide support for community health workers, including adequate salaries and best practices for scope of practice that incorporate CHWs into decision-making; and establishment of a racial justice advisory board, as well as clear expectation for the establishment of infrastructure to address health disparities, e.g., health equity committees, strategic plans, health equity and anti-racism staff trainings.

We thank you for your commitment to advancing health equity, and we urge you to make these three changes to achieve these shared goals. We look forward to discussing these recommendations with you further. Please do not hesitate to contact us if we can answer any questions or provide any additional information.

Sincerely,

Jessica Aguilera-Steinert, Director of Health Services, **Action for Boston Community Development**

Tierney Flaherty, Director of Intergovernmental Relations, **Boston Public Health Commission**

Robert Greenwald, Faculty Director & Clinical Professor of Law, **Center for Health Law and Policy of Harvard Law School**

Carl Sciortino, Executive Vice President of External Relations, **Fenway Health**

Alex Sheff, Co-Director of Policy and Government Relations, **Health Care For All**

Jennifer Valenzuela, Chief People & Equity Officer, MA Exec Dir, **Health Leads**

Steven Ridini, EdD, President & CEO, **Health Resources in Action**

Lisette Blondet, **Massachusetts Association of Community Health Workers**

Victoria Pulos, Senior Health Law Attorney, **Massachusetts Law Reform Institute**

Maddie Ribble, Director of Public Policy, **Massachusetts Public Health Association**

Samantha Morton, CEO, **MLPB**

Jennifer Obadia, Senior Director Healthcare Partnerships, **Project Bread**

Jessica Collins, **Public Health Institute of Western MA**



September 20, 2021

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

Amanda Cassel Kraft, Assistant Secretary
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: AllWays Health Partners Comments in Response to the MassHealth 1115 Demonstration Waiver Extension Proposal-Public Notice

Dear Secretary Sudders and Assistant Secretary Cassel Kraft,

AllWays Health Partners is writing to provide feedback on the MassHealth 1115 Demonstration Waiver Extension Proposal (Waiver Extension) posted on August 18, 2021. We appreciate your engagement with all stakeholders as you are shaping the waiver renewal proposal and thank you for the opportunity to provide feedback.

We support MassHealth’s overarching goals proposed in the current Waiver Extension request. AllWays Health Partners, as long-time participant and partner with MVACO strongly aligns with MassHealth’s goal to move toward value-based care while continuing to support Safety Net Providers. MassHealth’s focus on health equity and eligibility policy enhancement will assist AllWays Health Partners and our ACO partner in making progress toward work we have already started. During this current waiver, it has become clear that improving the health and lives of our members in the Merrimack Valley will require continued support to advance health equity and address social determinants of health.

Additionally, we commend and fully support the Commonwealth of Massachusetts on its commitment to improve behavioral health care for our members through this waiver based on the *Roadmap for Behavioral Health Reform*. During this current demonstration period, our ACO partnership, My Care Family, has worked to address the behavioral health needs of our members through collaboration with Greater Lawrence Family Health Center behavioral health team, Behavioral Health Community Partners; Home Care Agencies and Acute Hospitals to optimize care our members receive.

While supporting the Waiver Extension, AllWays Health Partners would like to ensure that MassHealth allows for adequate time and resources that will be needed for the planning and implementation related to the multiple changes being requested in the Waiver Extension. Reasonable time and resources will be essential to successfully achieve these goals. Specific areas we have highlighted the for this consideration are:

- Establishment of a uniform pharmacy formulary.
- Establishment of primary care sub-capitation payment models that support enhanced care delivery expectations and provider flexibility;
- Alignment of the ACO model with the Commonwealth’s [Roadmap for Behavioral Health Reform](#) to expand behavioral health access and integration; and,
- Transitioning the Behavioral Health and Long-Term Services and Supports Community Partners program to a sustainable financing and accountable structure;

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company.

399 Revolution Drive / Suite 810 / Somerville, MA 02145 / allwayshealthpartners.org

Pharmacy Policy

AllWays Health Partners appreciates the collaborative pharmacy discussions during the waiver process. We believe the decision to allow plans to continue to work with existing pharmacy benefit managers (PBMs) properly is essential and aligns with goals improving member experience and coordinating care. As we prepare to implement the uniform pharmacy formulary, AllWays Health Partners looks forward to working with MassHealth to create a reasonable timeline and process that ensures an efficient transition that has minimal member and provider impact. Additionally, we would like to ensure that the uniform pharmacy formulary is accounted for prospectively in the capitation in a transparent actuarially sound manner, and that it reflects the underlying costs of our community health center pharmacies appropriately.

Behavioral Health

AllWays Health Partners supports Executive Office of Health and Human Services (EOHHS)/MassHealth vision for behavioral health, the *Behavioral Health Road Map*, as well as the supporting policy decisions outlined in the Waiver Extension proposal. We do believe that further integration of physical and behavioral health care will ultimately provide the best care for our members. We also support the Commonwealth's related initiatives to increase access to quality behavioral health care to ensure members receive the care that they need, when they need it. We encourage EOHHS to require practitioners who receive loan forgiveness to practice in underserved communities such as Lawrence. We also support the simplification of administrative processes (e.g., credentialing and implementing new benefits/services while preserving flexibility to create programs that meet specific needs of our unique membership). Similar to our concerns with the proposed pharmacy changes, we want to ensure that there is an efficient coordinated process between MassHealth and health plans to ensure that we can deliver on requirements in a timely fashion.

Primary Care Sub-Capitation Model

AllWays Health Partners supports the transition toward a sub-capitated model that encourages quality whole person care as a core belief. However, as MassHealth moves toward implementation of this model, AllWays Health Partners will need requirements well in advance in order to successfully implement this significant change to provider reimbursement. Additionally, we would request full transparency in setting primary care sub-capitation rates and plan medical base rates. For MCOs with primary care concentrated in FQHCs, MassHealth should consider the requirement to continue to reconcile provider reimbursement to actual utilization as rates are developed. We look forward to an ongoing collaboration with MassHealth with respect to appropriately financing this model and ensuring overall success.

Care Management

AllWays Health Partners appreciates MassHealth's efforts to standardize requirements for care management. However, it will be essential that we are provided with flexibility to tailor programs to meet the needs of our specific population and primary care settings which ensure effective and efficient care management programs.

We understand and appreciate MassHealth's efforts to align the Community Partners programs more closely with the ACOs. We will continue to work with the Community Partners to ensure collaboration on services and to avoid duplication. Additionally, AllWays Health Partners is a strong advocate for keeping the majority of care coordination at the primary care location in order to facilitate effective collaboration between care managers and providers. This collaboration fosters improved quality of care and member outcomes.

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company.

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AllWays Health Partners is looking forward to the continued improvements as outlined for the Flexible Services program. This program is critical in assisting us to directly address the significant health-related social needs of our population.

Finally, as DSRIP funding is discontinued, AllWays Health Partners requests that MassHealth ensure adequate administrative funding to continue valuable care management programs and invest in new programs envisioned to drive outcomes. These effective programs allow us to manage care, contain costs and most importantly, ensure that our most complex members receive the right care, at the right time.

Financing

During this current waiver, we fully appreciate the time and effort MassHealth has put into working with plans to refine the funding structure to improve sustainability of the ACO program. We would implore MassHealth to continue to increase transparency needed in rate development and risk adjustment models. As DSRIP sunsets and programs are funded through our base rates and administrative funding, we want to ensure that rates are adequate to support programs required by MassHealth. With an emphasis on reducing health equity disparities, we request that funding be increased for plans with members struggling disproportionately with social determinants of health. We also request that as MassHealth continues expand the market construct, factors unique to individual ACOs are accounted for in rate setting.

AllWays Health Partners is committed to working collaboratively with the Commonwealth of Massachusetts to address the goals set out in this Waiver Extension proposal which aims to improve the lives of our members. We appreciate the opportunity to provide comment and look forward to continued participation in a continually improving and successful MassHealth ACO program that benefits all consumers.

Thank you for the opportunity to provide feedback related to this thoughtful, forward-thinking Waiver Extension proposal.

Sincerely,

Steve Tringale
CEO AllWays Health Partners

Commented [MS1]: Sujata can you weigh in?

Commented [SS2R1]: I think this is fine. I think we should add something on SDOH.

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company.

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September 20, 2021

Marylou Sudders, MSW, ACSW
Secretary, Health and Human Services
Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Asburton Place, 11th Floor
Boston, MA 02108

Re: 1115 Demonstration Extension Request

Dear Secretary Sudders:

The American Lung Association in Massachusetts appreciates the opportunity to submit comments on the Massachusetts 1115 Demonstration Extension Request for the MassHealth program.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the more than 36 million Americans living with lung diseases including asthma, lung cancer and COPD, including more than 779,000 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, MassHealth, provides quality and affordable healthcare coverage. We applaud Massachusetts' focus on health equity in this proposal, and offering twelve-month and twenty-four-month continuous eligibility for incarcerated individuals and individuals experiencing homelessness, respectively, will improve continuity of care for individuals with lung disease. However, the Lung Association remains concerned with the continued elimination of retroactive coverage for all non-pregnant adults as this does not meet the objectives of the Medicaid program and will instead continue to create administrative and financial barriers that jeopardize access to healthcare for patients with serious and chronic conditions.

The American Lung Association in Massachusetts offers the following comments on the 1115 Demonstration Extension Request for the MassHealth Program.

Continuous Eligibility for Justice-Involved Individuals and Individuals Experiencing Homelessness

The Lung Association strongly supports the proposal to provide twelve-month continuous eligibility to individuals upon release from incarceration to facilitate re-entry transition, as well as offer continuous eligibility of twenty-four months for individuals with confirmed status of homelessness for a specific amount of time. This proposal will help these high-risk populations access critical supports needed to treat physical and behavioral health conditions. For example, studies in Florida and Washington 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.¹

This policy change will improve continuity of care for individuals with the serious and chronic health conditions. A gap in healthcare coverage could mean that a patient with lung cancer would have to pause treatment or someone with COPD might have to stop taking their medication, leading to an irreversible worsening of their condition. Additionally, continuous eligibility will reduce administrative burdens and

promote health equity. The Lung Association urges MassHealth to move forward with these expansions of continuous eligibility.

Retroactive Eligibility

Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. 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, such as lung cancer or COPD, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

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.² Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For patients with asthmas, this could result in not having emergency inhalers and ending up in the emergency department or newly diagnosed lung cancer patients having to delay their treatment.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.³ Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs.

The Lung Association is supportive of the reinstatement of 3-month retroactive coverage for pregnant women and children, however, the continued elimination of retroactive coverage for most other Medicaid beneficiaries does not promote the objectives of the Medicaid program. The Lung Association requests that MassHealth strongly consider reinstating 3-month retroactive coverage for all Medicaid beneficiaries.

Conclusion

The American Lung Association applauds MassHealth for seeking to improve access to care by providing continuous eligibility for targeted adult populations, including the justice-involved and homeless population. Unfortunately, the continuance of eliminating retroactive eligibility for all non-pregnant adults does not advance the objectives of the state's Medicaid program and will continue to make care unaffordable or inaccessible to Medicaid patients. The Lung Association in Massachusetts requests that the State of Massachusetts extend retroactive eligibility coverage for all non-pregnant adults to three months.

Thank you for the opportunity to provide comments.

Sincerely,

/s/

Trevor Summerfield

Director, Advocacy | MA, NY, VT

American Lung Association

O: 518-362-5055 | C: 518-414-1571

Lung HelpLine: 1-800-LUNGUSA

[Lung.org](https://www.lung.org) | Trevor.Summerfield@Lung.org

Preferred Pronouns: He/Him/His

¹ Joseph Morrissey et al. Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness. *Psychiatric Services* 57, no. 6 (June 2006): 809-815. DOI: 10.1176/ps.2006.57.6.809, and Joseph Morrissey et al. The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness. *Psychiatric Services* 58, no. 6 (June 2007): 794–801. DOI: 10.1176/ps.2007.58.6.794.

² 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>

³ Virgil Dickson, “Ohio Medicaid waiver could cost hospitals \$2.5 billion”, Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)



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ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE

September 20, 2021

EOHHS

Office of Medicaid, Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: ABH Comments on 1115 Demonstration Extension Request

To Whom It May Concern,

As you may know, the Association for Behavioral Healthcare (ABH) is a statewide association representing eighty community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily and 1.5 million residents annually, and employing over 46,500 people.

ABH's membership represents the Commonwealth's safety net for behavioral health with decades of experience and expertise serving MassHealth members. Approximately 75% of our members are Medicaid mental health centers. Our members represent approximately 1/3 of MassHealth's mental health center network. ABH also represents:

- 97% of MassHealth Community Service Agencies (CSAs);
- All current Behavioral Health Community Partners (BHCPs) - *More than 50% of ABH members are part of CP entities. ABH members also reflect a significant number of the Social Service Organizations (SSOs) managing the Flexible Services programs through partnership with participating ACOs; and,*
- A significant portion of the publicly-funded SUD treatment system across all levels of care:
 - 35% of ATS providers
 - 60% of CSS providers
 - 91% of TSS providers
 - 56% of RRS providers
 - 38% of SUD outpatient sites

Thank you for the opportunity to provide comments on MassHealth's *Request to Extend the MassHealth Section 1115 Demonstration*. On behalf of ABH and our members, we want to take

the opportunity to congratulate MassHealth on its truly visionary proposal, which once again showcases Massachusetts as a leader in healthcare innovation.

ABH and our members have greatly appreciated your partnership throughout the development and implementation of the current demonstration, which has led to the successful expansion of Substance Use Disorder (SUD) services, implementation of the BHCP Program, significant investment in the behavioral health workforce through DSRIP statewide initiatives (SWI), and fee floors for behavioral health services to better ensure providers are compensated at market levels.

We are particularly appreciative of the significant investments proposed for behavioral health care in this extension request, including continuation of the SUD waiver, continuation of the BHCP program, expansion of diversionary behavioral health services to MassHealth's fee-for-services members, service eligibility for incarcerated individuals and behavioral health workforce retention and diversity initiatives.

As we look toward the final 10 months of the current demonstration and plan for the proposed five-year extension, ABH offers comment on the following:

- **Health Equity**

ABH strongly supports MassHealth's commitment to prioritizing health equity. This critical work requires collective focus and effort across the entirety of the healthcare system. ABH supports the proposed incorporation of health equity in the ACO accountability framework including collecting, analyzing, and reporting on social risk factor data. We recommend this initiative be expanded beyond ACOs and ACO-participating hospitals **to all safety-net providers**, including community-based CPs, behavioral health centers, and health centers who are closest to the MassHealth members. As we understand the current proposal, ACO-participating hospitals will be receiving incentive payments totaling \$100 million annually and non-state owned public hospitals earning up to \$90 million annually. It appears the budget for all other equity payments annually totals approximately 40% of the hospital incentive payments. It is unclear what other provider types will be eligible for these equity payments, but **ABH requests that both the budget and providers eligible be expanded to include community-based providers.** By leveraging providers with long histories and expertise in serving the most vulnerable and under-represented populations in this initiative, we believe this effort will be more successful in collecting complete and accurate social risk factor data. The opportunity to earn incentives for the completeness of data collection and reporting and receive investments in data collection infrastructure should be expanded to community-based, safety-net providers that know these vulnerable and underserved communities. We appreciate that MassHealth has acknowledged the importance of investing directly in health equity work, and we respectfully request that MassHealth at a minimum directs equal investment to the community-based system if not equitable investment.

In addition to data collection and reporting, providers must be resourced to recruit and retain clinicians with linguistic capacity that meet the needs of the community, including services for children, families, and special populations including LGBTQIA+, the deaf and hard of hearing, and older adults. Since there are limited numbers of qualified bi-lingual/bi-cultural staff, hiring and retaining them has become a highly competitive process. As outlined further below, we fully support MassHealth's proposed student loan repayment

for behavioral health clinicians and psychiatrists. In addition to this critical program, MassHealth might look to the Massport Diversity Model which gives equal consideration and weight to a bidders' diversity as it does to other more traditional elements of the evaluation process. This may incentivize partnerships between ACOs and specialty behavioral health and other health care providers with expertise serving special populations.

- **Population Health**

To address health equity, as referenced above, it will also be critical that ACOs, CPs, and other providers, including the new Community Behavioral Health Centers (CBHCs), have the resources to further develop data collection and analysis. This includes continued access to timely claims data to further develop strategies and targeted interventions to promote population health. Through DSRIP funding, BHCPs have built the infrastructure upon which to further advance their data analytics capabilities. ABH strongly recommends MassHealth continue to provide claims data at an expedited rate to the health plans, BHCPs, and the newly created CBHCs and continues to invest in data capabilities across its provider network.

Additionally, a consequential gap in data for BHCPs has been the lack of SUD data. Only recently through Mathematica have BHCPs had a way to understand the prevalence of SUD within their BHCP populations. Even still, BHCPs do not receive individual-level SUD claims data needed to drill down to the member level and develop targeted interventions. BHCPs are also unable to use claims data to analyze impact on Total Cost of Care (TCOC) without SUD data. The work that many have done through Technical Assistance projects has been compromised by the lack of SUD claims. As noted in the recent Massachusetts Medicaid Policy Institute (MMPI) report on the MassHealth ACO program and opportunities for future success, while federal regulation pose obstacles to accessing this data, finding ways to work within or around these data limitations “is an essential step to ultimately making a measurable impact on health outcomes and total cost of care.” **ABH strongly urges MassHealth to identify a path forward to sharing this vital data with those entities responsible for complex care management as well as those delivering care under value-based or pay-for-performance arrangements.**

- **MassHealth Eligibility and Coverage Expansion**

Incarcerated Populations

Incarcerated individuals have a significantly increased incidence of mental health and substance use disorders, and they are 120 times more likely than the general population to die of an overdose, post release. Connecting incarcerated individuals to treatment through “warm hand-offs” and maintaining access to treatment while incarcerated is a critical step in addressing historic health and social inequities as the incarcerated population is disproportionately comprised of Black and Hispanic individuals.

ABH strongly supports MassHealth’s request to provide full, uninterrupted Medicaid coverage, inclusive of medical, behavioral health, and pharmacy services, to otherwise-eligible individuals during their incarceration and applauds MassHealth’s national leadership in this area. Additionally, we support MassHealth’s proposals to provide 12-months continuous eligibility for individuals upon release,

to ensure continuity of care and incentivize securing employment and additional social supports without fear of losing access to vital health care. Moving forward, we encourage MassHealth to look for ways to partner with providers and corrections facilities to facilitate transportation to treatment upon an individual's release.

Special Populations

ABH additionally supports MassHealth's proposals to expand targeted housing supports for members experiencing or at risk of homelessness (CSP-CHI and CSP-TPP), as well as coverage for pregnant and postpartum members, regardless of immigration status, and to update CommonHealth eligibility to include non-working disabled adults aged 65 and over. Providing increased supports to these vulnerable populations is critical to the state's work on health equity.

Housing stability is well-recognized as a critical social determinant of health. As noted in the MMPI report on the Community Support Program for People Experiencing Chronic Homelessness, persons experiencing housing instability face a number of barriers to accessing primary and preventative care, including lack of health insurance coverage, transportation, and challenges in meeting basic life necessities. As noted by MassHealth in the extension request, Black and Latinx people make up 9% and 12.4% of the state population, but disproportionately account for 34.8% and 40% of people experiencing homelessness. This is another area rightfully identified by MassHealth to focus health equity and social equity efforts. ABH additionally supports the 24-month continuous eligibility to individuals with a confirmed status of homelessness as this will improve access to services and continuity of care during a critical stabilization period. Similarly, we fully support initiatives around maternal health, including the proposed continuous eligibility for 12 months postpartum and extended access to Flexible Services, recognizing the fragility and importance of this period for both mother and baby.

- **Behavioral Health Workforce Investments**

Prescribers

ABH strongly and enthusiastically supports the proposed loan repayment program for psychiatrists working in safety net settings. We believe this will be extremely valuable, if not the most valuable tool, to the recruitment and retention of prescribers in the community-based system.

Recruitment of prescribers is essential to executing same-day and just-in-time prescribing contemplated in EOHHS's *Roadmap to Behavioral Health Reform*. Outpatient clinics struggle to find prescribers and must offer extremely high salaries and generous benefits to compete with hospitals and private practices. ABH members have reported that salary rates for psychiatrists have more than doubled over the past decade. In 2019, ABH members paid approximately \$300,000 for a full-time psychiatrist. For child psychiatrists, competitive salaries are even higher. The nurse practitioner salaries required to attract staff are close to what psychiatry salaries were a decade ago, approximately \$143,000 in 2019. This is another area in which cultural and linguistic diversity is essential to address health inequities, necessitating adequate funding to recruit prescribers who meet these criteria.

With the complex demands related to the populations served and the administrative requirements facing prescribers who may consider working in these settings, as well as

their high salary expectations, the ability to offer attractive student loan repayment programs to prescribers will be extremely valuable in both their recruitment and retention. This is critical to preserving and expanding the ability of the community-based behavioral health system to meet the needs of individuals in their community. Prescriber vacancies in the community-based system are very often the driver of wait lists for outpatient services. In FY19, 52% of ABH members reported wait times for children of more than one month for routine assessments with a psychiatrist/nurse prescriber and 60% reported wait times for adults of more than one month to see a prescriber. Hospital settings continue to pay on average 18% more than the community-based behavioral health system making it extremely challenging to retain such high-demand staff in the community-based system.

The CMHC Behavioral Health Recruitment Fund included in the DSRIP Statewide Investments (SWI) component has been met with enthusiasm. However, in practice, our members report it was not as impactful as anticipated due to the fact that the loan forgiveness amount was neither commensurate with the loan amounts prescribers incur nor sufficient to offset the value of moving to high compensation-settings such as hospital systems and private practice. We believe the proposed student loan repayment program will have substantially more impact. In addition, as has been observed in the Medi-CAL physician loan repayment program, this may help to attract and retain a more diverse psychiatry workforce. Of the 313 total awardees in the FY 2019-2020 cohort, 59% were persons of color, 54% were women, and 79% work in medically underserved communities.¹

Clinicians

ABH additionally strongly and enthusiastically supports MassHealth's proposed student loan repayment programs for behavioral health clinicians and particular focus on retention of clinicians with cultural and linguistic competence. This loan repayment program is an important step to retaining clinicians with cultural and linguistic competence in the field. Through the DSRIP funded SWI in the current demonstration, the student loan repayment program alone has provided 416 awards. That said, more than a third of loan repayment applicants have had to be turned away in the current program. The significant number of applicants highlights the value of this type of program in retaining the existing workforce. ABH understands that the retention rate from these programs is very high, and we anticipate that it would be highest for BH providers. In particular, this type of program helps make it possible for mission-oriented providers, many of whom come from diverse and often disadvantaged backgrounds, to continue to practice within their own communities and in community-based system.

Continuation of Other Successful Tools for the Safety Net

In addition, we urge more consideration be given to providing supplemental resources focused on growing this workforce and bringing more clinicians into the pipeline. As noted in the 1115 demonstration Independent Evaluation Interim Report, ACOs and CPs found the statewide investments (SWI) and different funding streams provided by the state extremely beneficial. In addition to loan repayment SWI, we strongly recommend MassHealth continue its Primary Care/Behavioral Health Special Projects Program and Investment in Community-based Training and Recruitment Program, inclusive of the Family Medicine and Nurse Practitioner Residency Training program, and the Workforce Development Grant Program. These programs have provided critical access to care and the loss of these programs as a retention tool for the community-based system is

¹ Data from CalHealthCares website: <https://www.phcdocs.org/programs/calhealthcares>

concerning.

- **Behavioral Health Integration**

ABH supports MassHealth's vision of behavioral health integration. Individuals and families should be able to access integrated healthcare in the setting most accessible and comfortable to them, inclusive of both physical health and behavioral health care settings.

We urge MassHealth to augment this vision to ensure that both primary and specialty behavioral healthcare are appropriately resourced to partner and to promote leveraging of the behavioral healthcare workforce. To be effective, primary care and behavioral health care integration must be bidirectional, incentivizing both primary care and behavioral health providers to draw from each other's expertise, rather than building parallel systems and further diffusing a strained workforce.

Without strategies that strongly encourage or direct partnership among primary care providers and specialty behavioral healthcare providers, we anticipate that the behavioral health treatment system will see increased workforce strain with expansion within primary care. The community behavioral health system already sees significant staff loss to less acute settings including schools, private practices, and state agencies and to other higher paying health care settings such as hospitals.

Existing integration financing models tend to be unidirectional with a singular focus on supporting primary care practices. Behavioral health providers must also be supported as the specialty providers that primary care practices can access for their members in need of more acute, longitudinal behavioral health care. This requires reimbursement mechanisms to engage in care integration models and activities. Financing of integrated behavioral health care should mirror financing of integrated primary care and, in keeping with the spirit of parity, there must not be payment differentials for the same services or combinations of services between primary care and community-based behavioral health settings.

Investment in primary care integration is not a substitute for specialty behavioral health care, including low barrier maintenance care in the community for individuals with chronic mental health, substance use, and co-occurring disorders. With increased build out of behavioral health competencies within primary care settings, anticipated to address mild to moderate behavioral health concerns, the community-based behavioral health treatment system will see higher acuity and need significant resources to attract and retain staff. In order to ensure robust delivery models, we believe the following are necessary:

- Program and payment regulations that do not prevent and that actively promote integrated care, including information sharing, population health, and delivery of primary care in behavioral healthcare spaces for individuals with Serious Mental Illness and substance use disorders;
- Payment and contracting levers that support the leveraging of the workforce willing to work in the safety net space;
- Student loan repayment for behavioral health professionals in the safety net to ensure a robust pipeline as well as retention of experienced staff to treat individuals with complex needs; and

- Rates for clinics that support evidence-based services delivered by staff that are well-trained and have robust supervision.

- **Behavioral Health Community Partners**

ABH ***applauds and appreciates the proposed continuation of the Behavioral Health Community Partner (BHCP) program.*** ABH endorses MassHealth’s plan for the CP program to continue to work with the current target population, maintain the current set of services and responsibilities, ensure CPs are community-based, provide minimum volume assurances, set a rate floor, and streamline and align performance goals.

BHCPs were envisioned to function as “feet in the street,” local community-based behavioral health experts with particular experience in engaging the hardest to reach individuals with SMI and SUD to improve health outcomes and reduce healthcare costs for this population. As referenced in MassHealth’s extension request to CMS, BHCP early indicators of success include a more than 3-fold increase in member engagement within the first year of the program.

Additionally, throughout the duration of the BHCP program, the vital need for coordination of Health Related Social Needs (HRSN) has been a key factor in working with BHCP-assigned members. Housing, nutrition, and other needs must be addressed to move BHCP-assigned members toward better health outcomes and reduced TCOC. Addressing an enrollee’s HRSN is often the most effective strategy for engaging them, positioning the BHCP to then assist them with addressing physical health and behavioral health needs. Once HRSN needs are met, the BHCPs work to keep individuals in the community and out of the hospital, aiming for increased utilization of community- based primary care, behavioral health, and other specialty services; reduction in ED visits and inpatient hospitalization, both medical and behavioral health; and medication management.

As MassHealth plans for re-procurement of the BHCPs, we re-emphasize the need for a continued strong focus on community connectedness and population expertise, and ensuring the following:

- statewide access to CP services;
- established community embeddedness;
- demonstrated competencies in serving individuals with complex BH needs;
- strong cultural and linguistic competence in serving the target population(s); and
- sufficient MassHealth member participation for sustainable services.

BHCP Program Standardization and Guardrails. As BHCPs become material subcontractors to ACOs, ABH reiterates our concerns that this will lead to greater administrative complexity, potential for wide variation in the BHCP service model, and less consistency in member experience.

ABH strongly recommends that MassHealth develop specific guardrails for the BHCP program, including but not limited to the following:

- Predictable volume for each BHCP, not just aggregate volume minimum for the program
- Monitoring of ACO assignment to enhanced care coordination programs by requiring reporting from ACOs, stratifying the following data elements by program type (CP Program and the ACO Complex Care Management program) to compare referral volume and performance:
 - Referral number and percent
 - Percentage of in- person visits with enrollees, e.g. percent of Enrollees with in- person visits and percent of visits that are in- person.
 - MassHealth Rating category
 - Quality Measures
- ACO reporting on BHCP claims payment timeliness and monthly referral volume to BHCPs.

In addition, ABH recommends the following standardization:

- Common definitions including *high risk, rising risk, and population health*;
- Material subcontract across all ACOs with standardized requirements (e.g., related to enrollment and dis- enrollment processes, eligibility management processes, real- time ADT feeds, Transitions of Care, Care Plan Sign Off within 7-10 days, care plan escalation), and enforceable claims processing timeliness standards;
- File Specifications;
- Monthly referral cadence; and,
- Reporting requirements.

BHCP Accountability Framework. ABH recommends that for reasons of simplicity, measuring success, and scaling successful initiatives, MassHealth and ACOs align quality and performance measures and reporting. Leaving ACOs, MCOs, and CPs to develop individual accountability frameworks will make it challenging to scale initiatives, compare results across the CP program, and set priorities.

ACCS population. We understand that MassHealth will continue to offer this critical support to individuals in Adult Community Clinical Services (ACCS) and look forward to additional details. We likewise recommend MassHealth consider expanding BHCP to the broader Fee-For-Service population.

- **Specialized Care Coordination**

ABH strongly supports MassHealth’s recognition of the special needs of certain high-risk populations, including its request to build upon the success of CSP for members with justice involvement (CSP-JI) and add CSP for Homeless Individuals (CSP-

HI) and the CSP Tenancy Preservation Program (CSP-TPP). These targeted, intensive case management and outreach services have shown great promise in reducing health care costs and keeping individuals healthy and in their communities. As MassHealth has rightly recognized, an individual's health related social needs, such as housing, must be addressed and stable in order for an individual to get and remain healthy.

- **Flexible Services**

ABH strongly endorses the continuation and expansion of Flexible Support Services. We reiterate our recommendation that CPs, given their significant role in identifying Health Related Social Needs and expertise in connecting members to social services, be able to directly access flexible services funding for their assigned members. In addition, given the significant care coordination expectations outlined in the CBHC Payment RFI, we recommend CBHCs have access to these supports.

We strongly support MassHealth's requested changes to allow nutrition supports to extend to a MassHealth members' household, acknowledging the impact that will have on the individual's health; to allow Flexible Services to be used for childcare when it is a barrier to accessing and engaging in health care and/or social supports; and allowing Flexible Services to serve postpartum members for 12 months.

- **Expansion of Diversionary Behavioral Health and Substance Use Disorder Services**

ABH strongly supports MassHealth's proposal to extend certain diversionary services to the fee-for-service population and increase benefit alignment between the Section 1115 Demonstration and the Medicaid State Plan, including:

- Program of Assertive Community Treatment (PACT),
- 24-hour diversionary services (e.g., Community Crisis Stabilization (CCS), Acute Treatment Services for Substance Abuse (ATS), Clinical Support Services for Substance Abuse (CSS),
- Community Support Program (CSP) and CSP for Chronically Homeless Individuals,
- the proposed specialized CSP programs,
- Structured Outpatient Addiction Program (SOAP), and
- Intensive Outpatient Program (IOP).

We urge Masshealth to consider including community-based Partial Hospital Programs (PHP) in the diversionary services to be extended to the fee-for-service population. While this is a small network, the services provide critical supports to those individuals who are able to access it and provide an important alternative to inpatient treatment as individuals stabilize.

ABH anticipates that universal access to service types for all MassHealth members, regardless of aid category or benefit type will improve the health and outcomes of individuals enrolled in MassHealth fee-for-service.

We reiterate our recommendation that ICC, Family Partners, In-Home Behavioral Services, and Therapeutic Mentors services be extended to youth who have MassHealth Family Assistance.

- **SUD Continuance of Service Expansion**

ABH strongly endorses the proposed continuance of the service expansion and coordinated care framework in the current demonstration, as well as the request to extend coverage of ATS and CSS to the fee-for-service population. We continue to greatly appreciate the Baker Administration's leadership in this area.

The MassHealth 1115 waiver expansion for diversionary SUD services has increased the recognition of the publicly-funded addiction treatment service providers and the important role they play in the Massachusetts health care system, which ABH and its provider members greatly appreciate.

Co-Occurring Enhanced Residential Rehabilitation Service (COE RRS) beds significantly increased the system's capacity to provide enhanced specialty services to people with mental health and substance use disorders. There is always a high demand for admission to these specialty services, and they have been a welcome addition to the treatment ecosystem.

Likewise, the incorporation of Recovery Coaches (RCs) and Recovery Support Navigators (RSNs) as covered MassHealth services has significantly advanced and promoted the importance of peers, and the value they bring to the addiction treatment system. The demand for trained and certified Recovery Coaches/Recovery Coach Supervisors and Navigators continues to exceed the supply, as they are also in high demand in other sectors (ERs, law enforcement) that pay higher wages. MassHealth should take this labor market pressure into consideration when considering when and where to expand these critical recovery resources.

Finally, ABH looks forward to continuing our work with MassHealth and other stakeholders to strengthen the SUD diversionary services system. By increasing the clinical capacity in levels of diversionary care, the system will be able to better address and treat the multiple complex needs of the patients entering SUD treatment.

Again, thank you for the opportunity provide comment on MassHealth's Section 1115 demonstration extension request. We are grateful for your consideration.

Sincerely,



Lydia D. Conley
President/CEO



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September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted Electronically

RE: Comments on Demonstration Extension Request

Dear Acting Assistant Secretary Cassel Kraft:

I am writing to provide comments related the Section 1115 Demonstration Project Extension Request on behalf of Atrius Health, Inc. ("Atrius Health"). Atrius Health is a non-profit, multi-specialty, value-based group practice that cares for more than 705,000 adult and pediatric patients across eastern Massachusetts. Our practice is not affiliated with a hospital system, and value-based primary care is at the center of everything we do. Atrius Health applauds the goals outlined in MassHealth's extension request, especially Goal 2 ("Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care") and Goal 3 ("Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals").

While we support the goals MassHealth has articulated, we believe that the investments in primary care outlined in the demonstration fall short of a full commitment to transforming the delivery system. We would like to offer comments for your consideration related to primary care investment and opportunities for further model refinement, as we take this opportunity to reflect on the progress of the past five years and identify opportunities for improvement for the next five.

Primary Care Reform and Investment

Atrius Health supports the state's desire to make targeted investments in primary care and behavioral health as outlined in the Extension Request (pp. 35-41). Such an approach could represent an important step towards realizing Governor Baker's vision to shift delivery system financing away from facility-based care towards primary care. However, while the details of actual funding opportunities are not yet clear, we do not believe that the proposed overall level of funding goes far enough to meet Goal 2 or is sufficient to support the level of investment required to implement the delivery system changes contemplated in the extension request. We urge you to consider a more significant re-balancing of funding between primary care and facility-based care to more directly support these primary care goals.

We specifically recommend an approach more in line with Governor Baker's prior proposal in "An Act to Improve Health Care By Investing in Value" to increase primary care and behavioral health spending by 30% while containing overall spending within HPC targets for overall spending growth.

In relation to the specific elements of the primary care sub-capitation proposal, we support the state's focus on care delivery expectations related to behavioral health integration; care coordination and health-related social needs; the unique needs of children, youth, and families; and expanded access. When fleshing out program specifics, we urge EOHHS to consider the following:

- We urge the state to provide additional details for stakeholders to better understand how proposed primary care payments and requirements will be operationalized;
- We strongly encourage EOHHS to continue to accept feedback and collaborate with ACO stakeholders in the design of these requirements, which, when implemented, will have a significant financial and operational impact on primary care providers;
- In crafting specific model requirements, we urge the state to adopt standards that prioritize ACO flexibility in achieving EOHHS goals, recognize existing ACO capabilities and limitations rather than offer overly prescriptive solutions, and seek wherever possible to minimize unnecessary administrative burden so that primary care organizations can focus their energies on delivering outstanding care.

We look forward to continuing to collaborate with EOHHS and our fellow ACOs in the design of this program.

Further Refinement Opportunities

The MassHealth ACO model initiated in 2018 was intended to re-orient the system on a value-based care model, but several features of the program created barriers to success for those providers that have historically invested significantly in value-based primary care and achieved high levels of historical performance. The MassHealth Delivery System Restructuring 2019 Update Report confirms that physician-led ACOs such as Atrius Health offer the lowest relative cost of care compared to market average, after adjusting for price of service and member acuity. However, the pricing models adopted by the state, including the network variance factor, have actually reduced payments to lower-cost ACOs rather than providing surplus value to offset the high costs of investing in robust primary care models. We welcome progress that has been made in migrating away from this payment model and encourage additional efforts in shifting towards a system that more fully recognizes and values the investments made by primary care practices to achieve high levels of efficiency in care delivery.

In addition, while the state relies heavily on facility-based funding streams to offset inadequacies in Medicaid reimbursement, these measures do not impact non-hospital affiliated providers such as Atrius Health, despite the fact that these organizations consistently lead the state in managing cost and minimizing low-value care. We ask that you allocate system supports in a way that strikes an equitable balance between practices associated and not associated with hospital systems, advances the goals of nurturing a high-performance primary care network, and recognizes the unique value and challenges specific to non-facility affiliated physician practices such as Atrius Health.

Finally, the ability of ACOs to focus on and be fairly compensated for managing our patients has been severely challenged by the manner in which the state has deployed its risk adjustment model. The extreme volatility and frequent model changes that we have experienced create high levels of uncertainty, significant economic impacts, and draw resources away from care-focused activities. By reducing uncertainty, a more transparent, less volatile risk adjustment program will incentivize ACO investment in care delivery changes and yield greater program sustainability. As EOHHS examines program features in this new waiver period, we urge refinements to the risk adjustment model prioritizing transparency and stability.

Thank you in advance for your consideration. We would be delighted to discuss this further with you at your earliest convenience. If you have any questions please contact Kathy Keough, Director of Government Affairs, at (617) 347-1455.

Sincerely,

Steven Strongwater, MD
President and CEO, Atrius Health

Cc: Marylou Sudders, Secretary, EOHHS



September 20, 2021

Amanda Cassel Kraft
Assistant Secretary (Acting), MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Acting Assistant Secretary Cassel Kraft:

Beth Israel Lahey Health (BILH) appreciates the significant work the Executive Office of Health and Human Services (EOHHS) has put into compiling the 1115 Demonstration Waiver Extension Proposal and we appreciate the opportunity to provide our comments and feedback. BILH is supportive of the goals EOHHS has delineated in the proposal, and as an integrated healthcare system, we are aligned with the objectives outlined in the Waiver. BILH is also very pleased to see MassHealth's focus on creating a framework across Accountable Care Organizations (ACOs) that is explicitly focused on addressing health equity; this focus closely aligns with BILH's work aimed at eradicating disparities in health outcomes throughout our diverse patient populations.

The Beth Israel Lahey Health Performance Network (BILHPN) has been leading BILH's participation in MassHealth's ACO program. Our two ACOs (Tufts Health Public Plan Together with Beth Israel Deaconess Care Organization and Lahey, which partners with both Tufts Health Public Plan and Boston Medical Center Health Plan) were created at the program's inception and collectively serve approximately 55,000 MassHealth members. As participants in the MassHealth ACO program and other accountable care models, we share MassHealth's belief in the philosophy and potential of a coordinated, high-quality, value-based care model.

We are especially pleased that through the proposed Waiver extension request, MassHealth is reinforcing its commitment to serving the needs of its members, while strengthening the sustainability of its payment model. There are a number of areas to which we would like to call attention, and in some instances, suggest adjustments or improvements for MassHealth to consider in order to improve quality and health outcomes, reduce cost, and ensure sustainability of the model.

Primary Care Sub-capitation and Tiering

BILH believes that primary care is the foundation of a solid medical home and supports the creation of a primary care sub-capitation program. This program would replace the traditional fee-for-service payments for defined primary care services with a payment model that allows for flexibility to determine how to best meet member needs, including by creating teams that provide supports beyond those medical providers have traditionally been able to offer.

BILH further supports MassHealth's proposed tiered approach to the sub-capitation model that lays out differing expectations of integration within primary care and enables providers to participate at varying levels of readiness. We encourage MassHealth to work with participating ACOs to define the tiers in a manner that maximizes participation and provides a glide path and upfront financial support for practices to transition to higher tiers with greater integration of services over time. In particular, BILH encourages MassHealth to consider:

- Defining Tier 1 in a way that enables all primary care practices to participate in the model from day one.
- Creating a pathway for advancement from one tier to the next (e.g., providing upfront payments for practices that need to build infrastructure and hire new roles).
- Allowing for the use of telehealth (through all modes) to meet certain requirements within all tiers (including behavioral health and other integrated services). Provision of services via telehealth is critical to enabling member access to a broad array of services in a manner that is more flexible and accommodating to our members. Additionally, telehealth supports practices that may not have significant volume or demand for certain services to be able to provide access to services that might not otherwise be possible due to low volumes. Telehealth also serves as a way to extend professional clinical expertise as we face mounting workforce shortages across all areas of healthcare.
- Allowing urgent care services integrated within the same health system to meet access standards for extended hours. For example, BILH has the ability to provide a member with access to care through the BILH network of urgent care centers, staffed by BILH providers who utilize and have access to shared EMRs. BILH urgent care centers have an established set of protocols ensuring the care received at the urgent care centers is incorporated into a patient's care plan, thus

ensuring continuity and the seamless collaboration of care and information with a patient's providers.

- Basing Tier 1 design on the evidence-based Collaborative Care Model, which has increased access to behavioral health services in the primary care office by supporting care delivery, coding, and payment for specific services. Establishing a base level that incorporates the Collaborative Care Model will allow for capitation payments that appropriately account for and fund existing COCM care delivery, as well as additional critical services.
- Ensuring payments cover the expense and added burden of creating a team-based primary care model and account for additional services that will be provided (e.g., medication assisted treatment, medical management of higher acuity diagnoses, increased time spent on provider-provider consultations), as well as the requisite training and team restructuring necessary to facilitate such services;
- Providing up front funding to enable practices to move meet Tier 1 requirements and evolve to higher tiers, improving the integration of behavioral health care with primary care including community health workers (CHW) and peer roles within primary care.
- Ensuring additional non-medical payments to ACOs account for the additional costs associated with administering prospective sub-capitation payments to participating practices.

If the sub-capitation model is based on historical performance, we encourage MassHealth to make adjustments to reflect reduced utilization during the pandemic, as well as to take all steps possible to improve the accuracy of both attribution and risk-adjustment methodologies to ensure appropriate distribution of funds at the practice level. Additionally, it is critical that MassHealth provide (1) specific, itemized CPT and HCPCs code-level detail on those services included in the sub-capitated rate, (2) how services will be added or removed as necessary (e.g., novel services such as COVID testing and vaccinations), as well as (3) transparency with respect to how rates are adjusted to account for increased expectations on primary care (e.g., enhanced team-based care including behavioral health).

Care Coordination

With primary care as the foundation of the medical home, BILH believes that high-quality care coordination serves as the critical connection to facilitate transitions between different parts of the healthcare system. BILH appreciates the attention

MassHealth has paid to the nuances associated with successful care coordination as well as acknowledging that patients require different levels of care coordination based on their biopsychosocial needs. We support the proposed three-tiered framework that continues to involve Community Partner (CP) engagement as appropriate for member needs, while simultaneously recognizing the importance of having an identified “lead” entity to avoid member and provider confusion as well as duplication of efforts and spend. BILH encourages MassHealth to consider the following as it refines the details of its care coordination expectations:

- Baseline care coordination, including foundational supports such as an assigned primary care clinician and appropriate care needs screenings and referrals is fundamental for all patients. However, BILH believes that assistance with all transitions of care may not be needed and that a more appropriate use of scarce resources would be to require that all patient transitions of care be evaluated for the need for assistance. Enhanced care coordination for high- and rising-risk patients from ACOs and CPs is an important component for effective population health management. BILH believes that ~10% (possibly as much as 20%) of the population should be evaluated for enhanced care coordination and the ACO along with their CP and other partners should determine whether to engage the patient with enhanced care coordination services.
- Enabling a CP partnership that balances the need for accountability and standardization with the flexibility to build mature, trusted collaboration and partnership between the CPs and the ACO providers that will maximize collaboration for the member. It has been BILH’s experience that the patient, provider, and CP experience are maximized by incenting collaboration that incorporates CPs with ACO providers in decision making related to patient-centered treatment planning. This includes deliberative activities like joint patient rounding where patient case review leads to shared decision making with a clear understanding of capabilities and responsibility for action for the identified patient.
- Supporting flexibility and innovation within the program related to care coordination for targeted populations, MassHealth should afford the ACOs flexibility in identifying the need for care management, including transitions of care support and Community Partner involvement, to allow for the clinical judgment that is critical to member care;
- Continuing the Behavioral Health Community Partner's program with an emphasis on predictable volume, not just a volume minimum for the program.

- Making daily pharmacy claims feed available, either from MassHealth or partner MCOs, to support rapid appropriate identification of need for care coordination or management.
- Allowing ACOs and CPs to determine via contract terms which entity will serve as the lead, based on member needs;
- Providing adequate administrative funding rates to sustain intensive care coordination efforts that are not otherwise billable;
- Ensuring additional non-medical payments to ACOs account for the additional costs associated with administering payments to Community Partners.

Behavioral Health

With primary care as the foundation of the medical home and care coordination as a critical connection tying to the various parts of the healthcare system together, behavioral health is the essential set of services critical to providing the whole patient care. BILH is encouraged that MassHealth is pairing the 1115 Waiver renewal request with the Commonwealth's Behavioral Health Roadmap. The wide spectrum of services within behavioral health are in increasing demand and BILH has been focused on expanding and integrating behavioral service delivery in numerous community and home based settings in addition to our primary care practices.

BILH has been committed to the collaborative care model for many years. To date we have integrated it into more than half of our employed practices, providing patients with immediate access to psychiatric services directly from their PCP office. Through this experience, we have found that it takes a good deal of work to effectively enable a primary care practice to build the skills to seamlessly incorporate these services into their practices. We appreciate MassHealth's acknowledgment of the Collaborative Care Model with its emphasis on persons with mild to moderate behavioral health conditions. As PCP practices are expected to provide behavioral health services to a larger and more acute population, we will need flexibility and financial support to effectively incorporate new staff roles and more intensive service delivery within a primary care practice.

We are pleased and very supportive of MassHealth's commitment to increasing access to behavioral health services; these efforts will be critical to the sustainability of a delivery care and payment reform model that relies on both clinically appropriate reductions in acute care utilization and increased management of behavioral health within primary care. To ensure this is successful, BILH encourages MassHealth to consider the importance of:

- Incentivizing appropriate coordination between newly created Community Behavioral Health Centers (CBHCs) and ACOs, without being overly prescriptive about how entities collaborate to better manage member care;
- Providing clarity on how benchmarks and thresholds are defined and developed, ensuring that an appropriate quality measure vendor is fully engaged in the process, and providing for a minimum of two years of measure development and a one-year reporting-only time period prior to incorporation into the payment methodology beyond pay-for-reporting;
- Continuing to provide expedited claims data to behavioral health CPs and CBHCs when they are operational and continue to work towards including SUD data in order to understand the total cost of care.
- Adequately funding new and existing covered services, in part to ensure workforce adequacy and sustainability; and
- Developing innovative strategies to support recruitment and retention of a diverse workforce.

Behavioral Health Workforce

In the proposed Behavioral Health Redesign, the CBHC will need to enhance services to ensure access is available 24 hours per day, 7 days of the week. Meeting this important access goal will require an innovative and adaptable approach to secure and retain a significant increase in the behavioral health workforce. The proposed loan forgiveness program for psychiatrists and behavioral health clinicians will be very helpful; it is one piece of numerous efforts that will be needed to ensure adequate workforce exists to support the important initiatives proposed in the Behavioral Health Roadmap. We would like to see continuation of the Primary Care/Behavioral Health Special Projects Program and Community Based Training and Recruitment Program that was inclusive of other behavioral health disciplines and served as a pipeline for workforce development.

BILH supports how MassHealth has echoed EOHHS' emphasis to expand efforts to provide culturally competent and responsive care. Achieving the important objectives of providing culturally and linguistically appropriate services depends directly on providers' ability to recruit and retain bilingual and culturally diverse staff. We strongly recommend consideration be given to the recruitment and retention costs of clinicians with cultural and linguistic capacity who meet the needs of the community, including services for children, families, and special populations including the Deaf and Hard of

Hearing. This includes flexibility to provide salary differentials to attract bilingual clinicians and peer staff or to help attract staff to work overnight shifts.

Diversions Services, Substance Use Disorder Services and Justice Involved Populations

BILH has long been committed to offering patients a wide spectrum of behavioral health services across various settings throughout the EDs, community, schools, homes and clinics. This includes diversionary and substance use disorder services, an area of care with a sharp increase in demand. BILH is appreciative of MassHealth's continued support and expansion of access to these services for the fee-for-service population and we look forward to continuing to partner with MassHealth on providing this crucial care.

We also feel uninterrupted MassHealth coverage for those who are incarcerated which continues for 12 months upon release is an important investment. This initiative will reduce barriers to those seeking care upon their release, which is especially important given the substantial risk of fatal opioid overdose post incarceration.

Health Equity Incentives

BILH strongly endorses MassHealth's efforts to improve health equity across the Commonwealth by engaging providers and payers to better measure, address, and reduce health-related disparities. MassHealth's plan to identify target metrics, from which ACOs will be expected to perform on a given subset of prioritized inequities, will provide the market with the flexibility necessary to invest in initiatives in a community appropriate manner. To ensure emerging health equity incentives are successful in reducing disparities in health outcomes, BILH encourages MassHealth to consider:

- Engaging providers in the development of clearly defined benchmarks and thresholds;
- Ensuring an appropriate quality measure vendor is fully engaged in the process
- Providing for a minimum of two years of measure development and a one-year reporting-only time period prior to incorporation into the payment methodology beyond pay-for-reporting;
- Incorporating the collected health equity-related data into the risk adjustment model to ensure that funding follows the population health needs;
- Ensuring capitated rates or non-medical funding sources are adequate to support the additional resources necessary to address disparities in health outcomes

- Providing funding for the interim investments necessary such as adjusting data capture capabilities
- Providing payments to other community providers who traditionally serve MassHealth clients and where overlap with an ACO may not exist; and
- Developing interim process measures that enable the state and its participating ACOs to pivot quickly as we collectively work towards long term change.

Given the importance of adequately supporting systems to effectively-impact disparities in health outcomes, and the limitations on the current risk adjustment methodology to account for such disparities, BILH strongly encourages MassHealth to invest additional resources into strengthening this model. While a deliberate effort to pursue this work and move toward more standardized data collection and assessment is important, equally important will be keeping the patient or member experience at the forefront as we delve into this work. Ensuring practices have the time and resources available to build the capacity and sensitivity of frontline practice staff to inquire about and document patient information such as race, ethnicity, language, sexual orientation, gender identity and highly personal social risk information can make the difference between simply having an effort to collect data and capturing information that informs impactful interventions at the population level.

Flexible Services

BILH is pleased that MassHealth will continue to support the Flexible Services Program. To date, BILH has helped approximately 400 members receive either Housing Support, Nutritional Support, or a combination of both. BILH agrees that there is an opportunity to be had by increasing the availability of services to other individuals in the household, especially children.

BILH appreciates MassHealth's focus on supporting members' needs relative to housing, nutrition and childcare. Our experience has shown us that these are key areas of need. We have also seen a significant need to support members in improving the quality of their current housing to help address health and medical concerns, as well as significant need to provide transportation assistance to help patients access services.

Pharmacy

BILH appreciates the attention MassHealth has paid to the import of the role of pharmacy in the 1115 Waiver Extension and state plan amendments. BILH has dedicated efforts to providing enhanced and more integrated pharmacy support to our patients and our clinical practices across all service areas, including behavioral health. We have experienced firsthand the benefit of medication management, data sharing that helps inform care management to better support a patient's medication adherence, and the benefit of having a pharmacy team that has direct access to a patient's EMR to help provide input to the care team and to patients with the full knowledge of a patient's care and medication history. BILH appreciates MassHealth's efforts to streamline and standardize its pharmacy benefit program across its fee-for-service and managed care programs through the implementation of a unified formulary, thereby simplifying the process for prescribing medications across the Medicaid population and reducing the need for medication shifts for members who change Medicaid providers or plans. Ideally, the implementation of an expanded, unified formulary will reduce or stabilize overall prescription drug costs to the state, despite the significant trend in prescription drug spending.

As a 340B provider, BILH is committed to providing these enhanced pharmacy services and integration to our patients. We have seen the utilization of medication increase and we have seen how they can dramatically impact a patient's life, from a one-time dose of a targeted life-saving drug to a long-term prescription for management of numerous chronic diseases, including behavioral health diagnoses. BILH has worked to meet this increase in pharmaceutical demand with services to support our patients and providers, engaging pharmacists in data analysis and care management. Of critical importance to BILH is ensuring our patients have access to BILH pharmacies and the benefits they provide as an integrated care provider over other retail pharmacy settings.

As MassHealth further develops the pharmacy reimbursement model proposed in the 1115 waiver, we hope MassHealth will ensure payment to 340B provider pharmacies will not result in a negative financial impact to 340B retail pharmacy providers and that any reimbursement rates will sufficiently cover the cost of acquiring drugs and providing services to MassHealth members that are crucial to supporting the objectives of the accountable care model. We recommend that MassHealth consider:

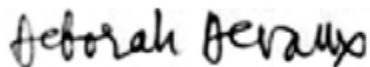
- Accounting for the impact of a unified formulary and formulary updates in the rate setting process, such that changes do not unintentionally and negatively impact provider budgets;
- Sharing the impact of the unified formulary and formulary changes on net pharmacy spend and trends, for MassHealth overall, and for each participating ACO; and
- Creating a more transparent formulary development process through expansion of MassHealth's Pharmacy and Therapeutics Committee to include input from all impacted provider organizations.

Financial Framework

Critical to the success of the ACO program and the shared goals MassHealth has reinforced in this Waiver proposal will be the assurance that it is built on a clear, equitable and sustainable financial framework that appropriately reimburses participants in the programs. BILH appreciates MassHealth's attention to this and the engagement in active dialogue with the provider community on the parameters of this financial construct. We look forward to continued discussions and a constructive outcome.

BILH thanks the Baker-Polito Administration for its unwavering commitment to delivery system reform in Massachusetts and this opportunity to provide comments on the proposed 1115 Extension Waiver. We look forward to continuing to work together to ensure the long-term success of the MassHealth ACO program, and the associated sustainability of affordable, high-quality care across the Commonwealth.

Sincerely,



Deborah Devaux
Executive Vice President, Chief Population Health Officer

Boston Medical Center Health System comments on MassHealth's Draft 1115 Waiver Renewal

September 20, 2021

I. Introduction

As a health system that both relies on MassHealth as its largest payer by far and a system that serves as one of the most significant entities in the MassHealth Accountable Care Organization (ACO), Managed Care Organization (MCO), and fee-for-service programs, Boston Medical Center Health System (BMCHS) has an enormous interest in, and role to play in the administration of the Medicaid program in Massachusetts. There is no single document that has a greater impact on our health system and the patients and members we serve than the 1115 Waiver Demonstration Project ("1115 Waiver"). Therefore, BMCHS appreciates the opportunity to comment on the Commonwealth's draft 1115 Demonstration Project extension request, as posted for public comment on August 18, 2021.

We want to acknowledge that this public draft is a significant milestone in the tremendous amount of work being done by the Massachusetts Executive Office of Health and Human Services (EOHHS) staff, including a robust engagement process to get input from all MassHealth stakeholders including members, advocacy organizations, providers and trade associations. We want to start by commending the Commonwealth's stated goals for the next waiver term, which are well aligned with the mission and daily work of BMCHS. In particular, we want to thank the Commonwealth for committing affirmatively to addressing health equity in the next waiver term as well as reiterating the commitment to ensure the sustainability of the Commonwealth's safety net providers.

During the last waiver renewal, the Commonwealth set the ambitious, but necessary goal of substantially reforming how health care is delivered to over a quarter of Massachusetts residents by aggressively aligning incentives between payers and providers in creating the MassHealth ACO program. While the MassHealth ACO program is still very new in relative terms, it already shows great promise. We are glad to see that MassHealth is opting to continue with both the Model A and Model B programs, and that it is opting to not move forward with ideas to carve out behavioral health and the administration of prescription drugs. However, MassHealth's comments about the perceived higher cost of the Model A program concern us a great deal because our analysis suggests that the programs' costs are much closer to parity than the state has suggested. Moving away from the Model A approach threatens to undermine many entities that are most invested in the transition to fully integrated and accountable care under MassHealth.

Please consider the detailed comments below in finalizing the 1115 Waiver extension request.

II. Safety Net Funding

Supplemental funding made available to Boston Medical Center through the 1115 Waiver has been foundational to BMC's sustainability and success since the inception of the 1115 Waiver in Massachusetts. Without it, BMC could no longer maintain its over 400 inpatient beds, provide over a million clinic visits per year, vaccinate over 100,000 people for COVID-19, or do any of the other work we do in our communities to promote the health of our patients and members. MassHealth and Health Safety Net reimbursement simply do not cover our costs, and with only about 20% commercially insured patients, we cannot make up those losses in our private contracts. It is essential to BMC that the 1115 Waiver provide sufficient and reliable funding throughout the waiver term to ensure that BMC is still here for MassHealth members and patients at the end of the five-year term. BMC has relied on essentially level funding throughout the last waiver term while health care costs have continued to rise,

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an unsustainable trajectory for our health system and a disservice to those who rely on BMC for care. Among the most important things that the Commonwealth can do to support health equity is to adequately finance safety net health systems.

In the released proposal, EOHHS appears to be putting some new money on the table for safety net providers with the creation of a new Health Equity Fund. BMC fully supports the Commonwealth's initiative to focus on health equity and devote new funding to the pursuit of that goal. But, we have two concerns. One is that the funding appears to be insufficient to meet our funding gap at BMC, especially with the discontinuation of the Delivery System Reform Incentive Payment (DSRIP), even if we achieve success on all the benchmarks yet to be established. The second is that this essential source of funding for us would be at risk on metrics yet to be designed or proven effective. We are concerned that certain metrics might unintentionally disadvantage safety net providers that serve a more vulnerable and complex patient population that faces the persistent and pervasive challenges created by poverty. This creates the prospect where the providers in the best position to help reduce health disparities might lack the essential funding to make strides there.

In choosing metrics of focus, EOHHS should consider allowing institutions to design their own progress benchmarks for equity that reflect the needs and starting points in the communities they serve, and we urge the Commonwealth to let systems focus on a relatively smaller number of topics to focus energy on rather than spreading themselves too thin. In addition to metrics, the data collection that would be required under the posted proposal goes beyond that which is typically collected by providers and may pose operational challenges to overcome—data MassHealth seeks collection of should have a clear path to clinical impact given the administrative hurdles.

We recognize the immense depth of complexity involved in addressing inequities in health outcomes. BMC is over a year into a very robust and coordinated effort throughout our health system to accelerate our efforts to address gaps in health outcomes by race and ethnicity. We have learned a lot through this process, but we know sustained progress will take significant effort—we are deeply committed to doing the work. We urge EOHHS to be careful not to penalize systems that are starting further behind, because of their patient population, or ahead, because of long-standing commitments to this issue. In addition, the data collection that would be required under the posted proposal goes beyond that which is typically collected by providers and beyond that which has been found to be associated with disparities in health outcomes, which would create unnecessary administrative burden without clear clinical benefit.

In summary, the Commonwealth should be sure not to design an equity incentive program that penalizes the entities best situated to address health care disparities. Failing to sustainably fund BMC would be a serious impediment to the Baker Administration's admirable commitment to address health equity, by preventing the success of the largest academic medical center serving communities hardest hit by healthcare disparities.

III. ACO Program Design

As stated above in the introduction, BMC is concerned about how MassHealth is contemplating allocating resources and setting requirements between Model A and B ACOs based on incomplete, and we believe misleading, analysis of the financial efficiency of Model A's vs. Model B's. Model A and Model B ACOs each serve a purpose for moving reform forward, but Model A ACOs are the means by which

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MassHealth can evolve care delivery to focus on truly keeping people healthy. We encourage the Commonwealth to make modest course corrections to the program, rather than sweeping in new requirements and incentives that will destabilize progress made by Model A ACOs and require the use of scarce administrative resources. With that objective in mind, we offer the following suggestions to improve on the Commonwealth's proposed changes to the ACO program.

We generally support the changes suggested for the Community Partners (CP) program, but with the discontinuation of DSRIP, we need to see the funds flow to our providers to know that BMC and our affiliated providers have sufficient funding available to administer the program as proposed. In addition, administrative funds at the ACO level need to be sufficient to allow ACOs to invest in integration. We would also like assurance that ACOs can pick their own CPs and hold them to additional accountability measures if they deem necessary.

Given the centrality of primary care to the ACO model, the approach to ACO Primary Care Physician (PCP) attribution should evolve in the next waiver term based on lessons learned from this waiver. Changing a PCP is a big challenge: patients struggle to navigate this with MassHealth; providers will be more impacted by risk for patients that are not attributed to them, and we risk having patients turned away from care if they cannot navigate PCP assignment. Potential modifications include making it easier for patients to correct their PCP, allowing PCPs to correct on behalf of patients, or allowing submission of claims data to prove that patients are getting care elsewhere.

This commitment to primary care – and likelihood of MCO/Model C patients being on Model A ACO panels in the next waiver term – also means we need to do more to address PCP shortages and increase capacity. We are seeing significant access issues because increased ACO membership is relying on the same, largely fixed primary care workforce, which results in PCP shortages, needing to pay higher salaries to attract PCPs, not enough appointment capacity, and ACO patients crowding out access for other patients. Approaches for EOHHS to explore could include factoring these added costs into the sub-capitation rate set by MassHealth, requiring all PCPs to have MassHealth patient panels of a certain percentage, or incentivizing PCP participation in reform.

IV. Care Management/Care Coordination

While BMCHS supports providing robust care coordination for members who need it, the proposal that ACOs provide care coordination for 10% of members is very concerning, particularly considering the level of resourcing the state is allocating. If MassHealth is proposing committing \$135M in funding for population health and care coordination for 10% of the MassHealth population, the true cost of delivering those care coordination services could be 2-3x the \$135M funding, based on the cost of care management and coordination programs today. If ACOs are going to be required to do robust care management for this large a percentage of our members, ACOs need to be able to control which care management services we use and be able to make assignments to different levels of care.

V. Behavioral Health

BMCHS appreciates the Baker Administration's steadfast commitment to improving behavioral health access and care delivery in the Commonwealth, as articulated in EOHHS Behavioral Health Roadmap and as evidenced in this waiver renewal proposal. As an ACO struggling to ensure sufficient access to behavioral services for all our members who need them, and as a provider looking to expand our care

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offerings to include inpatient behavioral health, we are concerned that rates will not be sufficient to support the access needs. The Commonwealth needs to both increase fee-for-service rates and allow MCOs to pay above the fee schedule where necessary to ensure access for their members. One of the best tools we have to expand behavioral health access is to integrate it in into primary care settings, but the funding needs to be there to support those initiatives as well. The Commonwealth's proposal for tuition reimbursement is commendable but will be insufficient without short-term and enduring rate increases.

VI. Pharmacy

BMCHS appreciates MassHealth staff's receptiveness to our input in on pharmacy policy to-date. The federal 340B Drug Pricing Program is an essential component of BMC's financial sustainability. Without the margin afforded to us by the 340B program, BMC would be forced to rely on the Commonwealth for significantly more supplemental funding than it does currently. We therefore appreciate that the Commonwealth's proposal allows safety net providers to continue to reap financial benefit from the pharmacy program. We support the Commonwealth's proposal to pay high-Medicaid providers like BMC more for prescription drugs administered and/or dispensed to fee-for-service members, where we currently lose money on every prescription filled, while reducing reimbursement for drugs for MCO members. We believe that this new structure, if priced at the level discussed with our staff, will be a net benefit to our hospital and other safety net providers without negatively impacting our health plan. However, one important clarification needs to be made: we expect and hope that the reimbursement for drugs prescribed to Health Safety Net members will follow the same pricing structure as MassHealth fee-for-service. Failing to do so would be inconsistent with health safety net pricing policy and would change the net benefit to a likely loss for BMC, when combined with other changes to the pharmacy program, that MassHealth is making outside the waiver that would reduce our 340B margin.

VII. Quality

In addition to our comments on the Health Equity Incentive Fund, which we see as an important quality initiative for MassHealth members, we have comments on the administration of the quality incentive program in the current waiver term that would be useful to consider in the next waiver term. The quality program is one of the big success stories from the current waiver. The Commonwealth should incorporate lessons learned into the next waiver, including:

- If metric specifications are not defined by February of a performance year, we suggest pay-for-reporting instead of pay-for-performance. It is especially challenging to hit benchmarks or improve performance if we do not know at the start of the rate year how we are being measured. This will be especially important to factor into the structure of the Health Equity Incentive Fund.
- The Commonwealth should reconsider the role of improvement points. The amount of weight given to sustained year-over-year improvements (one-third of the overall quality score), disadvantages ACOs already performing at a high level. We suggest exploring scoring based on

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either absolute performance or improvement or allowing demonstrated improvement to be part of an at-risk earn-back in place of pay-for-performance.

- The draft proposal does not make clear if MassHealth will continue withholds without DSRIP into the next waiver term or how quality performance will impact gains. BMCHS seeks clarification on this point.

VIII. Health-Related Social Needs

While we at BMCHS greatly appreciate EOHHS’ commitment to better address health-related social needs as part of its health equity strategy in the redesign of the 1115 Waiver, we want to challenge the Commonwealth to look further upstream to prevent, rather than treat, social inequity and poverty. Without that upstream focus, we are stuck in a self-perpetuating paradigm where people have very little opportunity to change their circumstances. With that context in mind, we offer the following recommendations:

- Housing: We welcome the proposed expansions of housing supports to make them available to high utilizers who do not necessarily meet the definition of chronically homeless, and to provide tenancy assistance to members who face eviction as result of behavior associated with a disability, such as mental illness or a substance use disorder. We request that ACOs be allowed to validate high utilizers and that a clinical component be included in the housing assistance programs to promote success. More units also need to be funded to pair with the Community Support Program.
- Flexible Services: While we support the proposed changes, particularly the proposal to provide nutrition support to all household members and access to flexible services for 12 months post-partum, we need to know that there will be sufficient administrative dollars in the ACO program to support these services. We fear that there is an erroneous assumption that there are excess administrative dollars in the Model A program to support these additional programmatic requirements.
- Justice-Involved Individuals: BMCHS strongly supports MassHealth’s proposals to provide coverage to MassHealth-eligible individuals who are incarcerated and to provide transition supports to improve health outcomes for justice-involved populations pre- and post-release. BMC currently provides services to many people in the criminal justice system, particularly because of our proximity to the Suffolk County House of Correction. These changes have long been needed and will advance the Commonwealth’s health equity goals and help reduce death by overdose. We would be happy to share our expertise and insights with MassHealth and/or other providers embarking on this important work. Further clarification is need around how transitions to primary care providers will happen and how rates for these members will be risk-adjusted.

IX. Eligibility

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Finally, but importantly, we want to commend the Commonwealth for the eligibility expansions proposed on page 75, particularly 24 months of continuous eligibility for people experiencing persistent homelessness. Expanding MassHealth eligibility is probably the single greatest thing MassHealth can do to address health inequity. We would like to see MassHealth take the additional step to extend **3-month retroactive eligibility** to all MassHealth eligible members, not only pregnant mothers and children. All MassHealth-eligible members are subject to bills they cannot pay for care provided in that 3-month period, and safety net providers routinely provide care that is unreimbursed for eligible individuals during that time.

X. Conclusion

Thank you again for the opportunity to provide feedback on the 1115 Waiver extension request. The comments here provide a high-level summary of our support for and concerns with particular provisions of the proposal as posted. We would welcome the opportunity to discuss any of these areas in greater detail. BMCHS not only depends on the 1115 Waiver renewal for its success, but also has a lot of experience working to achieve the goals the Commonwealth is looking to advance. We welcome the opportunity to share that expertise with MassHealth and EOHHS staff, as always.

Memorandum

To: EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

From: Joshua Greenberg, Vice President of Government Relations, Boston Children's Hospital
Michael A. Lee MD, Executive Director & Medical Director, Department of Accountable Care & Clinical Integration, Boston Children's Hospital

Date: September 20, 2021

RE: Comments on 1115 Demonstration Extension Request

Boston Children's Hospital and Boston Children's Accountable Care Organization appreciate the opportunity to comment on the Commonwealth's 1115 Waiver renewal. At the outset, we wish to express our appreciation for the attention given to children in this iteration of our waiver, and the engagement that MassHealth leadership has had with a number of organized child health coalitions in developing its approach throughout the planning process. We are broadly committed to the ACO model, and the focal emphases for the next five years, especially improvements in the behavioral health delivery system and attention to ongoing disparities in health care delivery.

As with all such proposals, we sometimes find that broad concepts can only be understood and truly vetted when the details are clearer. As such, we offer many of these comments in the spirit of requesting more information about the design, financing, and/or operational implications of the proposals for children.

We also offer a few specific comments about the Commonwealth's continued perpetuation of a system of designation for safety net hospitals that does not include Boston Children's. Insofar as both MassHealth and state policy makers more generally increasingly tie policy approaches to this designation, it makes no sense to continue to artificially exclude the single most important safety net provider for children from this designation, or in the alternative to create an additional designation for pediatric safety net providers.

- Long Term Services and Supports/Care Management for Pediatric Members. We appreciate MassHealth applying what was learned during the current waiver period for the Long Term Services and Supports Community Partners (LTSS CP) Program to inform the proposed modified care coordination strategy and enhancements to the LTSS CP Program. We support the concept of the three tiered care coordination framework, and believe this approach will address some of the limitations experienced for complex pediatric patients in the current demonstration.

While more questions may arise when further details are shared regarding the care coordination strategy, new LTSS CP model, and Targeted Case Management (TCM), based on current information, we would like to highlight two key areas of concern; (1) the variable effectiveness of the LTSS CP program for pediatrics, and (2) the potential impact the inconsistency of funding streams for the CP program versus the TCM benefit may have on program design and member engagement.

Boston Children's ACO has observed the pediatric expertise and knowledge of family-centric approach remains variable across Community Partners (CPs), with some regions in the Commonwealth having very limited success with supporting pediatric patients and their families. Shifting the contracting with CPs to the ACO/MCO would help enable ACOs to choose with which CPs to deepen partnership. However, if MassHealth is going to expect certain volume targets or payments to CPs from each ACO, and will maintain member choice of which CP agencies patients can access, we would encourage MassHealth to have expectations for the less pediatric-friendly CPs to have a baseline knowledge/experience in pediatric LTSS support in order to be a pediatric-eligible CP. Additionally, MassHealth should plan to address the gaps of pediatric LTSS CP expertise in certain regions of the Commonwealth, or entertain an alternative for ACOs with the expertise to support those patients through other ACO programs and partnerships outside of the CP program.

Separately, our understanding is the LTSS CP program funding would be included in administrative rates, while the TCM would be calculated into capitation funding. Given the impact on complex pediatric patients who may be better suited for specialized care coordination through the TCM benefit, we question how the two different funding mechanisms may adversely impact how the two programs are designed, held accountable, and made available to patients and their families. With the current level of information in the waiver extension request, it is unclear if there will be significant impact, however, Boston Children's would like to identify this early, so MassHealth can continue to consider how mechanisms of care coordination program funding have downstream impact on the program expectations and accountability, and will have maximal impact in supporting children and families.

- Primary Care Investments. Boston Children's ACO very much appreciates the focus on improving primary care funding and sustainability evidenced in the waiver document. We have questions about both the sufficiency of the proposed funding and the distribution model that we have consistently raised and will reiterate here.

While the \$115 million investment in primary care is generous, it appears to fall far short of the governor's commitment of a 30% increase in primary care payments. The proposed level of support is unlikely to ensure financial sustainability of at least the pediatric primary care practices. DSRIP has helped support medical home care coordination work within the primary care network and without that ongoing support, it will be difficult for the practices to serve their patients at current levels.

Boston Children's Hospital ACO is in support of a sub-capitated primary care payment model, but is concerned that the model may not drive the right behaviors, especially for practices that have a high Medicaid patient panel. Ensuring that the base capitation level and enhanced tiers

are at appropriate levels and are outcome based will be critical. We expect the capitated payment model will result in revenue variability across practices, but ensuring that the base capitation rates are sufficient for the primary care providers from a business continuity perspective is critical for the accountable care program to function.

It is also unclear whether the primary care capitation budget will be developed at an individual provider or a practice level based on their respective tier and risk categorization of their patient panel. Depending on how the budget is developed, it will require different performance management strategies at the accountable care organization level. Lastly, any data required from the providers to support this model should be carefully considered and minimally burdensome. Providers are already stretched thin and short on staff and any additional operational or reporting burden will impact the care they are able to provide to their patient panel.

- Other Primary Care Requirements including Management of Children with Complex Care Needs. The Waiver proposal includes several other items of interest to pediatric primary care providers and specialists serving as medical homes.

MassHealth indicates that as part of the primary care sub-capitation program, primary care providers would be at risk for their quality performance. We support accountability and encourage MassHealth to ensure that the quality measures used in this program are relevant to pediatrics and to the objectives of the program and can be easily monitored on an interim basis in order to inform needed improvements.

We have concerns about the requirement for all primary care practices to provide fluoride varnish to children. In our experience, fluoride varnish is routinely provided in the primary care setting during early childhood until the child/family has established dental care (typically, up to age 5). The feasibility of providing fluoride varnish to older children must be explored in the context of access to dental care, which is known to be limited in the Medicaid population.

Lastly, Boston Children's ACO supports the strengthened expectations for investment in pediatric preventive care and care coordination for children with complex needs in the extension request. An evolved ACO model with enhanced focus on pediatrics could better support PCPs, address cost, and promote preventive care that supports long-term health outcomes. Additionally, supporting the families of patients who have a medically complex child through prioritizing effective care coordination is key to improving overall family health and improved system outcomes.

- Flexible Services. Boston Children's Hospital ACO supports the proposal to continue the Flexible Services Program. While early findings from this program are promising, additional time is needed to perform a robust evaluation of the health, utilization, and cost outcomes targeted by the program as well as the effectiveness and sustainability of processes for Flexible Services implementation. We encourage MassHealth to examine the potential for new supports (e.g.,

data sharing) that can improve collaboration between adult and pediatric ACOs in the implementation of Flexible Services. For example, the proposal to modify the health-based needs criteria for Flexible Services supports to apply to members postpartum for 12 months, rather than the current 60 days could facilitate important opportunities for collaboration between adult and pediatric ACOs during the postpartum (adult) and early infancy (pediatric) period.

- Accountability for Quality, Health Equity, and Social Determinants of Health. Boston Children's ACO agrees that "you can't improve what you don't measure" and understands MassHealth's desire to provide both operational and financial incentives to address areas of critical importance to children and families. We share the perspective that health disparities should be a focus of the upcoming waiver, while recognizing that many of the "solutions" may lie outside the traditional medical delivery system.

Boston Children's Hospital ACO is committed to providing high quality care to all of its patients and to ensuring health equity in the communities we serve, and supports the proposal to implement incentives related to addressing structural racism and reducing health disparities. We encourage MassHealth to work with ACOs, MCOs, and other state agencies to establish principles (or adopt existing principles) that will facilitate alignment of measures of equity of quality of care, such as standardization of data collection related to social risk factors such as RELD and SOGI.

Similarly, Boston Children's Hospital ACO supports MassHealth's goal to refine MassHealth's innovative risk-adjustment approach for ACO rates that accounts for members' medical and social needs. We continue to have concerns that the risk adjustment approach is not optimized for pediatrics, including pediatric health-related social needs.

More generally, the principles set forth for selecting quality measures for the ACO align with recommendations that Boston Children's Hospital ACO has previously shared with MassHealth. We look forward to ongoing conversation about the selection of measures and the relevance of certain adult measures to a pediatric-focused ACO.

- Proposed 340B Changes. The Administration's proposal related to 340B pricing is based on a tiered approach where tier 1 providers will receive a higher reimbursement rate and tier 2 provider will receive the 340B actual acquisition costs. Financially, this policy has the potential to dramatically affect provider revenues, and MassHealth should provide substantially more detail about its impact at the individual provider level before, and should seek to hold individual providers harmless, before adopting it.

The federal 340B program expressly includes children's hospitals in recognition that such facilities are large Medicaid providers and function as safety net providers that treat complex pediatric patients in the communities they serve. Children's hospitals have participated in the 340B program since 2009, when the Health Resources and Services Administration (HRSA) promulgated regulations to effectuate the inclusion of certain qualifying children's hospitals, which was written into Section 6004 of the Deficit Reduction Act of 2005. In 2010, Section 7101 of the Affordable Care Act (titled 'More Affordable Medicines for Children and Underserved Communities') amended the text of Section 340B of the Public Health Services Act to include freestanding children's hospitals as an eligible entity in the program. Congress was specifically

concerned that these safety net institutions had been inadvertently excluded from participation due to the original statutes reliance on Medicare definitions. Indeed, recent federal regulatory changes to the 340B program pricing in Medicare expressly exclude children's hospitals for just this reason (Calendar Year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems and Quality Reporting Programs proposed rule).

Moreover, changing the reimbursement for 340B drugs could erode Boston Children's Hospital's ability to safely care for MassHealth patients. The proposed reimbursement model may not sufficiently account for the significant clinical and administrative expenses that the hospital incurs to obtain the medication; obtain prior authorization; collect needed medical records; store, prepare, and administer the medication (including for example the need for pediatric infusion of biologics); and monitor the patient's response to the medication on an ongoing basis. These changes could have a significant impact on the way we currently do business and could negatively affect our ability to maintain specific expertise and capacity to safely provide emerging and costly therapies to pediatric MassHealth patients.

Lastly, should this new framework move forward, Boston Children's Hospital should be included as a tier 1 provider in this proposal and receive a higher payment rate for 340B drugs (likely between 340B AAC and NADAC/WAC, plus dispensing fee) and should be considered a pediatric safety net provider for the additional reasons outlined below.

- Safety Net Designation(s) and Funding Approach. Over 40% of MassHealth members are children, and approximately 10% of them have chronic and complex care needs and require specialized care management and care coordination either within or between subspecialties. A significant subset of these children have primary or co-morbid behavioral health needs. Medicaid is the single most important payor for these children, covering over 40% of all Massachusetts children.

Boston Children's Hospital is the only free standing pediatric children's hospital in the state and serves more MassHealth children (by far) than any other hospital in the Commonwealth. Our primary care network covers over 120,000 children with practices located throughout Massachusetts (by far the highest enrollment of children of any ACO).

Our importance to the Medicaid program is not limited to Massachusetts children; in 2019 Boston Children's Hospital saw children covered by the Medicaid from all 50 states. These children required complex medical and surgical interventions that could not be provided in their home state and on average had a Case Mix Index (CMI) above 3.5. Because children are so dependent on Medicaid and Boston Children's Hospital relies so heavily on Medicaid revenues we should be designated a safety net provider in the 1115 Medicaid Waiver renewal.

One of the five goals outlined by the Administration in the 1115 waiver renewal application is to sustainably support the Commonwealth's safety net and maintain near universal coverage – including level, **predictable funding for safety net providers**, with a continued linkage to accountable care, and updates to eligibility policies to support coverage and equity. There is also a separate goal **to make reforms and investments in primary care, behavioral health, and pediatric care** that expand access and move the delivery system away from siloed, fee-for-

service health care. These two goals are not fully aligned without including the safety net providers that care for children.

Boston Children's Hospital discharges about half of all pediatric patients requiring hospitalization in Massachusetts with five times the pediatric discharge volume of any other hospital in the state, and twice the number of discharges of all of the designated safety net hospitals combined. The group 1 and group 2 safety net¹ providers make up less than 30% of the overall pediatric discharges in the Commonwealth (less than 10% for group 1 hospitals and 17% for group 2 hospitals excluding the community hospitals that Boston Children's Hospital staffs)². In order to sustain a pediatric delivery system that supports children on Medicaid there needs to be consideration given to us as a safety net provider.

- We applaud the inclusion of standards that address retroactive eligibility for pregnant women and children as well as continuous 12-month postpartum eligibility regardless of immigration status. Ensuring all children and mothers have access to quality, affordable, and geographically appropriate health care is critical in the Commonwealth's efforts to advance equity.


We understand that this extension proposal is framed at a relatively high level and will be refined further as stakeholder feedback is digested and incorporated into the proposal. Boston Children's looks forward to exploring how we may assist and support you in this effort, providing feedback related to the delivery of pediatric care.

Thank you for the opportunity to participate in this important effort. We look forward to supporting the Commonwealth in improving health outcomes and closing health disparities.

Sincerely,



Joshua Greenberg
Vice President of Government Relations
Boston Children's Hospital



Michael A. Lee MD
Executive Director & Medical Director
Department of Accountable Care & Clinical Integration
Boston Children's Hospital

¹ <https://www.mass.gov/doc/july-1115-demonstration-deck/download>

² This is based on Year End FY2020 MHA Quarterly Utilization Survey.

Good Morning,

My name is Tania M. Barber and I am the President/CEO at Caring Health Center which is in Springfield Ma. I participated in the recent Demonstration Extension Request hearing offering my comments and questions, which is provided below.

We (Caring Health Center) serve 19,000 patients in over 34 different languages. We are the largest Refugee and Immigrant provider.

- Community health centers share MassHealth's commitment to ensuring health equity is a tangible priority in this waiver renewal. Striving for true health equity is what we live and breathe each day and why we exist. We are pleased to see proposals like postpartum coverage regardless of immigration status, and eligibility changes for homeless and justice-involved members.
- Health centers are proven leaders in measuring health outcomes by race and ethnicity and have honed a model of care designed to be responsive and close inequities by focusing on primary care and addressing patients' health related social needs. At health centers, we are on the front lines of leading the innovation in this arena.

For example: Caring Health Center is an equity leader in our approach to using data from multiple sources to inform practice innovations and improvements. **For instance, Caring Health uses a combination of data from population health and QI assessments as well as research to identify trends in disparities and to inform development of sustainable and integrated programing not otherwise funded by 3rd party billing.** Included in this is building a Wellness Center in response to seeing and hearing the needs of our patients, upon reviewing the data from focus groups, (which recently pivoted into a COVID infection control headquarters). Also included in this is an integrated Community Health Worker team, SDH screening and response, and our robust research program. This approach is strategic, focused, and tailored to the needs of our community and is scalable. This is a strategy we are in the process of disseminating to share with our FQHC community and other stakeholder partners. Direct investment of these funds will help us continue to scale and sustain these programs.

- For this reason, we were surprised and disappointed to see that health centers were not explicitly outlined as a part of the "Health Equity Incentives" program.
- We are unclear about how health centers and other community-based providers can access equitable levels of investments in this critical area.
- We are supportive of hospitals receiving equity dollars, **but we also request that MassHealth invest directly in health centers for targeted** efforts to close health inequities. We know what to do, we know how to do it, and we ask that you trust and empower us with equitable resources to make it happen.

Thank you for your time and consideration of this matter.

Tania

Tania M. Barber, MBA
President & CEO
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Caringhealth.org

September 20, 2021

Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to 1115-comments@mass.gov

Re: MassHealth Section 1115 Demonstration Project Extension Request

To Whom It May Concern:

Thank you for the opportunity to submit comments on the Massachusetts proposed Section 1115 demonstration project extension request. The Center for Health Law & Policy Innovation of Harvard Law School (CHLPI) advocates for health justice, with a focus on the needs of systemically marginalized individuals. CHLPI works with a range of stakeholders, in Massachusetts and across the country, to expand access to high-quality health care; to reduce health disparities; and to promote more equitable and sustainable health care systems.

We applaud MassHealth's clear commitment to advancing health equity through the waiver. Specifically, we are tremendously supportive of:

- **Expanding the Flexible Services Program (FSP):** We especially commend MassHealth for proposing family-level coverage for nutrition supports. Evidence strongly suggests that food is often shared across the household.¹ Adjusting nutrition supports according to household size is not only practical and just, but critical to testing the impact of the program on addressing food insecurity and individual health outcomes.
- **Providing continuous coverage for people who are incarcerated, people who are formerly incarcerated (12 months), and people experiencing homelessness (24 months):** Continuity of care for people incarcerated and recently released is critical to ensure that people receive proper care and avoid disruptions in long-term disease management. This is similarly true for people experiencing homelessness, who are more likely to have health care needs relating to substance use, behavioral health, and chronic conditions than the general population.²

¹ White JS, Vasconcelos G, Harding M, Carroll MM, Gardner CD, Basu S, et al. Heterogeneity in the Effects of Food Vouchers on Nutrition Among Low-Income Adults: A Quantile Regression Analysis. *American Journal of Health Promotion*. 2021 Feb;35(2):279-283. doi: 10.1177/0890117120952991. Epub 2020 Sep 3.

² See *Homelessness and Health: What's the Connection?*, NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL (Feb. 2019), <https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf>.

- **Eliminating barriers to participation in the CommonHealth program:** The CommonHealth program provides important health coverage access for disabled adults and children who may otherwise not qualify for MassHealth based on their income, but who need comprehensive coverage to address their health needs. Work requirements and other work incentives may create serious barriers to maintaining insurance coverage.³ By removing the one-time deductible for non-working adults and work requirements for CommonHealth enrollees over 65 years old, MassHealth will be ensuring improved access to the CommonHealth program and to necessary health care services.
- **Extending existing ConnectorCare subsidies:** ConnectorCare provides essential access to care for people who are low-income. ConnectorCare subsidies are necessary to ensure that Health Connector-based coverage is affordable and accessible for those who need it.⁴
- **Implementing robust goals for provider-led reductions in health disparities:** Health care systems are in a powerful position to address the impacts of social determinants of health and structural racism on health. Payment reforms that rely on stratified, equity-driven measures have the potential to strengthen accountability.

³ This is especially true at this moment, when the COVID-19 pandemic has created a national employment crisis that disproportionately impacts people with disabilities. Allen Smith, *A Million People with Disabilities Lost Jobs During the Pandemic*, SOCIETY FOR HUMAN RESOURCE MANAGEMENT (Aug. 28, 2020), <https://www.shrm.org/resourcesandtools/legal-and-compliance/employment-law/pages/coronavirus-unemployment-people-with-disabilities.aspx> (“Since March, 1 in 5 workers with disabilities have been dismissed from employment, compared with 1 in 7 in the general population....”). Recently, CMS has taken action to rollback approvals for states that sought to implement work requirements in their general Medicaid programs, noting that the current pandemic “greatly increased the risk” of “substantial coverage loss.” See, e.g., Letter from Chiquita Brooks-LaSure, Adm’r, Ctr, for Medicare and Medicaid Servs., to Emma Chacon, Interim Dir., Div. of Medicaid and Health Financing, Utah Dep’t of Health (Aug. 10, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-care-network-state-ltr-08102021.pdf?source=email>. This criticism holds true in the CommonHealth program, where work requirements create barriers to care for disabled individuals who may not be able to work 40 hours per month due to their disability, who are seeking retirement, or who may be unable to work because of pandemic-related losses in employment.

⁴ This is especially true as the COVID-19 pandemic continues to unfold, heightening the need for affordable health coverage options. During the Health Connector COVID-19 Special Enrollment Period that ran from March 11, 2020 and July 23, 2020, over 22,000 people newly enrolled in ConnectorCare. MASSACHUSETTS HEALTH CONNECTOR, MASSACHUSETTS HEALTH CONNECTOR COVID-19 SPECIAL ENROLLMENT PERIOD: FINAL ENROLLMENT RESULTS (2021).

While these are extremely promising changes, we encourage MassHealth to take the following steps to maximize the positive impact of these innovations and guard against harmful unintended consequences:

1. Continue SSO Infrastructure Support and Improve Evaluation Guidance to Strengthen the FSP.

CHLPI is supportive of the proposed changes of the FSP, yet there is ample opportunity to strengthen FSP operations and evaluation. Notably, continuation of a key support, the SSO Prep Fund, is missing from the waiver extension request. The SSO Prep Fund proved to be a lifeline for SSOs looking to participate in the FSP. Nearly all FSP nutrition service providers benefitted from the grant program to build the capacity to partner with health care entities. It was especially essential for smaller SSOs which provide critical services and have deep relationships with community members yet often lack the financial cushion needed to prepare for FSP participation.

Considering that the FSP is still nascent, now is not the time to abandon supports like the SSO Prep Fund. The resources the Prep Fund provides are critical for onboarding new SSOs and expanding the scope of nutrition organizations able to participate. Additionally, ACO partners have begun to expand the breadth and depth of partnerships which has created new infrastructure needs such as expanding technological systems and onboarding additional staff. By continuing the SSO Prep Fund, MassHealth can provide the supports needed to complete these concrete scaling efforts, thereby expanding the reach and impact of the FSP.

Enhancing guidance and coordination related to ACO FSP evaluations is another critical step to substantially improve the FSP. The broad evaluation requirements outlined by MassHealth have resulted in great variability in health outcome, implementation, and process measures across health care institutions. MassHealth should offer specifications for key standardized outcomes of interest so that data can be compared across partnerships. Guidance informing process measures may be particularly useful in assessing the broad value of nutrition services beyond ROI. Beyond those key metrics, MassHealth could, for example, suggest that ACOs capture changes in patient churn, primary care engagement, and specific program quality measures. By providing such guidance—and additional evaluation support to ACOs—MassHealth can better ensure that the FSP achieves its fundamental goal of establishing a robust set of data that can be compared across institutions and illustrate system-wide outcomes to guide future decision-making.

2. Establish an advisory committee to inform expansion of MassHealth coverage to people who are incarcerated.

There is tremendous potential in MassHealth’s proposal to expand MassHealth coverage to people in carceral settings. This initiative is necessary to improve continuity of care for individuals transitioning into and out of correctional facilities.⁵ Access to Medicaid for

⁵ Currently, many individuals transitioning into and out of correctional settings experience serious interruptions in care as a result of the federal Medicaid Inmate Exclusion Policy (MIEP). 42 U.S.C. §

people in carceral settings also supports appropriate and prompt medical care while incarcerated⁶ and sets a higher standard of care,⁷ which will improve outcomes and lower system costs. These efforts closely align with the goals of the Medicaid program, especially considering that the vast majority of people incarcerated in Massachusetts are eligible for Medicaid upon release.⁸

In order to ensure that the implementation of this program expansion is successful and meets the needs of beneficiaries currently and formerly incarcerated, we strongly recommend the formation of an advisory group, comprised of people who are incarcerated or were formerly incarcerated, advocacy groups focused on issues impacting people who

1396d(a). This interruption in Medicaid coverage during periods of incarceration has serious impacts on continuous access to necessary medical treatment, especially for individuals with chronic disease and substance use disorders, with devastating impacts on health outcomes. As one example, individuals receiving medication-assisted treatment for opioid addiction are at higher risk of overdosing if their treatment is interrupted or ended early than if they receive continuous treatment. *See* Arthur Robin Williams, Hillary Samples, Stephen Crystal & Mark Olsson, *Acute Care, Prescription Opioid Use, and Overdose Following Discontinuation of Long-Term Buprenorphine Treatment for Opioid Use Disorder*, 177 AM. J. PSYCHIATRY 117, 120 (2020). Although Massachusetts has taken steps to improve continuity of care for Medicaid-eligible people following release from prison or jail, gaps persist. The Massachusetts Department of Correction has a documented history of failing to meet requirements for the provision of reentry services, such that not all people released from DOC facilities receive supports to continue their care in the community. *Official Audit Report: Massachusetts Department of Correction, For the Period July 1, 2016 through June 30, 2018*, COMMONWEALTH OF MASSACHUSETTS OFFICE OF THE STATE AUDITOR (Jan. 9, 2020), <https://www.mass.gov/doc/audit-of-the-department-of-correction/download>. Provision of Medicaid during periods of incarceration will significantly reduce these interruptions in care and negative health outcomes.

⁶ Individuals have more comprehensive access to some services through the Medicaid program than they do through care provided in correctional facilities. For example, because correctional facilities do not qualify for 340B pricing and the cost of hepatitis C (HCV) treatment, access to HCV medication is more restrictive for people in prison or jail than for people on Medicaid. Nathaniel P. Morris, Matthew E. Hirschtritt & Anthony C. Tamburello, *Drug Formularies in Correctional Settings*, 48 J. AM. ACADEMY PSYCHIATRY & L. 2 (2020). This may mean that a person on a course of HCV treatment when they enter prison may be unable to receive the drug that they need for their treatment, interrupting their care and worsening their health outcomes.

⁷ Health care facilities that receive Medicaid funds are subject to standards set by CMS regulations, while correctional facilities are not. *See* Tyler Winkelman, Amy Young & Megan Zakerski, *Inmates are excluded from Medicaid – Here’s why it makes sense to change that*, UNIVERSITY OF MICHIGAN INSTITUTE FOR HEALTHCARE POLICY AND INNOVATION (Feb. 27, 2017), <https://ihpi.umich.edu/news/inmates-are-excluded-medicaid-%E2%80%93-here%E2%80%99s-why-it-makes-sense-change>. A recent audit of the Massachusetts Department of Correction found that people in DOC facilities were not always provided with timely access to health care putting those people at higher risk of negative health outcomes. *Official Audit Report: Massachusetts Department of Correction, For the Period July 1, 2016 through June 30, 2018*, COMMONWEALTH OF MASSACHUSETTS OFFICE OF THE STATE AUDITOR (Jan. 9, 2020), <https://www.mass.gov/doc/audit-of-the-department-of-correction/download>.

⁸ *See* Natasha Camhi, Dan Mistak & Vikki Wachino, *Medicaid’s Evolving Role in Advancing the Health of People Involved in the Justice System*, THE COMMONWEALTH FUND (Nov. 2020), <https://collections.nlm.nih.gov/master/borndig/101774874/Medicaid%E2%80%99s%E2%80%99s-Evolving%E2%80%99s-Role-in-Advancing-the-Health-of-People-Involved-in-the-Justice-System.pdf>.

are justice-involved, health care providers who work in carceral settings, and others. Implementation issues that this group could help address include, but are not limited to:

- Differences in culture and provision of health care within prisons and jails, compared to other health care settings;
- Strategies for monitoring quality of care within prisons and jails;
- Strategies for effectively integrating MassHealth services with services provided by DOC and CCF providers;
- Challenges related to privacy and obtaining consent from patients within prisons and jails; and
- Opportunities for improvements to post-release transitions of care.

The establishment of this group will play an important role in ensuring that implementation of this waiver is fully equitable and meets the needs of beneficiaries, while complimenting the current involvement of the Coordinating Council, comprised of officials from Massachusetts correctional facilities. We strongly encourage MassHealth to solicit input from all people involved in the criminal justice system in the State, including and especially those who are intended to benefit from this program expansion, not only officials representing correctional facilities.

3. Expand the eligibility proposals to better address gaps and vulnerabilities in access to care.

CHLPI strongly encourages MassHealth to consider providing continuous coverage more broadly to both adults and children. States have the option to provide continuous Medicaid and CHIP coverage to children without a waiver, which 34 states have chosen to implement.⁹ Other states have also implemented continuous coverage for adults through the waiver process.¹⁰ Although people experiencing homelessness and people with a recent history of incarceration are at particularly high risk for churn, low-income adults and families are generally at increased risk of income volatility, which is a known driver of churn in public program enrollment.¹¹ Pandemic-related job volatility only increases the risk that individuals will be forced to transition between different forms of health care coverage, with the potential for gaps in care. Continuous enrollment for all Medicaid-eligible people beyond the COVID-19 emergency is critical to allow for enhanced continuity of care and improved health outcomes for all Medicaid beneficiaries.

⁹ *Continuous Eligibility for Medicaid and CHIP Coverage*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html> (last visited Sept. 12, 2021).

¹⁰ See, e.g., *GIS 15 MA/022: Continuous Coverage for MAGI Individuals*, N.Y. STATE DEP'T OF PUBLIC HEALTH (Dec. 2015), https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma022.htm; *Section 1115 Waiver for Additional Services and Populations*, MONT. DEP'T OF PUBLIC HEALTH AND HUMAN SERVS., <https://dphhs.mt.gov/montanahealthcareprograms/medicaid/medicaid1115waiver/> (last visited Sept. 12, 2021).

¹¹ See *How Income Volatility Interacts with American Families' Financial Security*, THE PEW CHARITABLE TRUSTS (Mar. 2017), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security>.

Finally, we encourage the State to eliminate its waiver of retroactive eligibility requirements in its entirety,¹² making 3-month retroactive coverage available for all beneficiaries under age 65. Section 1115 waivers are specifically intended to facilitate experimental demonstration projects. There is nothing experimental about MassHealth’s existing waiver of retroactive coverage, which has been in effect since 1997. Numerous states have been allowed to waive the retroactive coverage requirement since at least the 1990s. To the extent that such waivers had experimental value at the time they were granted, that is not the case now. Continuing the waiver, at this point, would be tantamount to the State evading a federal requirement, which numerous courts have said is an improper use of section 1115.¹³ In addition, eliminating retroactive coverage subverts the objectives of the Medicaid Act because it “by definition, reduce[s] coverage.”¹⁴ Without retroactive coverage, Medicaid beneficiaries forgo vital health care and/or incur significant medical expenses. By eliminating the opportunity for retroactive coverage, beneficiaries may face disruptions in their health care coverage that prevent them from maintaining the care that they need, putting their health at risk.¹⁵ These are salient risks for pregnant people and children *and* for other Medicaid-eligible people.

4. Create a strong and transparent information governance framework for the enhanced collection and use of social risk information.

We agree that robust data collection and stratified analytics are critical to understanding health disparities and closing the health gap. However, it is imperative that MassHealth—as well as ACOs, ACO-participating hospitals, and other MassHealth-involved entities—commit to a strong and transparent data governance framework. Further, equity must be front and center in the design and implementation of any such framework itself.

We appreciate that MassHealth acknowledges the importance of transparency when it comes to the public reporting of social risk data and the ability for communities to monitor health equity performance across the system.¹⁶ Transparency and accountability are also essential for additional structural elements that come prior to reporting such as:

- how consent management works;
- specific data that will be collected and how the data will be collected;
- how data can and cannot be used and repurposed;
- who will have access to the data;

¹² *MassHealth Medicaid Section 1115 Demonstration Waiver List* Centers for Medicare and Medicaid Services (Oct. 23, 2018), <https://www.mass.gov/doc/1115-masshealth-demonstration-waiver-waiver-list-10-23-18-0/download>.

¹³ *See, e.g., Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

¹⁴ *See Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019).

¹⁵ *See Lindsey Dawson & Jennifer Kates, Insurance Coverage and Viral Suppression Among People with HIV, 2018*, KAISER FAMILY FOUND. (Sept. 24, 2020), <https://www.kff.org/hiv/aids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/> (“[S]ustained viral suppression rates varied by payer, and were higher among those with private insurance or Medicare, compared to the uninsured.”).

¹⁶ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 51. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

- mechanisms to prevent the encoding of biases into the collection, interpretation, and application of data;
- mechanisms to ensure compliance with privacy safeguards; and
- parties with decision-making authority as to these matters.

We urge MassHealth to proactively engage community members about these data collection efforts so that our health care system can anticipate and address potential consequences which may arise from the enhanced collection, use, and exchange of sensitive personal data envisioned under the proposal. Are there circumstances/under what circumstances could enrollees targeted by the equity initiatives be made worse off? How might social risk factor data be used, for example, to discriminate against enrollees? What additional guardrails are necessary to protect against this?

MassHealth should both (1) ensure that there is an opportunity for public input on information governance standards/requirements, and (2) mandate that entities participating in equity initiatives make their information governance frameworks publicly available. MassHealth should consider and respond to the persistent challenges relating to data standardization and technological interoperability, reported by a range of stakeholders, through the lens described here.

We thank you again for your commitment to advancing health equity, and we urge you to make these changes to further our shared goals. Please do not hesitate to contact us if we can answer any questions or provide any additional information. We would be happy to discuss these recommendations with you.

Sincerely,



Robert Greenwald
Faculty Director, Center for Health Law and Policy Innovation
Clinical Professor of Law
Harvard Law School

Charles River Community Health

September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
1 Ashburton Place
Boston, MA 02108

Re: Comments on Demonstration Extension Request

Submitted via email to: 1115-Comments@mass.gov

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of Charles River Community Health (CRCH), thank you for the opportunity to provide comments on the 1115 MassHealth Demonstration ("Waiver") Extension Request.

Charles River Community Health provides medical, dental, behavioral health, vision, and pharmacy services to over 15,000 patients annually. Over 80% of our patients are from communities of color, 60% need services in a language other than English, 43% have MassHealth or other public insurance, and 67% are at or below 100% of the Federal Poverty Level. We are serving the most vulnerable in Allston-Brighton, Waltham and surrounding areas and are the only Federally Qualified Health Center (FQHC) and safety net provider in our community.

CRCH joined the Community Care Cooperative (C3) MassHealth Accountable Care Organization (ACO) in 2017. We felt this was the best way to set our health center up for success in the MassHealth ACO program by having discussions regarding clinical workflows, quality metrics, population health activities, and total cost of care budgets and goals with like-minded FQHCs who share our mission and commitment to care for the underserved. In addition, C3's all-FQHC Board of Directors ensures that key decisions are made with FQHCs' needs and goals at the center of their work.

Regarding the Waiver extension, CRCH completely aligns with and supports the Mass League's comments on the key issues of payment/primary care capitation, health equity incentives, workforce, and 340B. Of particular importance to our health center is the following:

- **Payment**
 - Charles River Community Health is directionally supportive of moving from fee for service to primary care capitation reimbursement. However, given how essential MassHealth revenue is to our organization's fiscal health, it is critical to have more details before CRCH can provide full support, as there will be many program expectations, operational and billing workflows that will need to be worked through to ensure all FQHCs can succeed in the new payment environment.

- Most important regarding payment in the Waiver Extension is for MassHealth to ensure and provide data, formulas, methodologies, and other information to FQHCs that indicates any primary care capitation rate paid to FQHCs in the Waiver Extension will be at least equal to if not higher than the Prospective Payment System (PPS) rates recently agreed to and established by MassHealth effective January, 2022. This cannot be fully tested and confirmed until we have more details.
- **Equity**
 - The mission of FQHCs was founded in social justice and racial and health equity. We collect data on our patients' race and ethnicity, and also record in our Electronic Health Record system not simply what languages a patient speaks but what language do they wish to receive their health services in, to ensure that all patients can understand and fully participate actively in their health with their primary care provider and care team at CRCH.
 - It is important for CRCH to have the ability to design our own interventions to remedy health inequities such as by running our quality metric reports by race, ethnicity and language and addressing differences to ensure all of our patients are receiving the culturally sensitive and clinically excellent care they need and deserve, and to indicate to CRCH the additional health equity work we need to continue to do.
- **Workforce**
 - It is critical for MassHealth to make continued investments in loan repayment for CRCH to recruit and retain providers. As a smaller health center of about 200 employees and located a few miles from the Longwood Medical Area, we continue to fight to recruit the diverse talent we need, which includes hiring linguistically, ethnically, and racially diverse providers from our community. We are proud that two-thirds of our staff across CRCH self-identify as staff of color, and we have providers from Central and South America, the Caribbean, and Asia who mirror the diversity of our patients and are best able to care for them.
 - DSRIP investments have also been critical for us to have the workforce needed to conduct outreach to members newly assigned to CRCH who have not seen us, and to improve quality and outcomes through targeted care management and connection with community services to address patients' Health Related Social Needs.
- **340B**
 - Our Brighton and Waltham sites each have a 340B pharmacy that we own and operate ourselves. Prior to ACO implementation, any 340B savings we generated were invested right back into our health center to support items such as workforce recruitment and retention activities, and to purchase needed clinical and IT equipment, supplies and systems. This revenue stream should be restored to support the significant investment and work FQHCs will need to undertake to succeed in this next phase of the MassHealth ACO program.

Thank you for the opportunity to provide feedback on the 1115 waiver demonstration request and to share how the waiver has and will impact our health center. We look forward to continuing our work with MassHealth to provide high-quality, comprehensive care to patients.

Sincerely,



Elizabeth Browne
Chief Executive Officer



September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
1 Ashburton Place
Boston, MA 02108

Re: Comments on Demonstration Extension Request

[Submitted via email to: 1115-Comments@mass.gov]

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of Community Health Center of Cape Cod, thank you for the opportunity to provide comments on the 1115 MassHealth Demonstration ("Waiver") Extension Request.

Community Health Center of Cape Cod (CHC)'s main location is in Mashpee, with satellite centers in Falmouth, Bourne, Centerville and Sandwich. Overall, there are 22,000 patients registered for health center services. Approximately 78% of our patients are below 200% of the federal poverty level and over 80% are struggling with one or more chronic health condition. While we are fortunate to live and work on Cape Cod, this is also a tremendous struggle for many of our residents. The seasonal nature of employment, the high cost of living, and the severe shortage of affordable housing has created large income disparities, especially for those most vulnerable.

Our health center has been an active member of Community Care Cooperative (C3). This health center led and operated ACO, with the support of the Commonwealth and the 1115 Waiver continues to make great progress in addressing some of the challenges above. While we applaud many aspects of the draft waiver, we are concerned about several elements.

We align with the Mass League's comments on the key issues of payment/primary care capitation, health equity incentives, workforce, and 340B.

Of particular importance to our health center is the following:

- **Payment**
 - Overall, we are supportive however, with over 55% of our revenues from MassHealth, the payment methodology is critical.
 - It is essential that as this future capitation payment model is developed that it align with FQHC payment methodology; that cannot be "tested" until we get there with more details.
- **Workforce**
 - Recruiting and retaining providers on Cape Cod is challenging and it is extremely difficult to compete with the higher budgets of hospital systems. Access to loan repayment has been a significant differentiator for us; and has helped to improve our diversity among



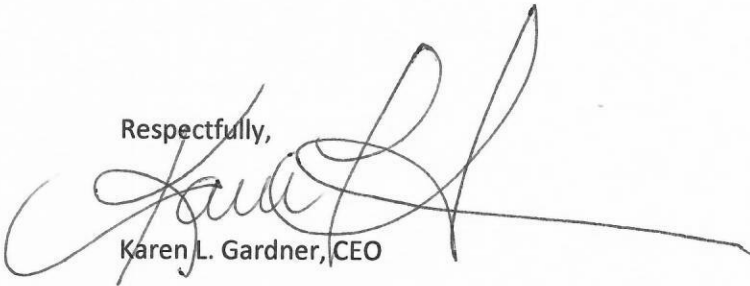
the professional staff. If investments do not continue, it would significantly reduce access for services. We currently register over 200 new patients on a monthly basis. Reduced access would disproportionately impact our non-english speaking population and those with the most significant behavioral health, substance use and other chronic conditions.

- **340B**

- Savings from the 340B program (pre-ACO implementation) has allowed us to continue to expand access to integrated programs and services within the health center and has resulted in improved medication compliance and reduced overall cost of care. It is critical we have access to a 340B rate(s)

Thank you for the opportunity to provide feedback about the 1115 waiver demonstration request and to share how the waiver has and will impact our health center. We look forward to continuing our work with MassHealth to provide high-quality, comprehensive care to patients.

Respectfully,

A handwritten signature in black ink, appearing to read 'Karen L. Gardner', with a long horizontal flourish extending to the right.

Karen L. Gardner, CEO

September 20, 2021

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108
submitted via email to 1115-Comments@mass.gov

To Whom It May Concern:

The Massachusetts Child and Adolescent Health Initiative (CAHI) is pleased to submit these comments on the MassHealth Section 1115 Demonstration Extension Request on behalf of our members. CAHI represents a diverse group of stakeholders with the vision of ensuring that all Massachusetts children and youth develop to their full potential in safe and nurturing families, schools, and communities. CAHI members include MassHealth ACO pediatricians, child and family care providers, behavioral health experts, community service experts, educators, families, and parent engagement advocates. Please see attachment 1 for a full list of CAHI members.

CAHI appreciates MassHealth's work in drafting this extension request and particularly appreciates the explicit focus on the health needs of children, youth, and families throughout the proposal. The intentionality of that focus throughout the waiver proposal is clear and laudable. The request highlights MassHealth's growing understanding and prioritization of pediatrics, the unique needs of children, youth, and families, and behavioral health access. Much of the content aligns with CAHI priorities, specifically:

- Inclusion of child and family care delivery enhancements in the primary care sub-capitation program.
- Streamlining care coordination and new programs for children with highly complex needs.
- Expanded family-based supports in the Flexible Services Program.
- The development of integrated, team-based care coordination for all children and families, especially as it pertains to behavioral health.
- Improved alignment and transparency of data collection and reporting.

Many of our questions, comments, and recommendations stem from interest in details of implementation. To that end, we strongly encourage engagement with child and family stakeholders, including CAHI, in the implementation to assure full accountability and transparency of work to achieve the waiver's commendable goals. We look forward to ongoing conversations with MassHealth to provide feedback and guidance throughout implementation of the waiver and to continue work to ensure an intentional focus on children, youth, and families.

Below are our comments and recommendations, organized by goals outlined in the extension request.

Goal 1: Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model

We strongly support MassHealth in its work toward accountable, value-based care. We recognize the importance of clarifying the value for pediatric care, where the timeline is usually much longer than for older populations requiring evaluation longer than five years and may involve sectors other than health care. Importantly, investments in the health of children are preventive for many of the most pervasive adult health conditions, such as cardiac, metabolic, and mental health conditions.

We look forward to working with MassHealth to develop and implement accountability measures for ACOs in order to assure adequate measurement of pediatric care and improvement. Accountability indicators and data should reflect the unique needs of families and children and be made available to stakeholders. The proposed measurement slate (shared outside the formal draft proposal) is a commendable step in this direction.

As part of the Long Term Services and Support Community Partners (LTSS CP) program, providers should be equipped to and demonstrate that they can meet the unique needs of children, youth, and families (p. 30). In addition, due to the high administrative costs of managing the LTSS CP program, MassHealth should robustly fund this program in order to orchestrate data sharing, communication, and coordination between primary care providers and CPs (p. 30). MassHealth should provide sustainable funding for its various providers, whether or not based in larger hospital settings.

MassHealth has been a leader in efforts to improve its workforce, and support for building and training of the primary care and behavioral health workforce should continue with the new waiver (p.14).

Goal 2: Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care

MassHealth has made major strides in its efforts to strengthen primary care for beneficiaries. The proposed enhancements in primary care for children and youth will make substantial improvements in the breadth and quality of care that people under age 21 receive. The emphasis on integrated mental/behavioral health and team-based care, inclusion of community health workers and family partners/peers, and team building will greatly strengthen primary care for young people and their families. Given the long-term impact of preventive care on children, we recommend behavioral health services for children explicitly include building resilience and emphasizing parent-child interactions. Virtual care (via video and/or telephone) has substantially increased access to behavioral health services and should be explicitly included in behavioral health integration and services.

We appreciate the work on a primary care tiering model and look forward to working with MassHealth on pediatric-specific tiers. Development of the capitation plan will require careful planning to address pediatric-specific needs.

Description of the primary care sub-capitation model (p. 38-39) refers to provider-level accountability for ACO total cost of care and quality: “Primary care providers will be at risk for their quality performance as well as the ACO’s overall quality performance, through their share in the ACO’s quality incentive.” We are concerned about potential downside risk borne by individual providers; rather, we believe systems or groups (e.g., ACOs) should carry any downside risk, especially in areas that require collaboration and partnerships across disciplines.

Goal 3: Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals

The intentional focus on health equity in this goal and throughout the waiver proposal is critical. MassHealth has pioneered the use of funds to support the social needs of recipients; we strongly support the proposal to increase access to the Flexible Services Program (FSP) for pregnant and postpartum women, children, and families, as well as the FSP family-level nutrition supports proposed. These provisions will likely lead to increased household food security and associated health benefits.

Under the FSP, we recommend broadening the definition of risk to include multiple social risk exposures and encouraging use of social risk alone as sufficient for eligibility for flexible spending dollars and other social services under the FSP. The request seems to define “rising risk” for children as inclusive only of medical complexity (p. 26) whereas “rising risk” for adult members includes “social needs” (p. 33).

We strongly approve of the expanded nutrition support under FSP to include the whole family and expansion of support to postpartum members for 12 months, but we see additional opportunities to expand FSP to benefit children and families. Within the changes to the FSP (p. 56-58), we recommend expanding eligible services beyond the two primary focus areas (e.g., nutrition and housing) to include other essential whole family needs (e.g., employment support, transportation, childcare beyond when the adult is receiving support, school support), parenting supports addressing the entire family, facilitating enrollment in public benefits, and interpersonal and intimate partner violence services. For FSP Change 3 (p. 58), we are unclear if the FSP services available to postpartum women for the full year will also benefit their children. We recommend that the benefits (e.g., nutrition supports) should be extended to their children.

It is critical that measurements to demonstrate annual reductions in health inequities be relevant and specific to children and families, including stratification by age. Ideally, the measurement tool to capture these data should be standardized across ACOs to enable comparison. To the extent that much of the data collection will occur at the primary care level, primary care sites should have sufficient resources, including technical assistance, to undertake the work and should share in the incentives related to both collection and reporting. Reducing inequities is a systems-level responsibility, and we concur with accountability at the ACO level.

Finally, we strongly support the continuity of coverage for incarcerated individuals of all ages. While few children and youth will directly benefit from this expanded coverage, there will be substantial benefits to families and communities as many incarcerated individuals have children highly affected by their parents’ status.

Goal 4: Sustainably support the Commonwealth’s safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care

CAHI strongly supports the role of safety net providers in providing care to individuals, while also being accountable for population health and health equity, as stated in the request. Safety net providers in Massachusetts provide much needed care to many children, youth, and families.

Goal 5: Maintain near-universal coverage including updates to eligibility policies to support coverage and equity

In line with MassHealth's goal to maintain near-universal coverage, we recommend providing 3-5 years of continuous eligibility for children and youth. Continuous eligibility for children not only ensures access to health care during a critical time in a person's development but is also an essential foundation for MassHealth's goal of continuing to move towards more accountable, value-based care.

In addition to the comments specific to each goal area outlined in the request, CAHI also notes the following:

- There is minimal reference to the role of schools in the request. Schools play an integral role in the lives of children and youth and should be partners in care coordination with community-based partners and PCPs, especially for those children with mental health/behavioral health issues.
- Although the waiver draft posted for public comment did not include a proposed measurement set, MassHealth has shared their proposed set through other venues. We strongly support the proposed set. This set includes several measures new to MassHealth that are high priority child health items (e.g., measures of developmental screening, use of topical fluoride), retains several other priority items (e.g., depression screening and follow up), and discontinues measures that were problematic. Data generated from ACOs around these measurements should be shared with stakeholder groups, including CAHI.
- Rather than a five-year evaluation period of the waiver (p. 90-92), we recommend a 10 year evaluation in order to assess the long-term return on investment and cross-sector savings that are particularly relevant in pediatrics and to track and analyze the Section 1115 waiver demonstration's impact on children and their families across health and non-health sectors.

CAHI will continue to communicate with MassHealth and advocate for a series of priorities that center children and families (outlined in CAHI's 2020 [Moving to the Vanguard on Pediatric Care](#) Report), including:

- Requiring optimal and equitable investment in pediatric care.
- Enhancing the collaboration and interface between health and education sectors.
- Developing a pediatric-specific dashboard and ongoing measurement taskforce.
- Engaging in ongoing review of child and adolescent care, both at the ACO plan level and statewide.
- Engaging families in decision-making on ACO/MCO Patient and Family Advisory Councils.
- Convening MassHealth stakeholders on pediatric issues.
- Assuring child and adolescent health representation on all key MassHealth oversight and technical committees.
- Requiring DC: 0-5 code utilization for young children and their families.
- Revising auto-assignment algorithm to promote family-based enrollment.

We look forward to discussing these recommendations with you. We again express our appreciation for your thoughtful work to weave in policies and programs into the 1115 waiver request that will enhance care for children, youth, and families. Please do not hesitate to reach out with any questions or clarifications.

Sincerely,

Lisette Blondet, EdM

Suzanne Curry

Greg Hagan, MD

Charles Homer, MD, MPH

James M. Perrin, MD

On behalf of the Child and Adolescent Health Initiative members

Attachment 1. Child and Adolescent Health Initiative Membership

Name	Organization	CAHI Sub-Workgroup Membership
Alexy Arauz Boudreau, MD, MPH	MassGeneral Brigham	Social Determinants of Health, Measurement
Richard Sheward, MPP	Children’s Health Watch	Social Determinants of Health, Community/School Interface
Eileen Costello, MD	Boston Medical Center	Unique Needs of Children/Youth, Behavioral Health
Suzanne Curry	Health Care For All	Unique Needs of Children/Youth, Behavioral Health, Complex Medical Conditions, Executive Committee
Chad d’Entremont, PhD	The Rennie Center for Education Research & Policy	Behavioral Health, Community/School Interface
Yaminette Diaz-Linhart, MSW, MPH	Brandeis University	Community/School Interface
Lloyd Fisher, MD	Reliant Medical Group; MA Chapter, American Academy of Pediatrics	Unique Needs of Children/Youth
Joshua Greenberg, JD	Boston Children’s Hospital	Unique Needs of Children/Youth, Social Determinants of Health
Greg Hagan, MD	Cambridge Health Alliance; Co-chair, MCAAP Medicaid ACO Task Force	Unique Needs of Children/Youth, Behavioral Health, Community/School Interface
Charles J. Homer, MD, MPH	EmPATH; senior advisor, MCAAP Medicaid ACO Task Force	Social Determinants of Health, Measurement, Executive Committee
Lisa Lambert	Parent Professional Advocacy League	Behavioral Health, Community/School Interface
Mike Lee, MD, MBA	Boston Children’s Hospital	Complex Medical Conditions
Patricia Nemia	Federation for Children with Special Needs	Complex Medical Conditions, Community/School Interface
James M. Perrin, MD	MassGeneral Brigham; Co-chair, MCAAP Medicaid ACO Task Force	Unique Needs of Children/Youth, Executive Committee
Dan Slater, MD	Atrius Health Care	Behavioral Health; Complex Medical Conditions, Measurement
Michael Tang, MD, MBA	Dimock Community Health Center	Behavioral Health
Lisette Blondet	Massachusetts Association of Community Health Workers	Executive Committee

MassHealth Leadership Attendees

Clara Filice, MD, MPH. MHS
 Kate Ginnis, MSW, MPH
 Aditya Mahalingam-Dhingra, MPH

Several other child/adolescent health professionals helped in the subgroups, including Drs. Rich Antonelli (Boston Children’s Hospital), Mark Mandell (Steward Health), Jack Maypole (Boston Medical Center), Matt Sadof (Baystate Medical Center), and Michael Yogman (Mental Health Task Force)



September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to 1115-Comments@mass.gov

RE: MassHealth Section 1115 Demonstration Waiver Extension Request

Dear Acting Assistant Secretary Cassel Kraft,

On behalf of the Children's Health Access Coalition (CHAC), thank you for the opportunity to submit comments on MassHealth's 1115 Waiver Extension proposal. CHAC is a coalition of providers, advocates, community organizations and other stakeholders committed to ensuring that every child in Massachusetts has access to high quality, affordable, and culturally appropriate health coverage and services. CHAC greatly appreciates MassHealth's commitment to improve access to coverage and care for the most underserved individuals and families in the Commonwealth. Importantly, MassHealth names improvements in pediatric care as one of its goals for the 1115 waiver renewal, which is clearly reflected in key portions of the 1115 waiver proposal. Children and youth comprise approximately 40% of MassHealth's membership, and it is vital to make investments in pediatric care reforms that improve long-term health outcomes. We ask you to consider our comments, questions and recommendations below as you prepare the 1115 waiver renewal for submission to the Centers for Medicare and Medicaid Services.

Health Equity

CHAC strongly supports MassHealth's goal to reduce health inequities among its members through an iterative approach of data collection, stratification and accountability. Both within the health equity framework and more broadly, we request that MassHealth also stratify data by age as well as zip code (although we understand this may be considered in other risk factor scores). We further request that MassHealth publicly share data about its programs and initiatives, including health equity, via an accessible dashboard or similar tool.

It is worth noting that while we strongly support the efforts to require data collection of demographic information, we also urge caution around privacy, particularly as it relates to sexual orientation and gender identity and children/adolescents who may have not "come out" to their caregivers.

Health-Related Social Needs

CHAC thanks MassHealth for highlighting health-related social needs (HRSNs) as a top priority and including a robust plan for the continuation of the Flexible Services program. We support the proposals to provide nutrition supports at the family level, offer child care while caregivers engage in supports, and allow the Flexible Services program to serve members 12 months postpartum. We ask MassHealth to consider additional allowable Flexible Services expenses, such as assistance with issues related to schools, parenting supports, and other services to specifically support children and families.

Primary Care

CHAC supports MassHealth's goals for the primary care sub-capitation program – recognizing the unique needs of children and families, promoting team-based integrated behavioral health, improving care coordination – including addressing health-related social needs (HRSNs), and expanding access. MassHealth must ensure that the capitation and any remaining fee-for-service rates do not underpay for pediatrics, which often focuses on promotion, prevention, and early intervention. The rates should also take into account complexity of a family's situation and needs, and make sure team members not typically eligible for reimbursement, such as Community Health Workers (CHWs), family partners, and other peers, are sustainable under this rate. Further, pediatric care often requires more coordination with “collateral contacts” outside the health care system, which also must be considered when setting care delivery expectations and rates. In order to measure the effectiveness of the primary care sub-capitation program, we encourage MassHealth to explore more quality measures tied to the pediatric-focused care delivery expectations and the family experience of care.

Behavioral Health

CHAC supports efforts to enable integration of behavioral health in primary care. Nearly all children have regular visits with a pediatrician, especially in infancy and early childhood, positioning pediatric primary care as an appropriate setting for addressing child behavioral, mental, social-emotional, relational, and developmental health. Pediatric primary care visits are also important opportunities to address the needs of caregivers. We are hopeful that the reforms contemplated in the 1115 waiver, State Plan, Behavioral Health Roadmap, and other initiatives will increase access to quality, culturally competent behavioral health care for children, that will help avert urgent and emergent situations that contribute to the Emergency Department (ED) boarding crisis, which has been exacerbated by the COVID-19 pandemic. We also appreciate the move to simplify behavioral health networks and want to make sure a top priority is continuity of care, increased access, and protections against coverage denials.

Care Coordination

We support MassHealth's efforts to simplify and streamline care coordination for individuals and families, and appreciate that MassHealth recognizes the importance of patients and family members as key partners on coordination of care. Currently, many families are often left with the responsibility of coordinating care, either because they do not have a care coordinator or they have too many. There should be a more rational system for facilitating access to across all levels of types of care and supports, including those that affect families' health but not be situated within the health care system, such as social services and schools. For example, many children with individualized education plans (IEPs) only receive services in school, and schools are often the first place that issues are identified. However, the primary care physician often has no knowledge of these services or issues. This is a major disconnect, and while MassHealth cannot exclusively mitigate these challenges, we are hopeful that the expectations built into the primary care sub-capitation program and the care coordination framework can begin to help break down some of these siloes.

For children with the most complex health care needs, we support a care coordination and case management program that is available across delivery systems and we look forward to learning more details about implementation of the benefit. The waiver documents states that “select” academic medical centers and primary care providers will provide this benefit. We request that MassHealth allow choice for families if their preferred coordinator is outside these institutions.

As indicated in the waiver document, MassHealth is collaborating with other state agencies, such as the Department of Public Health (Maternal Health/Title V), Department of Children and Families, Department of Youth Services and others for young people who may be receiving services through multiple agencies.

The most vulnerable children in the Commonwealth, including children in foster and congregate care, should benefit programs and policies that improve the quality, continuity, and experience of care.

Eligibility & Benefits

Maternal Health

CHAC reiterates our strong support of MassHealth's 1115 waiver amendment to extend postpartum coverage from 60 days to 12 months, and greatly appreciates MassHealth's commitment to extending the same postpartum coverage regardless of immigration status. This coverage extension is a foundational policy that will support other efforts that begin to address maternal health disparities, such as coverage for doula services and enhanced care coordination and support for pregnant members at high risk of adverse outcomes. We recommend that MassHealth work with doulas, advocates, and recipients of doula care when developing its State Plan Amendment for the doula benefit.

Continuous Eligibility

As with the extension to 12-months postpartum coverage, CHAC supports efforts to ensure members maintain coverage during especially vulnerable populations, such as homeless individuals and those leaving incarceration. We again urge MassHealth to implement 12-month continuous eligibility for children as 24 of states have done in their Medicaid and Children's Health Insurance Programs. Stable coverage not only helps ensure access and continuity of care, it is also a base for implementing payment and care delivery system reforms, such as those proposed in the waiver renewal.

Retroactive Eligibility

CHAC also appreciates that MassHealth prioritizes children and pregnant women in its proposal to rescind the waiver of 3-month retroactive coverage. We ask MassHealth consider expanding this policy in the future to all applicants under age 65 to help facilitate access to care and mitigate medical debt.

Thank you again for the opportunity to comment on MassHealth's 1115 waiver renewal. We appreciate the thought and hard work that went into developing a proposal that aims to improve care for MassHealth's diverse membership and lifts up the needs of children and families. Please email scurry@hcafma.org if you have any questions or wish to discuss our comment letter.

Sincerely,

Suzanne Curry
Behavioral Health Policy Director, Health Care For All
On behalf of the Children's Health Access Coalition

Cc: Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation, MassHealth
Emily Bailey, Chief of Behavioral Health, MassHealth
Mohammad Dar, MD, Senior Medical Director, MassHealth
Clara Filice, MD, Associate Medical Director for Payment & Care Delivery Innovation, MassHealth
Kate Ginnis, Senior Director, Child, Youth & Family Policy and Programs, MassHealth
Ryan Schwarz, MD, Director of Policy for Accountable Care, MassHealth
Martha Farlow, Deputy Director, Policy, MassHealth

CHAC Member Organizations

Action for Boston Community Development, Inc.
Alliance for Inclusion and Prevention
American Academy of Pediatrics MA Chapter
Association for Behavioral Healthcare
Boston Children's Hospital
Boston Public Health Commission
Cambridge Health Alliance
Children's Law Center of Massachusetts
Children's League of Massachusetts
Children's Vision Massachusetts
Coalition for Social Justice
Codman Square Health Center
Community Catalyst
Economic Mobility Pathways (EMPath)
East Boston Ecumenical Community Council (EBECC)
Federation for Children with Special Needs
Franciscan Children's
Health Care For All
The Health Foundation of Central Massachusetts
Health Law Advocates
Home Care Alliance of Massachusetts
The Home for Little Wanderers
Joint Committee for Children's Health Care in Everett
Massachusetts Advocates for Children
Massachusetts Coalition of School-Based Health Centers
Massachusetts Commission on LGBTQ Youth
Massachusetts Early Intervention Consortium
Massachusetts Health & Hospital Association
Massachusetts Immigrant and Refugee Advocacy (MIRA) Coalition
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Medical Society
Massachusetts Pediatric Home Nursing Care Campaign
Massachusetts School Based Health Alliance
Massachusetts School Nurse Organization, Inc.
Mass General Brigham
Medical-Legal Partnership Boston
Mental Health Legal Advisors Committee
Massachusetts Society for the Prevention of Cruelty to Children (MSPCC)
National Association of Social Workers, MA Chapter
New England Alliance for Children's Health
Parent/Professional Advocacy League
United Way of Massachusetts Bay and Merrimack Valley



September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to 1115-Comments@mass.gov

Re: MassHealth Section 1115 Demonstration Waiver Renewal

Dear Acting Assistant Secretary Cassel Kraft,

On behalf of the Children's Mental Health Campaign (CMHC), thank you for your commitment to ensuring that the unique needs of children, youth, and families are considered in MassHealth's Section 1115 Demonstration Waiver Renewal, including in the provision of behavioral health care. The CMHC is a large statewide network that advocates for policy, systems, and practice solutions to ensure all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way. The CMHC Executive Committee consists of six highly reputable partner organizations: The Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care For All, Health Law Advocates, and the Massachusetts Association for Mental Health.

The behavioral health needs of children, youth and families have increased substantially during the COVID-19 pandemic and these needs are not going to diminish in the months and years following the end of the public health emergency. Along with the Behavioral Health Roadmap, the 1115 waiver renewal presents a timely opportunity to improve behavioral health care access throughout the continuum – from promotion and prevention through acute inpatient treatment. We ask you to consider these comments as you finalize the waiver proposal and implement complementary changes through other policy vehicles.

Primary Care Reforms

Team-Based, Integrated Care

The CMHC supports the overall framework for MassHealth's primary care reforms, particularly the prioritization of integrated behavioral health. We are pleased to see specific expectations and requirements related to children, youth and families, as well as an emphasis on team-based care that includes behavioral health clinicians and family partners, peers and community health workers on the care team; and specific care delivery expectations for children, youth and families. We are optimistic that these features of the proposed primary care sub-capitation program will enhance care for children and families enrolled in Accountable Care Organizations (ACOs), increasing the opportunity for early intervention and potentially relieving some pressure on the specialty behavioral health system.

The 1115 waiver should enable more opportunities for pediatric practices and community behavioral health clinics to provide promotion, prevention, and early intervention services to families. The CMHC

enthusiastically supports MassHealth’s recent guidance allowing for coverage and payment for up to six behavioral health visits without a diagnosis for enrollees under the age of 21, within the pediatric primary care, community behavioral health, and/or school settings. Additional specific opportunities for this type of work include utilization of the DC:0-5 diagnostic tool for young children – which is also included in the specifications for the Community Behavioral Health Centers (CBHCs) – and covering a secondary Screening, Brief Intervention and Referral to Treatment (SBIRT) screen after an initial positive screen to catch possible substance use issues early.

Integrated Primary Care Rates

The primary care sub-capitation payment must be sufficient enough to enable good integrated care, including properly valuing pediatrics broadly and essential team members, including behavioral health clinicians and non-clinician professionals. We applaud MassHealth for taking multiple steps over recent years to address disparities in rates paid to both primary care and behavioral health practitioners. As you know well, these reimbursement rates have been significantly lower than other medical practice areas. Building rates upon historically low rates risks reinforcing the disparity and leaves little room for error in ensuring that resources are sufficient to deliver the important patient results the Commonwealth seeks in promoting integrated care. In particular, reimbursement rates must be reflective of the requisite staffing needs, especially of those roles that have previously been largely unreimbursed, including family partners, peer professionals, and community health workers.

While rates for physical health care are often adjusted for complexity, this is not the case for behavioral health. In addition, work with children can include more “collateral contacts” than adults, which is not often covered by current rate structures. In both the integrated primary care setting and in behavioral health care more generally, reimbursement should account for complexity. The COVID-19 pandemic has only increased the need to address more complex and acute conditions, requiring time-intensive and complicated interventions and, in many cases, coordination among multiple providers and different levels of care. At the same time, integrated care and behavioral health rates must consider the promotion and prevention focused work that pediatrics is built around, including the new ability to provide short-term behavioral health services without a diagnosis, which MassHealth indicates will be built into the primary care sub-capitation payments.

Peer Professionals

Peer support workers and community health workers are core roles in the behavioral health system. Family partners are caregivers of children with behavioral health needs who combine family-centered supports based on their lived experience navigating services and systems. Because of their own experience, family partners have a unique role in helping families access services, increase self-advocacy skills, and decrease caregiver anxiety and stress.^{1,2} In addition, family partners may come from diverse cultural backgrounds and understand the culture of the families they work with, and help design communication strategies that respond to the specific social, cultural and linguistic needs and values of that group. Family partners are a cost-effective

¹ Sameera S. Nyack, Carol Tobias, Jessica Wolfe, Kate Roper, Larisa Méndez-Peñate, Christy Moulin, Malika Arty, Arielle A.J. Scoglio, Amy Kelleher, Jacqueline Rue, Molly Brigham, Tarsha Bradshaw, Natasha Byars, Angelina Camacho, Sade Douglas & Beth E. Molnar, “Engaging and Supporting Young Children and their Families in Early Childhood Mental Health Services: The Role of the Family Partner.” February 28, 2021. Community Mental Health Journal, February 28, 2021. Available at: <https://link.springer.com/article/10.1007/s10597-021-00796-8>.

² Substance Abuse and Mental Health Services Administration, Value of Peers Infographics: Family Support. Available at: https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/family-parent-caregiver-support-behavioral-health-2017.pdf.

workforce that have been shown to be effective in improving access to care, reducing unmet needs, and achieving parental satisfaction with care, and maintaining long-term health coverage.³ Overall, family partners and peers are valuable in helping families feel more comfortable and welcome in medical settings. Fair payment for family partners, peers, and community health workers must be included in any care delivery and payment reforms. The CMHC also recognizes and supports the work underway to develop a certification process for family partners and other peers. We recommend that EOHHS consult with key stakeholders, especially people who already serve as peer and family support professionals and the families they serve, in the development and implementation of the certification process.

Care Coordination

The CMHC appreciates MassHealth's proposals to streamline, simplify, and increase oversight of care coordination activities, while allowing for some measure of provider flexibility and innovation. We particularly appreciate that MassHealth recognizes the role of families in choosing which provider(s) would best meet their care coordination needs, as is specifically spelled out in the new Targeted Case Management program for children with highly complex needs. Family involvement and choice in determining the entity that is best positioned to provide care coordination should be a baseline expectation across the board. We acknowledge that for most families, care coordination is done through primary care, and while closed-loop referrals and coordination with the Children's Behavioral Health Initiative (CBHI) is a current expectation for ACOs, this is rarely done successfully. In addition, CBHI is a time-limited service and care coordination needs for young people with significant behavioral health needs often extend beyond that time. Intensive Care Coordination (ICC) usually only coordinates the services outlined in their specifications and usually does not take on other services the primary care provider may add, such as occupational therapy. We are hopeful that the new care delivery expectations for primary care and community behavioral health will facilitate better collaboration for children who receive CBHI services.

Good pediatric care necessitates coordination both within the health care system and outside the health care system, most notably with schools. Those pediatricians in the Commonwealth who have taken the leadership in providing integrated care and care coordination stress the work with not only families but also childcare centers, schools, and related child-serving institutions. As children return to child care and school this fall, it is already evident that there are high mental and behavioral health needs. It is a longstanding challenge to coordinate care between the health care and education sectors, but one that is more important than ever. We request that MassHealth build in specific expectations for care coordination among all entities providing children's behavioral health services, including but not limited to, primary care, CBHI, the new CBHCs and youth Crisis Stabilization Services, community outpatient care, and more acute levels of care (e.g., Partial Hospitalization programs, inpatient, Community-Based Acute Treatment), and education. It is even more challenging, but imperative, that the Commonwealth's most vulnerable children, such as those engaged in Department of Children and Families services, benefit from more accountable, higher quality care. We appreciate that MassHealth is working across child-serving agencies to explore ways to improve access to care for multi-agency involved children and youth.

Quality & Accountability

Accountability mechanisms are necessary to ensure that primary care providers participating in the sub-capitation program are meeting care delivery expectations and the overarching goals of primary care

³ Glenn Fiores, MD, Hua Lin, PhD, Candy Walker, PhD, Michael Lee, MD, Janet M. Currie, PhD, Rick Allgeyer, PhD, Marco Fierro, BA, Monica Henry, BS, Alberto Portillo, BS, and Kenneth Massey, BA, "Parent Mentors and Insuring Uninsured Children: A Randomized Control Trial," PEDIATRICS Volume 137 , number 4 , April 2016. Available at: <https://pediatrics.aappublications.org/content/pediatrics/early/2016/03/16/peds.2015-3519.full.pdf>.

payment reform, and to protect members and families from underservice. One way to hold practices accountable is through quality measures tied to payment. The CMHC asks MassHealth to consider supplementing existing metrics with additional pediatric-specific metrics, such as screening follow up (including caregiver screenings) and effectiveness of integrated behavioral health. We also understand that there are long-standing efforts in the Commonwealth to align quality metrics across payers and that metrics must be carefully considered for their ability to meaningfully measure care quality and inform payment policies.

Health Equity

The CMHC appreciates that MassHealth includes addressing health equity and health-related social needs among its top priorities for the 1115 waiver renewal. We support the proposed health equity program to require ACOs to collect and stratify data and hold them accountable for reductions in disparities among its members. We appreciate that the data stratification will include race, ethnicity, language, disability, sexual orientation, and gender identity. Of note, it has been well documented that LGBTQ+ youth are disproportionately vulnerable to negative mental health consequences surrounding COVID-19.⁴ Here in Massachusetts, in an online survey conducted by the Massachusetts Department of Public Health (DPH), between September and November 2020, 83 percent of youth identifying as non-binary or queer reported more than 15 days of poor mental health in the past 30 days.⁵ Seventy-five percent of youth with any disability and 48 percent of all youth reported feeling sad or hopeless almost every day for 2 weeks or more. Parents of children with special health care needs who responded to the Community Survey were 60 percent more likely to report poor mental health.⁶ This both speaks to the importance of collecting accurate data and collecting in a respectful way that also honors privacy and comfort of each individual. For example, there are some serious concerns regarding data collection in pediatrics, especially with regard to sexual orientation and gender identity and child/adolescent privacy. While there is a very important need to collect this data, MassHealth and ACOs must do so in an informed way that assures necessary confidentiality when parents/caregivers are likely to have access to medical records and other types of health care information.

Given the significant impact that COVID-19 has had on the behavioral health needs of the Commonwealth's residents, we urge MassHealth to use meaningful, well-vetted measures to reflect the level of disparities in behavioral health care. Further, we request that MassHealth also stratify data by age groups, both for the health equity initiative and for data collection and dissemination more broadly, and that the data be publicly available to the extent feasible and appropriate.

Health-Related Social Needs

The CMHC also supports the continuation of Flexible Services Program (FSP) and other features of the ACO program meant to increase the health care system's role in supporting MassHealth members' health-related social needs (HRSN), such as housing and food insecurity. These factors are not only important contributors to physical and behavioral health outcomes overall, but are important drivers of racial health inequities. We applaud MassHealth for proposing that nutrition supports be provided on the family or household level and child care be provided during a caregiver's appointment to receive these supports. The

⁴ Panchal N, Kamal R, Cox C, Garfield R, Chidambaram P. "Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic, Kaiser Family Foundation", May 2021. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/>.

⁵ Massachusetts Department of Public Health, COVID-19 Community Impact Survey: Impact of COVID-19 on Youth, June 2021. Available at: <https://www.mass.gov/doc/ccis-webinar-youth-part-1/download>.

⁶ Massachusetts Department of Public Health, COVID-19 Community Impact Survey: Parents and Families, June 2021. Available at: <https://www.mass.gov/doc/ccis-webinar-parents-and-families/download>.

CMHC requests that MassHealth add assistance with school issues, including helping families receive appropriate school-based services and accommodations, including for behavioral health concerns. This is especially important in the aftermath of the pandemic, as the full breadth of the disruption and need for services caused by the pandemic is not yet evident.

MassHealth Behavioral Health Benefit & Administration

Access to Diversion and Step-Down Services

The CMHC appreciates MassHealth's proposal to expand coverage of all inpatient diversion and step-down support services to the fee-for-service population, which will help adults access intensive behavioral health services that help keep people in the community and out of inpatient settings. Similarly, the CMHC's goal is to ensure that children and families have access to the full continuum of services, and that all children can get the intensive services they need to prevent unnecessary inpatient hospital admissions and long lengths of stay. These services can be instrumental not only in diverting inpatient admissions and mitigating unnecessarily long stays, but also in preventing Emergency Department (ED) boarding among children and youth who might readily and effectively be served in intensive home and community care. MassHealth should ensure access to intensive treatment options for those children who may not meet medical necessity for CBHI, for example, the Program of Assertive Community Treatment (PACT) as modified to appropriately serve children and adolescents. The CMHC recommends that PACT for children preserve continuity with current providers and caregivers, including prescribers, if the family prefers. Our intent is to promote development of a benefit that would be provided through both MassHealth and private insurers, to avoid a similar dynamic to CBHI in which families with primary private insurance could only access CBHI's services through MassHealth secondary coverage, placing an undue burden on MassHealth resources. When the requirement was issued for private insurers to cover Behavioral Health for Children and Adolescents (BHCA), the services covered through private insurance did not quite match CBHI services. The CMHC's aspiration is that both MassHealth and private insurers cover intensive, community-based services that provide alternatives to inpatient care and that meet MassHealth's standards and adequately serve the needs of families.

Behavioral Health Network

As MassHealth considers new options to manage the behavioral health benefit, we urge you to incorporate the following principles:

- Promote continuity of care for members who shift between plans, allowing continuation of current/ongoing provider relationships without needing to take additional steps;
- Increase access to care through the development of broader, robust network(s), with special attention to sub-populations, such as children and youth, including young children (birth to six), people with co-occurring intellectual, developmental and/or other disabilities, Black, Indigenous and other People of People of Color (BIPOC), LGBTQ+, people with language access needs, and geographic diversity (e.g., Western Massachusetts);
- Ensure network adequacy at all levels of care;
- Implement consumer protections, such as a simple exceptions process, to allow members to go outside of the established behavioral health network if there is not capacity within the network to meet their needs; and
- Enforce federal mental health and addiction parity laws to ensure that administrative barriers to accessing behavioral health care are no more restrictive than those used to access medical treatment.

We are pleased to see that independent clinicians will be included in the proposed standard behavioral health network. An ongoing access issue with the MassHealth fee-for-service benefit has been the lack of coverage for independent psychologists and social workers who are not based at or bill through a community-based

behavioral health clinic or community health center. Ensuring that these providers are included in the network will increase the availability of providers for members who utilize the fee-for-service network through primary or secondary coverage.

Administrative Simplification

The CMHC is hopeful that, along with other changes, administrative simplification will increase access for MassHealth members by maintaining in-network providers and bringing new providers in network. There are also efforts underway in the commercial insurance space, such as through the Mass Collaborative, to streamline administrative forms requirements that MassHealth could align with to simplify across payers, if it does not result in inhibiting access for members, and adhere to the principles outlined above. Utilization management and medical necessity criteria should not be any stricter than today; in fact, there are opportunities to strengthen consumer protections from unnecessary denials of behavioral health care and reinforce mental health and addiction parity laws.

Behavioral Health Rates

The CMHC acknowledges and thanks the administration for making significant investments in MassHealth behavioral health rates for both community-based providers and the recent rate enhancement for inpatient care, to help address the ED boarding crisis. Even with these adjustments, there is still work ahead to adequately address the longstanding underinvestment in behavioral health care. Sufficient rates are important not only to support providers doing the work but also to ensure a strong provider network that is able to serve all MassHealth members. Targeted investments must also be made to build a behavioral health system and corresponding workforce that is able to meet the needs of a diverse patient population both in terms of level of need and factors such as age, race, ethnicity, language, co-occurring disorders, developmental stage, sexual orientation, gender identity, and disability.

Continuous Eligibility for Children

While MassHealth has made considerable efforts in the past several years to address coverage gaps, families still experience this problem. We applaud MassHealth for proposing eligibility changes that extend postpartum coverage to 12 months, allow formerly incarcerated adults to maintain coverage for 12 months, and homeless individuals to have continuous coverage for 24 months. In concert with these changes, MassHealth asks that the agency also consider filing a State Plan Amendment for 12 month continuous eligibility for children. Twenty-four states have already taken up this option for both Medicaid and the Children's Health Insurance Program (CHIP).⁷

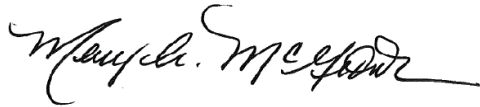
Continuous eligibility would not only ensure that children and adolescents maintain coverage, it could also help maintain a more stable foundation for MassHealth's payment and care delivery reforms. While continuity of care is important for all populations and health care services, it is especially crucial for children's behavioral health. With the ongoing impacts of the pandemic and the acceleration of the ED boarding crisis, now is a critical time to consider all available levers to mitigate access barriers. Any disruptions in behavioral health care could cause an escalation of symptoms, necessitating increasingly acute interventions in an already overburdened system; adding to family stressors; and impacting the ability of children and youth to engage in school and community activities.

Thank you for the opportunity to submit comments on MassHealth's Section 1115 Demonstration Waiver Renewal and for MassHealth's leadership to improve access to behavioral health care for children and families

⁷ Tricia Brooks and Allexa Gardner, Continuous Coverage in Medicaid and CHIP, July 2021. Available at: <https://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf>.

across the Commonwealth. Should you have any questions or wish to discuss the CMHC's recommendations further, please contact Suzanne Curry at Health Care For All at scurry@hcfama.org or Courtney Chelo at MSPCC at cchelo@mspcc.org.

Sincerely,



Mary A. McGeown, Executive Director, MSPCC
On behalf of the Children's Mental Health Campaign

Cc: Commissioner Brooke Doyle, Department of Mental Health
Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation, MassHealth
Emily Bailey, Chief of Behavioral Health, MassHealth
Mohammad Dar, MD, Senior Medical Director, MassHealth
Clara Filice, MD, Associate Medical Director for Payment & Care Delivery Innovation, MassHealth
Kate Ginnis, Senior Director, Child, Youth & Family Policy and Programs, MassHealth
Ryan Schwarz, MD, Director of Policy for Accountable Care, MassHealth
Martha Farlow, Deputy Director, Policy, MassHealth



CITY OF WORCESTER

The City of Worcester's Reentry Task Force, Chaired by the Department of Health and Human Services Commissioner Dr. Matilde Castiel, submits this letter in support of the 1115 MassHealth Demonstration Extension Request.

The City of Worcester's Reentry Task Force originated in 2019 from years of prior interest, activism and efforts made by various Worcester community members and stakeholders. In 2015, Massachusetts State Representative Mary Keefe and Worcester Commissioner of Health and Human Services Dr. Matilde Castiel began meeting with local stakeholders around the issues of reentry and criminal justice reform as a whole. These meetings raised awareness on the issue of reentry in the community and involved tours of the County Jail, presentations by experts in criminal justice, and meetings with individuals with lived experience.

In 2018, a group met, including Massachusetts State Representatives Mary Keefe and Jim O'Day, and local leaders, Executive Directors and stakeholders from UMass Medical School, Coughlin Electric, MassHire, Open Sky Community Services, Worcester Department of Health and Human Services (WHHS), and the Coalition for Healthy Greater Worcester, to plan a community forum regarding reentry needs in the community. Sheriff Lew Evangelidis and his staff worked alongside WHHS and this committee to start the Worcester Reentry Task Force (RTF) in July of 2019. The overarching goal of the RTF was to bring together all local stakeholders working on and invested in reentry to: 1) identify current gaps in the reentry system, 2) determine the resources that local and state agencies are able to provide, and 3) create an actionable plan to move this important work forward. The RTF has brought together over 150 individuals from over 40 agencies to collaborate on reentry systems improvement. The RTF has three working groups: 1) Health, 2) Housing, and 3) Education and Employment.

The 1115 MassHealth Demonstration Extension Request provides Massachusetts with an imperative opportunity to meet the healthcare needs of justice-involved individuals, reduce health disparities amongst BIPOC communities and neighborhoods impacted by incarceration, and ultimately reduce negative health outcomes for justice-involved populations. For these reasons, and those outlined below, the City of Worcester's Reentry Task Force recognizes this request as an essential step in working toward health equity for reentry populations.

Beginning in 2018, under the current 1115 demonstration, the Baker-Polito administration implemented the most significant delivery system reforms for MassHealth members in over two decades, restructuring the delivery system towards integrated, value-based and accountable care. The current demonstration period ends June 30, 2022. This fall, MassHealth will submit an 1115



HEALTH AND HUMAN SERVICES
City Hall
455 Main Street
Worcester, MA 01608



demonstration extension to continue progress in improving health outcomes and closing health disparities.

To further improve health outcomes and close health disparities, MassHealth will propose an 1115 demonstration waiver extension with five goals:

- 1) Continue the path of restructuring and re-affirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model
- 2) Reform and invest in primary care, behavioral health and pediatric care that expands access and moves the delivery system away from siloed, fee-for-service health care
- 3) Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals
- 4) Sustainably support the Commonwealth’s safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care
- 5) Maintain near-universal coverage, including updates to eligibility policies to support coverage and equity

The following outlines the importance of the Demonstration Extension Request, as they pertain to equitable social justice healthcare for individuals who are involved in our criminal justice system:

- Extensive stakeholder engagement:
 - MassHealth has completed extensive stakeholder engagement with justice partners over the past year in order to strategically develop an operational plan for this initiative, taking into account the needs and concerns of all agencies involved DOC, MSA, CCFs, and DYS are all key thought partners and have provide crucial time, resources, and partnership throughout this process and plan to continue to do so through implementation.
- Potential to address health equity concerns:
 - The aim of this request is to reduce the stark disparities in health outcomes experienced by these justice-involved populations, who are disproportionately Black and Hispanic.
 - This initiative has the potential to address numerous health equity concerns, given that:
 - While the Commonwealth has one of the lowest incarceration rates in the country, persons of color are still significantly overrepresented within the justice system.
 - In MA, about 55K individuals are incarcerated per year. Black & Hispanic individuals are disproportionately represented in this group, incarcerated at higher rates than white individuals (7.5 times and 4.3 times respectively)
 - Individuals entering carceral settings subject to MIEP exhibit a higher prevalence of health conditions that put them at elevated risk of mortality.
 - Compared to the general population, incarcerated individuals leaving carceral settings are 12.7 times more likely to die within two weeks of release, and are over 120 times more likely to die of a drug overdose within two weeks of release.

The Demonstration Extension Request will address the needs of individuals who are incarcerated in the following aspects:

- MassHealth proposes to provide **uninterrupted** Medicaid coverage to MassHealth-eligible individuals during their incarceration. This would:
 - Further streamline eligibility processes and more effectively integrate this population into the MassHealth program.
 - Decrease disruption of benefits and prevent individuals from “falling through the cracks” after release.
- Going above and beyond the applicable Community Standard of Care for correctional facilities, this expenditure authority is anticipated to contribute to ongoing continuous healthcare improvement efforts for incarcerated and newly released MassHealth members by:
 - Increasing continuity of care.
 - Improving transitions to and from correctional facilities.
 - Enhancing access to healthcare services.

MassHealth and its correctional partners are completing ongoing work to determine how this initiative will be operationalized, with the ultimate goal of ensuring that individuals will have continuous and timely access to coordinated care, consistent with, and in some cases exceeding, community standards

The request to cover individuals in correctional settings is a bold one, but it is a necessary step the Commonwealth must take in order to achieve social justice and health equity for incarcerated individuals, their families and communities at large. The expansion of MassHealth coverage for justice-involved populations would radically increase opportunities for appropriate healthcare services and address existing gaps in the current continuum of care. With this in mind, the Worcester Reentry Task Force also emphasizes that incarceration has historically affected Black and Latinx communities, and presently the generational trauma of incarceration continues to manifest itself through a multitude of negative health outcomes for youth, families and entire neighborhoods. The 1115 MassHealth Demonstration Extension Request would play a pivotal role in rectifying this harm for Black and Latinx communities across the Commonwealth.

Sincerely

The City of Worcester Reentry Task Force



Matilde “Mattie” Castiel MD
Commissioner of Health and Human Services
City of Worcester



Ken Bates
President and CEO
Open Sky Community Services

Diane Gould

Diane Gould, LICSW
President & CEO
Advocates

Michael Rezkalla
Chief Operating Officer
UMass Memorial Community Healthlink

Mark Wagner, Ph.D.
Binienda Center for Civic Engagement
Worcester State University

David McMahon
Co-Executive Director
Dismas House of Massachusetts, Inc.

Nicole Bell



Founder and Chief Executive Officer
Living in Freedom Together-LIFT



Marybeth Campbell
Executive Director
Worcester Community Action Council

Paul Koffi

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Karen Pelletier
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Linda S. Larrivee
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Worcester State University

Karen A. Koller
President & CEO
RCAP Solutions Inc.



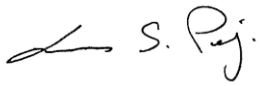
Jeffrey Turgeon
Executive Director
MassHire Central Region Workforce Board



Germán Chiriboga
Program Director
Science Participation Resource Center
UMass Medical School

Michael Coelho
Deputy Commissioner-Programs
Massachusetts Probation Service

Stephen J. Kerrigan
President and CEO
Edward M. Kennedy Community Health Center

A handwritten signature in black ink, appearing to read "L. G. Pedraja". The signature is fluid and cursive, with a large initial "L" and "P".

Luis G. Pedraja
President
Quinsigamond Community College

Vincent L. Lorenti
Director
MA Probation Service- Office of Community Corrections

My name is Kyla Biegun and I have been a Family Medicine NP at Codman Square Health Center for 9 years. I personally received DSRIP loan repayment and would not still be working in Community Health without it. I have been NP Residency Director for 18 months, and leadership training provided through this funding directly lead to my leadership position.

-We have had 4 total NP Residents. 2 of whom are from the Codman Community. Three of whom have language skills relevant for our patient population. All four of whom self-identify as a minority. This really does improve care for patients for a myriad of reasons, that is beyond the scope of this comment. There is one resident in particular, Nnemdi, who sees more staff as patients than any other provider I have seen in my tenure at Codman. To quote our CMO, our recently graduated residents are among "the most beloved providers at Codman." I recently went around the health center to take down our graduation fliers, and the nurses had folded the flier in half removing the graduation announcement and asked to keep up the pictures of our beloved NP Resident graduates. One year out of school, our graduated residents are clinically where it took me many many years to get without a residency. Family Medicine is a BIG job, and this program is essential not only to recruit top talent from the community, but also to train them well and position them for success. Our written goal is to retain 50% of graduates for long term service at Codman, but in our first year it was 100% and I am optimistic this trend will continue. Our residents had a rotation in Substance Use Disorder, and are currently carrying a SUDS patient panel. Our graduated residents are continuing the trend of learning and currently have a rotation in Psychiatry, under the guidance of an experience teacher and Psychiatrist. They are serving patients with significant mental health needs as well as filling the elusive need for provides who prescribe psychiatric drugs.

-The goals laid out in these waivers are important, and I want to emphasize that Primary Care and Community Health is where these goals are truly being addressed with the feet of our NP Residents on the ground.



**Written Comments from Community Care Cooperative on the
MassHealth 1115 Waiver Renewal Request
September 20, 2021**

The purpose of this document is to provide written comments on the MassHealth 1115 Waiver Extension Request (Waiver Request), posted for public comment on August 18, 2021.

First of all, we want to thank MassHealth for the opportunity to participate in the current five-year waiver. It has allowed us to build a strong ACO made up of 18 FQHCs across the state, to invest in the evolution of health centers to value-based care and provided a new level of programmatic focus on patients. Going along with this opportunity, we have appreciated the constructive partnership that MassHealth has maintained with ACOs and community organizations that has made the program successful and allowed unforeseen issues to be addressed in a thoughtful and equitable way.

Secondly, thank you for the opportunity to provide these comments. We want to acknowledge that the posted Waiver Request already reflects the input of C3 as well as other ACOs, FQHCs, community organizations and the larger community through listening sessions and written comments as well as the stakeholder workgroup process.

Our comments here are organized around the topics covered under the first three of MassHealth's five goals for the Waiver Request.

Goal 1: Continue the path of restructuring and reaffirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model

Care Coordination

We strongly support MassHealth's focus on streamlining care coordination and particularly the Community Partner (CP) program. In particular, we endorse the proposed design elements of CPs contracting directly with ACOs and ACOs making the decision of who to refer to CPs. These changes create the basis/preconditions for the type of close partnership between primary care and CPs that is required for the effort to be both successful and efficient. For example, it will allow ACOs and primary care to work with patients to determine where the primary point of engagement lies and rely on that organization to facilitate overall care coordination. If MassHealth plans to have targeted referral requirements for ACOs to CPs, we strongly urge that those targets not be set so high as to limit this flexibility.

This design will also allow ACOs to focus their efforts on working well with a few CPs – developing and automating processes for care planning and coordination, developing co-location arrangement -- and less on the administrative requirements that currently dominate ACO's CP focused work.

Pharmacy

The proposal to introduce a new 340B drug reimbursement model for eligible providers that meet specific criteria is potentially beneficial for health centers. The current model that reimburses 340B



actual acquisition cost plus the dispensing fee does not allow any margin related to health centers' Medicaid patients, which represent the vast majority of patients for most health centers. While Tier 1 status would ultimately be best, and should be assigned to all Federally Qualified Health Centers, we have questions about the criteria for Tier 1. They are as follows:

- What is the threshold determination for “a high percentage of MassHealth members”?
- How is the reimbursement determined between the 340B AAC and NADAC/WAC?
- What constitutes strong clinical pharmacy integration?
- How long would these Tiers be effective before being reassessed?
- Is simply being part of an ACO enough to constitute ACO participation or are more specific measures required?

While welcomed, the proposal does leave room for interpretation as it pertains to the Tier 1 criteria. Is meeting all criteria required for Tier 1 status, or would there be a minimum short of 100% adherence? Given the importance that additional reimbursement can have on health centers being able to meet the needs of our patient population, it will be advantageous for FQHCs to always be considered Tier 1. An increase in reimbursement that can be sustained and relied upon when eligible drugs are dispensed will be invaluable to fulfilling our collective missions.

Goal 2: Make reforms and investments in Primary Care, Behavioral Health and Pediatric Care that expand access and move the delivery system away from siloed, fee-for-service health care

Primary Care

We strongly support the focus of the waiver renewal request on primary care and behavioral health integration, and particularly the transformation of payment to a primary care subcapitation (PC Cap).

We share with MassHealth the conviction that PC Cap has the potential to drive transformation in how care is delivered resulting in better outcomes for patients. We believe that the next waiver provides the opportunity for the Federally Qualified Health Centers (FQHCs) in C3 as well as other FQHCs and advanced primary care organizations in the state to develop a model of Integrated Primary Care that will truly meet the physical, behavioral, and social needs of MassHealth members in a value-based environment.

The PC Cap allows providers and care teams to focus on providing the right care by the right team member via a variety of synchronous or asynchronous modalities, focusing on outcomes for the population served, not on productivity. We believe this will make a huge difference in the patient experience, population health, and provider and care team well-being. At the same time, the ongoing incentives around quality measures and total cost of care (TCOC) will provide incentives against unnecessary referrals and stinting on needed care that are often cited as the potential weaknesses of PC Cap.

We also endorse the overall three-tiered structure that is included in the waiver request, tying increasingly higher clinical expectations to proportionally higher rates. Such a structure will allow primary care to move quickly into the environment of PC Cap while incentivizing the journey to a more comprehensive model.



However, it has become clear in the MassHealth Primary Care Stakeholder Workgroup and other forums for public comment that many FQHCs have achieved a level of team-based primary care, including integration of behavioral health and SDOHs, that will enable them to provide a more fully integrated and comprehensive model of primary care than that initially defined by MassHealth in the Primary Care workgroup and geared to meet the needs of the majority of primary care practices.

Given this, we recommend that MassHealth incorporate into its design an alternative option for more advanced Integrated Primary Care, with an appropriate level of PC Cap. Such an option – incorporating components such as requirements for BHI along the lines of the SAMHSA model and access that focuses on empanelment and continuity of care, to give two examples – would invest in primary care transformation to a model that would truly and proactively manage the needs of the complex MassHealth population in a value-based environment.

We do want to underscore that success of primary care in the PC Cap model is completely dependent on both the adequacy of the PC Cap and the adjustment of the PC Cap based on factors such as the age and gender of the patient panel. We are delighted that the MassHealth waiver request acknowledges it would be insufficient to convert the historic level of reimbursement for primary care into a monthly PMPM.

It is generally recognized that underinvestment in primary care limits its potential to improve outcomes and create more limited use of some services, such as emergency department visits, outpatient visits and inpatient hospitalizations.¹ In addition to Massachusetts, many states have recognized and begun to take steps to address this underinvestment. Some notable examples include the state of Oregon, which has set a goal to increase investment in primary care to 12% by 2023; Delaware, which has set a similar goal; and Rhode Island, which has nearly doubled the amount it spends for primary care since 2004 to 10.6%. For the 22 nations that comprise the Organization for Economic Cooperation and Development, the average spending for primary care is 14%. Based on our research and initial modeling, we recommend that the first tier of PC Cap should be 12% of TCOC and increase as primary care practices reach tiers 2 and 3.

In the Waiver Request, MassHealth suggests several methodological components of the PC Cap, including the method for ensuring appropriate FFS rates, that we look forward to understanding in greater detail, when we will be in a position to comment on them more. However, below are the overarching principles that we believe are critical to be considered in setting the PC Cap:

- We strongly believe that the PC Cap needs to be built up based on the members of the primary care team (assuming market-based salaries and reasonable overhead) required to provide care to a panel of patients, rather than based on historic utilization. Historic utilization reflects the requirements of the FFS system that visits with licensed providers be maximized and, prior to 2020, occur largely in the office. This is not a predictor of the activities and staffing that should and will occur when patient contact is spread among the team and occurs through a variety of modalities and locations.

¹ <https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf>



- For the same reason, we strongly advocate that accountability should be measured based on clearly defined outcomes, providing flexibility for primary care practices to develop their model of care and services to be provided by the care team. We oppose a model where the value of primary care under a PC Cap is determined by a reconciliation to visits or encounters. At the same time, it is key that PC Cap rates to FQHCs are no less than they would have received under PPS rates. As long as encounters must be submitted to MassHealth, provider and support staff time that could be spent on direct patient care or coaching and coordinating with team members will be absorbed in administrative tasks.
- While the PC Cap needs to be adjusted to reflect the predicted costs of providing primary care based on the population served, we do not recommend the use of a risk adjustment methodology developed to predict total cost of care. Global risk models (such as MassHealth’s v3.1 risk model) would under-fund primary care for children and over-fund primary care for healthy adults compared to a reasonable average of primary care funding. We suggest that PC Cap be adjusted to reflect member age and gender and that MassHealth the capitation be adjustment based on a Social Vulnerability Index such as the one developed by the HHS Office of Minority Health and found [here](#). In doing so, MassHealth will ensure that the capitation payments are equitable as opposed to equal.

Finally, we have heard from our FQHC colleagues that a transformed model of care under a PC Cap will not be as effective if implemented for a single payer, even their largest payer. Therefore, we strongly support MassHealth’s intention to advocate with other payers and other agencies providing health care coverage through the Commonwealth (such as the Group Insurance Commission and the Connector) to move to PC Cap financing for primary care.

Behavioral Health Workforce

We are very supportive of MassHealth’s proposal to fund loan repayment to increase the number of behavioral health professionals and psychiatrists serving the MassHealth population. These are critical resources at this point in time – and in short supply.

However, we also want to highlight the importance that workforce related funding has played during the current waiver in providing health centers with the funds to train and retain valuable primary care providers in FQHCs. These include:

- Targeted CHC/CMHC Loan Repayment program for primary care and behavioral health
- Special Projects Program
- Nurse Practitioner Residency Program
- Family Medicine (MD) Residency program

Given the shortages of primary care providers and the competition faced by health centers in hiring, these have been important tools for our health centers. We strongly urge MassHealth continue these programs as well during the next waiver.

Goal 3: Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals



Health Equity

We enthusiastically support MassHealth’s focus on health equity in this waiver request. Speaking broadly, we believe that MassHealth’s expansion of eligibility, including 24-month guaranteed eligibility for individuals who are homeless and one year for post-partum are important policy changes to address health equity and we support them whole heartedly. The proposal to expand coverage to include incarcerated individuals and to improve transitions back to the community are critical in this regard as well.

We also support the MassHealth plan to provide incentives to address disparities that result from inequities across race, ethnicity, language, and sexual and gender orientation. FQHCs – with a population this is disproportionately low income, BIPOC and preferring to be served in a language other than English – have been focused for many years on the disparities in health outcomes across racial, ethnic, and language groups. In addition, as a result of HRSA requirements, they have more reliable data on their patients’ report of race, ethnicity, and preferred language and more experience reporting on these data than many health care organizations.

However, we have several concerns with regard to the program design related to health equity. The first concern relates to the \$100 million annual that MassHealth proposes to direct at hospitals in the form of health equity incentive payments. It is not clear why incentives are directed at hospitals and not at primary care organizations who play a key role in addressing disparities.

While we are supportive of hospitals receiving equity dollars, we are requesting that MassHealth *equitably* invest in and incentivize equity among providers. We suggest that a way to make this distribution equitable is to consider the patients served by health care providers using a Social Vulnerability Index such as the index developed by the HHS Office of Minority Health found [here](#). Such an approach would equitably adjust payments levels based on the current and historical inequities experienced by the population served. We also suggest that hospitals who are currently being reimbursed for commercial business at a rate that is greater than 150% of Medicare, be excluded from eligibility for this investment. We would suggest using the data in the most current HPC reports to obtain this commercial pricing information.

Relatedly, although the waiver request uses the term “investment”, it is not clear whether there is upfront investment contemplated or if all the expenditure will be directed toward incentive payments. As MassHealth acknowledges “increasing standardization and data completeness will be resource intensive for ACOs, ACO-participating hospitals, and non-state-owned public hospitals to achieve systems enhancements necessary to collect and report on such data for members.” Our concern is that without up-front investments, entities that have the resources will likely excel and receive the incentives while those who cannot afford the upfront capital costs for compliance will lag and be deprived of the very resources they need to invest.

In summary, we suggest that MassHealth consider equitable up-front investments to enable all ACOs, ACO-participating hospitals, and non-state-owned public hospitals and providers, including primary care, to have the minimum capabilities for meeting the proposed requirements related to RELD. We also



suggest that these payments be progressive regarding investing with equity and not regressive by investment the money with equality.

Our second concern relates to the proposed reporting of health care disparities by ACOs. It is not clear from the program design what types of disparities will be included, for example, whether MassHealth intends to address all social risk factors, including those that are collected through the HRSN screening or if the section is intended to address only the demographic characteristics that are associated with health disparities (race and ethnicity; language, disability, gender, gender identity, and sexual orientation). We suggest that since social determinant screening data is a quality measure in and of itself, this reporting should begin by focusing on the demographic characteristics, until such data is fully understood and SDOH screening data is more complete.

Thirdly, it appears that the collection and reporting of social risk factor data will remain voluntary, with improvements driven through an incentive. While voluntary participation allows for the ease of the deployment of the program, it is not without unintended consequences:

- **Increasing disparities across ACOs:** Making the collection of key demographic data voluntary will increase disparities between entities. Those entities with a strong commitment to and capabilities for reducing disparities will excel, thus increasing the disparity gap with those who postpone the needed action due to limited resources and will.
- **Consent to allowing a consequential gap in the delivery of quality care to continue:** The collection of key demographic data is **consequential** to the quality of the health care people receive should not be voluntary. Doing so would be akin to making the collection of data on age, for example, voluntary. If MassHealth agrees that the absence of this data will adversely affect the quality of care members receive, then the decision not to collect the data should not be a choice. It can only be made a choice if the absence of the data is inconsequential.

Thus, MassHealth may wish to consider making the collection and reporting of, at least RELD data, mandatory, with a flexible timeline for implementation that all entities are comfortable with.

Flex Services and SDOHs

We applaud MassHealth's ongoing commitment to the Flexible Services Program and the request for its continuation. As we have seen promising preliminary results, we are enthusiastic about the recommended changes, especially the opportunity to leverage the Flexible Services program to address household-level food insecurity. In addition to the proposed change to allow Flexible Services to be used for childcare to facilitate access to relevant nutrition and tenancy support services, we would also recommend an expansion of the Transportation benefit to be allowable for family members of the member approved for FS. While in many cases, support for childcare will be a more appropriate solution for parents with young children, there are many scenarios where the ability to transport other members of the household to a nutrition or housing service would be beneficial or even a preferable option for the family. For example, this benefit could be extended to support the transportation to the grocery store for a parent when the member approved for FS is a minor, or to allow a parent to take his/her children to an appointment for housing support.



Through our Flexible Services Tenancy Preservation Programs, we have experienced the challenges of supporting members who are experiencing or at risk of homelessness as a result of their behavioral health conditions. As such, we support the expansion of the targeted housing support services through the CSP for Homeless Individuals and CSP Tenancy Preservation Program. We encourage the flexibility of funding to allow for staffing that supports effective care coordination for these complex members, as we have seen the value in intensive “case rounds” and collaborative problem solving between our SSO partners for Housing programs and the health center staff who have trusted relationships with these members with complex behavioral health needs.

Our preliminary data points to the greatest impact from the FSP for members who received a greater investment in goods and services. As such, we encourage MassHealth to avoid setting any ACO-specific targets about the minimum number of members served in such a way that will result in dilution of the ability to make the necessary investments that support achievement of food security and/or housing stability of the target population.

Finally, the FSP current reporting structure is such that race and ethnicity data is combined. As the ACOs move to a more strategic focus on Health Equity and the collection and analysis of racial and ethnic demographic data of our members, we recommend standardization of the Flexible Service data to align with other reporting in ways that allow for more direct comparison.

In conclusion, we want to thank you again for the opportunity to work with you on designing the next 1115 Waiver. We are happy to answer any questions or develop the ideas laid out in these comments further.

Thank you for your time and consideration,

A handwritten signature in blue ink, appearing to read 'Christina Severin', is positioned above the typed name.

Christina Severin
President and CEO
Community Care Cooperative (C3)



September 20, 2021

Honorable Marylou Sudders
Secretary, Health and Human Services
EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108.

Submitted electronically

Dear Secretary Sudders,

We appreciate the opportunity to comment on the MassHealth 1115 Demonstration Waiver Extension application. These comments focus solely on the behavioral health portions of the waiver.

We particularly appreciate that the proposal prioritizes health and racial equity, would expand access to and scope of substance use disorders and mental health services, would provide MassHealth coverage during incarceration, and would newly cover preventive behavioral health services to youth who screen positive for behavioral health symptoms, but who do not meet the clinical threshold for diagnosis and treatment.

As you move forward with this proposal, **we ask that you consider the recommendations below to strengthen the proposal and ensure Massachusetts residents' health and social equity.**

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Our Substance Use Disorders and Justice-Involved Population Program helps people lead healthier lives by improving the quality of and access to health services, comprehensive integrated care and community supports to promote recovery and, for those leaving incarceration, successful reentry into the community. Additionally, Community Catalyst works to improve the care delivery system for older adults, those with disabilities and people dually eligible for Medicare and Medicaid.

Providing MassHealth Services to Justice-Involved Individuals

Community Catalyst supports the innovative proposal to make MassHealth benefits available to justice-involved individuals during incarceration. As the waiver proposal explains, extensive behavioral health care, coordinated with physical health care, is essential due to the many health needs of those incarcerated. We also support extending MassHealth benefits to individuals for 12 months after they are released from incarceration to ensure continuity of services.

However, we are concerned about two elements of this proposal.

First, we are concerned about the apparent absence of people with lived experience of substance use disorders, mental illness and incarceration, as well as their advocates, in the planning group for this service expansion. According to the proposal, Massachusetts “convened an Interagency Coordinating Council with representatives from the DOC, Massachusetts’ Sheriffs Association, the thirteen Massachusetts Sheriffs’ Offices within the Commonwealth, DYS, Parole, Probation, and EOHHS.” **We recommend you include voices of people with lived experience in the planning and implementation of this initiative, which is essential to ensure it is responsive to their needs.**

Second, we are concerned about payments by MassHealth to correctional health providers without more comprehensive safeguards for quality and access, especially since the proposal would allow correctional facilities to limit or modify services. Correctional health providers often have other imperatives that may affect the health of people incarcerated. **We urge you consider contracting with community providers to serve incarcerated people during their time behind bars. We recommend you establish more rigorous standards for correctional health providers, especially in light of recent two-year investigation concluding that the Department of Correction failed to adequately supervise prisoners in mental health crisis and failed to provide them with adequate mental health care¹. We also urge you to establish an oversight board comprised of advocates and people who were formerly incarcerated.**

Separately, we recommend you add to the overall waiver proposal the establishment of an independent Implementation Council, which holds public meetings, similar to the council that oversaw the state’s One Care program. The council should be representative of the beneficiaries served, including people with lived experience of substance use disorders, mental illness and criminal legal system involvement. We recommend the council be co-chaired by a

¹ <https://commonwealthmagazine.org/criminal-justice/justice-department-says-mass-prisons-fail-to-provide-mental-health-care/>

beneficiary and comprised of at least 51 percent beneficiaries and advocates to ensure this complicated waiver improves care for those it is designed to serve.

Expanded modes of access

The need for greater access to services is crucial to improving treatment and recovery outcomes for those with mental health illness or substance use disorder². We fully support the integration of mental health and substance use disorder services into the primary care setting, and MassHealth’s focus on expanding access through weekend hours and telehealth, as outlined in this proposal and the *Roadmap for Behavioral Reform* posted by the Executive Office of HHS in February 2021³. Telehealth does increase access to care if the internet and broadband access are available. However, broadband inadequacies would hinder access to services, despite telehealth implementation by Community Behavioral Health Centers and other providers. Some data suggests only about 63 percent of households in Massachusetts have adequate internet access⁴.

We urge MassHealth to work with other state officials to prioritize the buildup of broadband infrastructure in Massachusetts so telehealth can represent an actual and equitable increase in access.

Behavioral workforce

We support the student loan repayment program that prioritizes clinicians with cultural and linguistic competence. The four-year binding commitment of these new providers to communities with a significant number of MassHealth members and maintenance of patient panels comprised of 40% MassHealth members will help ensure that this program ultimately serves MassHealth members. **We encourage MassHealth to direct these providers to the most underserved communities, especially those with a major of people of color and other marginalized populations.**

Collection of complete, accurate, and self-reported social risk data

MassHealth rightly understands that “complete and accurate social risk factor data will be essential to identifying inequities.” In fact, without such data, it will be hard to determine the effectiveness of the proposed 1115 waiver extension. Community Catalyst fully supports MassHealth’s proposal to incentivize ACOs and ACO-participating hospitals to gather complete and accurate social risk factor data for MassHealth members, report that data by quality risk factors, and attain significant reductions in health inequities.

² <https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/>

³ <https://www.mass.gov/doc/roadmap-for-behavioral-health-reform-overview-of-the-community-behavioral-health-program/download>

⁴ <https://www.heraldnews.com/story/news/2021/07/07/gda-broadband-local-ma-nher/47205505/>

Community Catalyst strongly suggests that MassHealth set protocols for the standardization of the data collected, its reporting, and steps to alleviate the issues identified within the data so solid conclusions can be drawn and positive outcomes achieved. We also recommend the data be made public in accessible “report cards” that are easy for community members to understand.

Children, Youth and Families

Community Catalyst’s work in Massachusetts has focused on expanding access to youth substance use prevention and early intervention services in schools, clinical settings, and youth-serving, community-based organizations. As part of this effort, Massachusetts became the first state in the country to require substance use screening, brief intervention, and referral to treatment (SBIRT) services in all public middle and high schools.

Community Catalyst fully supports the state’s plan to cover preventive behavioral health services for youth who screen positive for behavioral health symptoms, but who do not meet the clinical threshold for diagnosis and treatment. This will remove a significant barrier to services that can keep youth healthy. Within the SBIRT framework, this will expand access to brief interventions and other tier II services for young people who screen at moderate risk for substance misuse.

Thank you for this opportunity to comment on the proposed 1115 Demonstration Project Extension Request. If you have questions about these comments, please contact Alice Dembner, program director for Substance Use Disorders and Justice-Involved Populations at adembner@communitycatalyst.org

Sincerely,



Emily Stewart
Executive Director

EOHHS
Office of Medicaid
1 Ashburton Place, 11th Floor
Boston, MA 02108

ATTENTION: 1115 Demonstration Extension Request Comments

RE: Comments from Community Counseling of Bristol County

September 20, 2021

To Whom It May Concern:

Community Counseling of Bristol County (CCBC) is a large community mental health center serving residents of Southeastern Massachusetts since 1970. We are proud providers of a full range of behavioral health services that are referenced in the Demonstration Extension draft and have comments on the proposal we describe below.

CCBC Supports Continuation and Growth of the ACO and CP Programs

CCBC is strongly supportive of the Behavioral Health Community Partner Program. We appreciate MassHealth's recognition of the value the program provides to ACOs in meeting the needs of MassHealth members with complex medical and behavioral health conditions and the ability of the CP programs to link these members to the essential supports and services in the community, such as housing and food security resources. We have seen how CP supports have provided a vital foundation to improved health and recovery for our members.

CCBC urges continued support of the infrastructure established to collect, aggregate and report on both MassHealth claims and EMR activities as an **essential element** of the BH CP program. The reports and dashboards have improved member engagement and strengthened relationships with ACOs in identifying and improving member outcomes. **This resource should be preserved and stabilized in the new waiver as part of the 80% of DSRIP funding referenced in the Waiver Extension Request.** Our ability to aggregate these data has been critical to demonstrating value of the CP to our ACO partners. We have been learning, practicing and **improving "Population Health"** through sharing of the individual members journey as well as of targeted cohorts. Continuing the receipt of claims data from MassHealth for active members and supporting the health informatics functions is essential to improved health outcomes for members and continued success for both CPs and ACOs in delivering high quality of care in the least restrictive setting.

CCBC Recommends Establishing Common Understanding of High-Risk and Rising Risk Populations

Throughout the public forums in the stakeholder process, CCBC has heard MassHealth reference terms such as “High Risk” “Rising Risk” and “Low Risk” as a means of describing the populations to be served by the CP programs. “Risk” is also referenced in the payment methodologies for ACOs. **CCBC urges MassHealth to establish clearer definitions of “Risk” in the criteria for assignment to CPs**, so that ACOs and CPs can align more closely in their efforts to engage members at risk and determine which members’ utilization can be impacted through CP and ACO Care Management interventions. As MassHealth delegates more responsibility to the ACOs, we would encourage MassHealth to work with the ACOs to make the ACO risk stratification methodology more transparent to the CPs and their PCP providers and to set achievable goals on interventions for targeted cohorts.

In short, MassHealth can foster a collective improvement in competency in understanding and addressing the high risk and rising risk among MassHealth ACO members by:

- Making definitions and criteria more explicit;
- Providing training, technical assistance and supporting ongoing learning collaborative among ACOs and CPs;
- Building consensus on the criteria, definitions and best practices in interpreting population health data and implementing steps to improve outcomes.

CCBC Supports the Health Equity Initiative in the Waiver Extension Request

CCBC supports MassHealth’s commitment to addressing health equity. We have undertaken independent data collection and reporting on housing, income and food insecurity for our members and in a dedicated project with one partner ACO. We support increased accountability from ACOs in collecting, analyzing and improving on key health equity metrics.

CCBC also urges **that community-based behavioral health providers and community health centers be included in the initiative and share in the incentives.**

CCBC Supports Improved Resources to Address Population Health

CCBC supports the continued sharing of MassHealth claims data to CPs and also urges that the same claims data be provided to ACOs to align common initiatives and strengthen the capacity of ACOs and CPs to practice population health.

Essential in this effort is the inclusion of SUD services and SUD diagnosis-related services in the MassHealth claims. CCBC believes that there are solutions that can address the barriers of 42 CFR, Part 2.

CCBC Supports MassHealth Efforts to Improve the Behavioral Health Workforce

CCBC strongly supports the continuation of the loan forgiveness program for psychiatrists. CCBC recognizes that the workforce issue must be addressed in multiple ways: a viable career track, generous benefits, ongoing professional development, and a supportive, collegial work place. We strive for all of those elements and believe that the loan forgiveness program will enhance our ability to recruit, retain, and promoted psychiatrists.

CCBC also strongly supports MassHealth’s student loan repayment program for behavioral health clinicians that focus on recruitment and retention of clinicals with linguistic and cultural competence. CCBC has been successful at recruiting a diverse workforce especially in our BH CP and CSP programs that is made up of Bachelor Level staff. Loan forgiveness provides a career track that removes some of the financial insecurity faced by those seeking advanced degrees in the behavioral health field.

CCBC Supports Behavioral Health Integration

CCBC works closely with primary care practices, community health centers and hospital-based providers throughout Southeastern Massachusetts. We align and support the many different ways that these providers implement integration. We support continued maturation of these models and encourage MassHealth to establish standards for these providers to measure, report and improve on their progress in developing “integratedness” within their programs and practices. Our CSP, BH CP and ESP programs regularly engage in multi-disciplinary clinical meetings with primary care providers, Emergency Room teams, and health center staff to promote integration. CCBC can better complement our behavioral health services with their scope of activity based on the model they establish. Continued investment in behavioral health resources in primary care will benefit members and should include the establishment of protocols for accessing providers such as CCBC with appropriate linkages and sharing of information.

CCBC Supports Strengthening and Expanding Behavioral Health Diversionary Services

CCBC strongly supports the continuation of the BH CP program. We also appreciate MassHealth’s recognition of the value and importance of other diversionary services, BH-JI Community Partner, Community Support Program, PACT, and Community Crisis Stabilization, as alternatives to more restrictive services. In these setting staff are better able to match a MassHealth member’s individualized need to community-based services, through identifying and develop his/her strengths and promoting their recovery in the community.

CCBC is committed to being an active partner with MassHealth in the development of these programs and in our growing partnerships with ACOs in Southeastern Mass.

CCBC looks forward to participating in the 1115 Waiver Extension and appreciates the inclusion of stakeholders in the development and comments throughout.

Respectfully submitted,

Philip Shea, CEO
Community Counseling of Bristol County
1 Washington St.
Taunton, MA



179 Amory Street
Jamaica Plain, MA 02130

617.522.7777
servings.org

September 17, 2021

Acting Assistant Secretary Amanda Cassel Kraft
Gary Sing, Director, Delivery System Investment and Social Services Integration
Stephanie Buckler, Deputy Director of Social Services Integration
Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation
MassHealth
Via email

Re: Comments on 1115 Demonstration Extension Request

Dear Acting Secretary Cassel Kraft, Mr. Sing, Ms. Buckler, and Mr. Mahalingam-Dhingra,

On behalf of Community Servings, we appreciate the opportunity to comment on MassHealth's recently released 1115 Demonstration Extension Request and the proposals it includes regarding the Flexible Services Program (FSP).

A not-for-profit organization providing medically tailored meals to individuals experiencing serious illness and food insecurity throughout the Commonwealth, Community Servings has secured contracts with eleven Accountable Care Organizations (ACOs) through the Flexible Services Program (FSP), and have served over 1600 members. We anticipate receiving up to an additional 600 member referrals from our ACO partners by the end of 2021, and maintaining or growing our ACO partnerships in 2022 and through the next Demonstration period.

As the largest provider of nutrition services in the FSP to date, Community Servings fully supports MassHealth's vision for the next iteration of the FSP. We particularly commend MassHealth for proposing to allow provision of nutrition services at the household-level, lengthening the postpartum eligibility timeframe, and expanding the scope of allowable uses to include support for child-care

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services. These groundbreaking changes will expand the ability of the FSP to meet the needs of MassHealth members and their families.

Community Servings also recognizes that the next waiver period is crucial to the long-term success of the FSP. Over the next five years, MassHealth, ACOs, and Social Service Organizations (SSOs), will have the opportunity to expand, refine, and evaluate flexible services to inform the future of the program. We therefore urge MassHealth to take the following additional actions as part of its Extension Request to maximize the impact of the FSP in this critical window:

- Establish the infrastructure, resources, and technical assistance needed to allow SSO and ACO partnerships to scale;
- Strategically expand the FSP evaluation strategy to maximize learnings;
- Expand FSP eligibility to be more inclusive of pediatric populations; and
- Provide additional detail regarding the MassHealth’s vision for establishing long-term sustainable funding for the FSP.

1. Establish Infrastructure to Allow SSO and ACO Partnerships to Scale

a. Improve Technological Interoperability for Referrals

Through the SSO Prep Fund, we have made considerable enhancements to our technology infrastructure, allowing multiple ACO contract partners to seamlessly make referrals and generate programmatic reports through a single bi-directional web portal. This allows for an efficient referral process capturing data unique to home-delivered meals, and offers ACO’s access to usage data in real time when reporting back to MassHealth. Of note, when we applied for the SSO Prep Fund we had 6 ACO partners (the most in the state) and we now have 11 ACO partners. Although the Prep Fund was essential to allow us to build our Community Referral Portal and integrate with two external referral transaction platforms, we did not anticipate the significant additional investment required for each new integration when an existing or new ACO partner implements their own referral transaction platform. For example, the technical investment to build and test each additional API integration per ACO is between \$35,000 and \$70,000. For Community Servings to fully integrate with existing ACO partners’ referral transaction platforms as well as integrate with new ACOs or existing ACOs who may decide in the future to implement their own referral transaction platform it could mean a total potential technology cost of \$525,000 – \$1M. The burden of building these technology platforms is not sustainable for Community Servings to continue to scale, and meet the demand for our services. Accordingly, we recommend the following improvements to the FSP infrastructure:

- Invest in a system-wide technology “hub” that would allow for bi-directional referral activity between all ACOs and SSOs.
- Restructure the SSO Prep Fund to allow SSOs to apply for funds at multiple stages of the Demonstration period and increase the SSO Prep Fund maximum grant awards for SSO’s with multiple ACO partners.

- Ensure that there is funding for SSOs and ACOs to access the technology “hub” (funding to support the technical builds for existing ACO and SSO platforms to connect to the statewide “hub”).
- Continue to allow SSOs to include both one-time or maintenance fees related to technology in an SSO Administrative rate

b. Continue and Enhance Technical Assistance

Community Servings found tremendous value in participating in learning collaborative meetings, facilitated by Health Resources in Action, which allowed stakeholders to share experiences and lessons learned, and receive helpful information from experts in the field. The need for technical assistance on topics such as IT, data sharing, and program evaluation will continue in the next waiver period, particularly for new and emerging nutrition programs. Community Servings therefore urges MassHealth to include support for technical assistance in its Extension Request in order to assist SSOs and ACOs as they look to onboard or scale flexible services partnerships over the next waiver period. In implementing these supports, Community Servings recommends that MassHealth—at a minimum—create a centralized repository or toolkit of lessons learned/best practices and templates of important documents and forms for ACOs and SSOs.

2. Enhance FSP Evaluation

Given the critical role evaluation will ultimately play in determining the future of the FSP, we urge MassHealth to use the Extension Request to specifically and strategically enhance flexible services evaluation.

Thus far, the FSP evaluation strategy has prioritized assessing the program’s impact on health care costs and utilization, two specific and meaningful indicators that both determine overall success for the demonstration and allow for cross-program and cross-institutional comparison. Notably, preliminary results indicate that the FSP has been successful in these arenas. One ACO reported reductions in total cost of care by nearly \$11,000 for members participating in the FSP compared to eligible members not participating. Similarly, data showed remarkable reductions in emergency department visits for FSP participants.

MassHealth’s current FSP Protocol document outlines two additional evaluation requirements for ACOs participating in the FSP. ACOs must report on:

- At least one health outcome measure (such as hemoglobin A1c) and
- At least one indicator of change in members’ risk factors or a program implementation/process measure.

These reporting requirements have also proven useful. For example, by evaluating the impact of providing nutrition and housing supports on hemoglobin

A1c, one ACO was able to demonstrate that the FSP was associated with improved diabetes management since the program resulted in both an average reduction of hemoglobin A1c levels and decreased the number of members experiencing uncontrolled type-2 diabetes.

However, while illustrative of impact at the program-or-ACO level, the flexibility of the requirements surrounding health outcomes and implementation/process measures has made it challenging to compare impacts across programs or ACOs. Additionally, the current evaluation framework may not address certain priority questions for the next waiver period. To address these issues, Community Servings recommends that MassHealth take the following actions:

Enhance FSP Evaluation Alignment Across ACOs

ACOs have expressed a desire for enhanced guidance and coordination related to FSP evaluation. The broad evaluation requirements outlined by MassHealth have resulted in great variability in health outcome and implementation/process measures across ACOs.

MassHealth should offer specifications for key standardized outcomes of interest so that data can be compared across partnerships for both health and implementation/process measures. Guidance informing process measures may be particularly useful in assessing the broad value of nutrition services beyond ROI. Beyond those key metrics, MassHealth could suggest – and provide support for – that ACOs capture changes in patient churn, primary care engagement, and specific program quality measures. By providing such guidance, MassHealth can better ensure that the FSP achieves its fundamental goal of establishing a robust set of data that can be compared across institutions and illustrate system-wide outcomes to guide future decision-making.

Seize Opportunities to Build the Evidence-Base for Providing Nutrition Services at the Household-level

As we have previously commented, Community Servings is highly supportive of the expansion of nutrition services to the household-level, as doing so will better respond to the needs and improve the health of MassHealth members. However, the current evaluation framework may not capture the impact of this crucial change. Given the importance of this question, we recommend that MassHealth specifically call for its examination as part of the FSP evaluation framework.

3. Expand FSP Eligibility to be More Inclusive of Pediatric Populations

Community Servings applauds all three changes MassHealth has proposed in the demonstration Extension Request regarding scope of services and eligibility for the FSP. We are particularly pleased that MassHealth is proposing to allow nutrition supports to extend to a MassHealth member's household based on the

SNAP definition of a household. This change brings the FSP into better alignment with both the practical experience of Community Servings and current research on program design. One study analyzing the impact of household size on fruit and vegetable intake with produce vouchers found that household size dramatically reduced fruit and vegetable intake when using produce vouchers. The study found that the difference in the voucher effect between a household of 1 person versus a household of 8 people was about 0.8 cups per day. Study authors therefore recommended that “subsidies for food purchases should be adjusted for household size because food is shared across the household.” We enthusiastically agree with MassHealth that “this approach would maximize the impact of the nutritional supports for the individual member, and would also significantly simplify program implementation.” We therefore strongly support this critical change.

Community Servings similarly commends MassHealth’s inclusion of childcare (while accessing nutrition or housing services) as an allowable use for FSP funding and MassHealth’s extension of FSP eligibility for pregnant individuals from 60 days to 12 months postpartum. These changes illustrate MassHealth’s attention to creating a person-centered program that responds to the practical needs of families across the state. Lastly, we appreciate that MassHealth has valued flexibility in the delivery of services and “meeting members where they are” by strengthening telehealth and other electronic service delivery. We recommend that this strategy carries over to the FSP as well.

Overall, Community Servings has also been impressed by MassHealth’s attention to the unique needs of children throughout the extension request. However, we continue to urge MassHealth to further amend FSP eligibility to be more inclusive of pediatric populations.

4. Provide additional detail regarding the MassHealth’s vision for establishing long-term sustainable funding for the FSP

Finally, Community Servings applauds MassHealth for proposing to continue the FSP which has quickly become an indispensable program in the Commonwealth. We also applaud the amount of funding MassHealth is proposing to allocate to the FSP throughout the next waiver period. Adequate FSP funding in the waiver will expand access to vital nutrition and housing services for many Massachusetts residents over the next five years. However, we continue to urge MassHealth to outline a pathway to transition the FSP away from reliance on waiver savings/set aside funds and towards sustainable funding pathways.

Develop Sustainable Pathways to Support Flexible Services Beyond the Next Waiver

To support long-term sustainability, we encourage MassHealth to begin to develop pathways to support flexible services beyond the next waiver cycle.

States such as New York and California are taking innovative steps to utilize ‘in lieu of’ services authority to cover health-related social needs interventions. Similarly, Oregon has incorporated payment for HRSN interventions into the capitation rates for its Coordinated Care Organizations based on regulations governing “activities that improve health care quality.” The nutrition and housing services provided through the waiver-dependent FSP warrant long-term integration into MassHealth programs. We therefore encourage MassHealth to examine approaches used by other states to create sustainable funding streams that protect access to these vital supports.

Finally, while Community Servings is particularly focused on the continuation and refinement of the FSP, we also applaud MassHealth’s broader efforts to advance access to care, improve care coordination, and reduce disparities through the waiver process. Community Servings is especially supportive of MassHealth’s attention to health equity throughout the Extension Request. We appreciate the proposed three-tiered approach of pay-for-reporting, pay-for-performance, and incentivizing process on reducing health disparities. Dedicating \$190 million across ACO-participating hospital and non-state-owned hospital classes for these incentives is an essential first step, yet we encourage MassHealth to go beyond imposing an incentive structure to ensure greater health equity accountability.

In closing we want to reiterate our support for the general direction of the Demonstration Extension Request, and we appreciate the opportunity to offer these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "David B. Waters", written over a horizontal line.

David B. Waters
CEO

To Whom It May Concern,

I am in support of multiple aspects of this proposal. Providing loan forgiveness as well as a base salary in addition to fee for service providers will provide incentive for quality employees who are well trained in respective fields. Additionally, expansion of services and cost coverage will allow a higher percentage of the population to benefit from quality providers and interventions.

Thank you for your time and consideration.

--

Paul Avolese

Outpatient Clinician

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I am thrilled about the proposed student loan repayments and would like this to be considered for those in the active workforce. This is one of the most common requests we get from our staff. We serve mostly masshealth clients and finding and retaining staff is difficult in our area. Having a robust student loan repayment plan at all levels including nurses, clinicians and other direct care providers would be an invaluable tool to our ability to successfully serve our clients.

Bridgette Hylton,

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Assistant Director - CAC Worcester
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Comments on MassHealth's
Proposed Request to Extend Section 1115 Demonstration

As advocates of currently and formerly incarcerated individuals, we strongly support initiatives that work to address the deep health disparities faced by these community members. As noted in the MassHealth Section 1115 Demonstration Project Extension Request (the “Request”) posted on August 18, 2021, individuals who are or have been incarcerated suffer from stark health disparities, including in substance use and mental health disorders.¹ Incarcerated individuals are also more likely to suffer from chronic illnesses and have a higher rate of morbidity and mortality than individuals in the community.²

Our experience with the correctional health care system allows us to understand that these disparities are driven in part by substandard and untimely care,³ which results from the continuous disregard of the health and health care needs of incarcerated individuals, the perverse incentives created by private healthcare flat-rate contracting, and the persistent problem of correctional health under-funding and under-staffing. In Massachusetts, the failings of this system have become especially apparent during the COVID-19 pandemic. Lack of appropriate care during and in transition from incarceration increases the need for emergent and in-patient services, putting the lives of justice-involved individuals in jeopardy and driving up costs to MassHealth and taxpayers.

We hope that the Request will work to address some of those issues, and write to emphasize the importance of (1) facilitating the participation of the stakeholders most directly impacted – justice-involved individuals themselves – in the process; (2) establishing appropriate oversight and accountability to ensure there are no barriers to patients receiving the full array of MassHealth-covered services; and (3) encouraging access and engagement by community health care providers while patients are incarcerated.

First, we urge MassHealth to form an advisory committee of currently and formerly incarcerated individuals, their families, and community advocates to provide ongoing input on the Request process. No one is better suited to help change the provision of health services in Massachusetts corrections than individuals who have received these services firsthand and the advocates and community members who work alongside them.

¹ See, *Incarceration and Health: A Family Medicine Perspective*, American Association of Family Physicians (July 2021), available at <https://www.aafp.org/about/policies/all/incarceration.html>.

² *Id.*

³ See e.g., *Audit of the Massachusetts Department of Correction (DOC)*, Office of the State Auditor (January 9, 2020), available at <https://www.mass.gov/audit/audit-of-the-massachusetts-department-of-correction-doc> (finding sick call slips were not timely processed and did not result in being seen by a health care provider within seven days); *Reaves v. Mass. Dep't of Correction*, 392 F. Supp. 3d 195, 200, 210 (D. Mass. 2019) (finding that the Department of Correction was “neither able nor willing to provide” for a quadriplegic prisoner’s medical needs and that as a result of its “woeful disregard” for his well being, the Department was “slowly killing him.”); Press Release: Justice Department Alleges Conditions at Massachusetts Department of Corrections Violate the Constitution, U.S. Department of Justice, available at <https://www.justice.gov/opa/pr/justice-department-alleges-conditions-massachusetts-department-corrections-violate> (finding reasonable cause that the DOC failed to provide constitutionally adequate mental health care to prisoners, resulting in self-harm, serious injury, or death to prisoners on mental health watch).

Second, we note the importance of ensuring that *all* MassHealth-covered services are made available, in policy and in practice, to justice-involved individuals. We are concerned that in several places the Request proposes to cover only “certain” MassHealth covered services in light of “the unique circumstances of this population, including the security requirements of the correctional facilities.” (p. 59, 68, 69). The Request notes that the proposal will go “above and beyond the applicable Community Standard of Care for correctional facilities” (p. 66), but this commitment is inconsistent with the footnote that the MassHealth standard will be interpreted “in light of a prison system environment,” which is a departure from the actual community standard (p. 66). There is no public health or moral basis for providing substandard or limited services to justice-involved individuals, and MassHealth should not limit its coverage of services on the basis of vague “unique circumstances” or “security requirements.” Furthermore, we strongly support MassHealth oversight to ensure that incarcerated people’s right to access the standard of care is supported and protected. We encourage MassHealth to consider not only the quality of care provided by correctional agencies and private healthcare contractors, but also the role of correctional officers, who play a significant part in the day-to-day experience of incarcerated individuals and their access to care. We also urge MassHealth to establish safeguards around the collection of healthcare information regarding incarcerated individuals to ensure their privacy.

Finally, we note the importance of ensuring that correctional health providers are adequately coordinating with providers in the community to guarantee that incarcerated individuals have access to the full range of services covered under MassHealth, including increased access to continuity with outpatient providers and virtual visits with specialty providers. While incarcerated individuals in theory have access to telehealth services and transportation to specialists in the community, telehealth and in-person visits are often delayed or never scheduled – even for individuals with a dire need to be seen by specialists. It is unclear under the existing proposal how MassHealth plans to address this lack of adequate coordination with community providers. Furthermore, as provision of the full services covered by Masshealth will require a significant expansion of services provided to justice-involved individuals, we encourage MassHealth to consider what services can be made available to incarcerated individuals beyond telehealth visits and transportation, and to seek feedback on this issue from community health care providers who currently treat incarcerated individuals.

September 20, 2021

Signed,

Prisoners’ Legal Services of Massachusetts
Committee for Public Counsel Services
Criminal Justice Policy Coalition
F8 Foundation
National Association of Social Workers – Massachusetts Chapter
Deborah Goldfarb, LICSW
Monik C. Jiménez, ScD SM, Associate Epidemiologist, Brigham and Women’s Hospital
Benjamin A. Barsky, JD, MBE

DANIELLE THOMPSON, MPP

33 Ossipee Road #1, Somerville, MA 02144 | 540.520.3583 | DanielleKThompson@gmail.com

September 20, 2021

EOHHS Office of Medicaid
1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

To Whom It May Concern,

I am writing to request that the following comments be considered in the 1115 MassHealth Demonstration (“Waiver”) Extension Request to the U.S. Centers for Medicare and Medicaid Services this fall. My suggestions for the waiver will improve health outcomes and close health disparities in alignment with the following two goals outlined in the waiver extension proposal:

- Continue the path of restructuring and re-affirm accountable, value-based care- increasing expectations for how ACOs improve care and trend management, and refining the model.
- Reform and invest in primary care, behavioral health and pediatric care that expands access and moves the system away from siloed, fee-for-service care.

In January 2021, I asked my State Representative Christine Barber (34th Middlesex) to file legislation on my behalf to add requirements for ACOs certified by the Health Policy Commission. This legislation: *An Act Relative to Patient Centered Access to Behavioral Health Services in Accountable Care Organizations* (H. 1244/S. 806) requires ACOs to offer patient navigation and care coordination services along the continuum of care for patients diagnosed with a mental illness or substance use disorder and for patients with symptoms that suggest a possible mental illness or substance use disorder as determined by a licensed healthcare provider. I drafted this legislation with the support of hospital and insurance industry leaders who recognize that it’s not only the right thing to do- it’s also cost effective and will help reduce total medical expenditures in Massachusetts by lowering hospital readmission rates for people with substance use disorders and serious mental illness, getting them timely access to quality care. The Senate sponsor is Michael Moore (2nd Worcester).

H. 1244/S. 806 reduces the burden on over-worked PCPs to manage serious mental illnesses and the physical complaints that originate from SMIs. PCPs will now be able to refer behavioral health cases to a Patient Engagement Advocate (either in-house or via contract) who will provide support along the continuum of care beginning with empowering patients to seek care in the first place. This is important given that most symptoms of mental illnesses initially present themselves in a PCP’s office, not in a psychiatrist’s office. Advocates will conduct a needs assessment, screen potential specialists and conduct provider matching follow-up (in case a recommended specialist is not a good fit), assist with health insurance, provide support while on waiting lists, schedule and coordinate transportation to appointments, assist with medication adherence, coordinate care between specialists and provide post-treatment follow-up to ensure patients don’t relapse. These services can be billed to insurance as part of the existing bundled payment structure in ACOs, meaning that patients will not pay for them out-of-pocket. ***In my discussions with MassHealth ACOs, they expressed concern that this legislation could become a mandate without support from their regulator (MassHealth). Therefore, I ask that MassHealth***

include these requirements in the 1115 Waiver. A full list of the requirements for ACOs can be found in the [House](#) and [Senate](#) versions of this legislation. (The two versions have identical language).

My Story and Why Change Is Needed

I am committed to seeing this legislation passed and making corresponding regulatory changes because at one point in my life, I was one of the patients this legislation was designed to help. Today, I am a successful health policy professional with a Masters degree in public policy from the Heller School at Brandeis University, but when I was thirteen, I was diagnosed with severe Obsessive Compulsive Disorder (OCD) and major depression. No one who met me today would believe that 25 years ago, I was housebound and urinated on my mattress because I thought the toilet seat would give me AIDS. I had no personal hygiene and looked like a wild animal. I was hospitalized and tried to end my life several times. My mother was told by several Harvard-educated doctors that I was too far gone. There was no hope for me and I would have to be put away in an institution for the rest of my life. I was standing in the room when one of these doctors gave my mother my “terminal” prognosis. My mother took her check back, walked out of that doctor’s office, and said “I will find someone who *will* help her and it *won’t* be you.” My parents found me a treatment team and a therapist came to my house three times a week for two years until I got better. None of my therapy was covered by health insurance. Today, I live independently, pay my own bills and can take care of myself.

I am very fortunate that none of the traditional barriers to care that this bill addresses prevented me from receiving treatment. Most people with a mental illness do not have dedicated advocates like my parents with the education and financial resources to obtain quality care and support them during and after treatment. One in five Americans lives with a mental illness, but over 60 percent of them do not receive timely access to services. This legislation (and the MassHealth 1115 waiver) offers a way to change statistics like this in Massachusetts by removing barriers to care and empowering patients to stay in treatment so that more stories can end like mine. My story should not be an anomaly, but it is. And it doesn’t need to be that way.

This is the third time we have filed this legislation. We came very close to getting it voted favorably out of committee in 2020, but the COVID-19 emergency brought discussion of this bill and many others to a standstill. A major point of discussion has been the minimum required qualifications of the Patient Engagement Advocates described in the bill. After receiving feedback from ACOs and advocacy groups and talking with the Joint Committee on Healthcare Financing last year, I believe we have reached a comfortable middle ground where the Advocates need to hold one of a handful of respected certifications, but the requirements are not overly restrictive. Advocates can be a licensed social worker, a certified nursing aide, a community health worker or peer recovery coach certified by the Department of Public Health, or a peer support specialist certified by the Department of Mental Health.

The vast majority of the people this bill is designed to help are not able to share their stories. They can’t show up at the State House or online to testify in support of this bill or any other nor are they able to submit comments through a State agency website. Most of them are sick and have no one to turn to. So, I am here to speak for them.

I respectfully ask that you add the requirements for ACOs described in this legislation to the MassHealth 1115 waiver. By doing so, you have the opportunity to make Massachusetts a leader in addressing behavioral health needs and can make these people seen and heard in our health care system so that more stories end like mine.

Sincerely,



Danielle Thompson

Disability Advocates Advancing our Healthcare Rights

September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
One Ashburton Place
Boston, MA 02101

Sent by email to: 1115-Comments@mass.gov

Re: Comments on Demonstration Extension Request

Dear Amanda:

Disability Advocates Advancing our Healthcare Rights (DAAHR), coordinated by the Disability Policy Consortium and the Boston Center for Independent Living, appreciates the opportunity to comment on the MassHealth proposal to CMS for an extension of its 1115 Demonstration Waiver. We wish to acknowledge the extremely wide range of intensive work being done by MassHealth to increase access to health care, including not only the waiver but also, among other things, work on American Rescue Plan Act funding for Home and Community Based Services, One Care 2.0, the prioritization of health equity for BIPOC communities, and the Roadmap for Behavioral Health Reform. We look forward to partnering with you on these initiatives as you also continue to navigate and respond to the ongoing Covid-19 pandemic.

The waiver incorporates numerous significant elements of the MassHealth program, but DAAHR will focus its comments on areas which have major significance to persons with disabilities across the lifespan. Fundamental to this is a belief—which we will repeat—for continued discussion with MassHealth on the matters raised, most especially on the positive efforts to improve the LTSS CP program and expand CommonHealth eligibility. These are major steps that will truly benefit from continued consumer and advocate input.

Following are key areas of concern for DAAHR.

CommonHealth Expansion: DAAHR applauds the proposal to expand CommonHealth, which reflects a need we expressed along with Health Care for All and the Metrowest Center for Independent Living, among others, on a number of occasions with MassHealth. And we appreciate the mutual understanding that continued discussion on the details is needed. It is important to highlight the commendable goals of the extension request posted on August 18, including these excerpts:

MassHealth recognizes that the original design over 20 years ago of the CommonHealth program, including the deductible for non-working adults, was intended to create work incentives for individuals with disabilities. However, it may unintendedly result in a disincentive because individuals with disabilities may be concerned about starting to work, gaining income above MassHealth Standard levels (138% of the Federal Poverty Level, or less than \$18,000 a year for an individual), and losing their health coverage if they are unable to maintain stable employment and meet CommonHealth criteria. Individuals with disabilities, including both physical and behavioral health disabilities, face barriers to maintaining steady employment due to their health conditions. This challenge has been exacerbated by the COVID-19 pandemic, which has had a disproportionate impact on access to employment for individuals with disabilities due to economic and health vulnerability.

Therefore, MassHealth proposes to eliminate the linkage between CommonHealth coverage and employment in order to provide a more reliable and stable source of health care coverage for individuals with disabilities. As they do today, CommonHealth members will continue to pay sliding-scale premiums based on their income.

MassHealth also proposes to enable long-time CommonHealth members (those who have been enrolled in CommonHealth for ten years or longer) to retain their coverage after age 65 regardless of whether they are working. The goal is to support ongoing coverage for disabled adults as they approach retirement.

Health Equity: Advancing health equity must be a central goal of the 1115 waiver application. Reducing disparities that impact BIPOC populations and under-resourced communities is key to the success of the 1115 waiver. DAAHR has from its inception been committed to advancing health policies that address the needs of the Commonwealth's most vulnerable and underserved populations. We applaud efforts by MassHealth to reduce disparities that impact BIPOC communities. At the same time we are concerned that MassHealth may do so in a manner that exacerbate disparities impacting persons with disabilities from BIPOC populations or people with disabilities who already experience disparate rates of morbidity and mortality because of their disability status.

It is imperative that MassHealth keep at the forefront the insights of Dr. Camara Jones's *Cliff Analogy*. Dr. Jones states that it is critical to recognize the "parallels between racism and able-ism as systems of power, similarities and differences between 'race' and disability status as axes of inequities, intersection of "race" and disability status of individuals and communities, and the promise of convergent strength between the anti-racism community and the disability rights community." ¹

¹ https://www.tfah.org/wp-content/uploads/2020/08/Jones_SystemsofPower.pdf

MassHealth should convene antiracism and anti-ableism groups to address the intersectional barriers to quality health care. We specifically urge MassHealth to:

- Work with antiracism and anti-ableism advocates to advance short-term, intermediate, and longer-term strategies for collecting data on race, disability, and other aspects of identity.
- Create an interim scaffolding system that enables MassHealth to measure ACO and MCO progress in reducing disparities in BIPOC communities and persons with disabilities that include, but are not limited to:
 - Advancing project-based approaches like what Minnesota is doing with its Health Equity Intervention Integrated Health Partnerships.²
 - Using MassHealth eligibility criteria data to begin the process of identifying disability populations.
- Take steps to identify data collection and advancement of health equity that include gender, sexual orientation, gender identity, age and other aspects of identity.

It is important that MassHealth enter into such a conversation valuing not just the data but the means to obtain it, which necessarily will include people sharing personal aspects of their identities. Approaches to this must include members of target populations in design and implementation.

Additionally, we believe the specific recommendations by the Alliance for Community Health Integration relative to the waiver should be given maximum attention.

Also of significance are gaps in care that may have disproportionate impact on BIPOC with I-DD, including those transitioning from adolescence, as they often face a compounded risk of underutilization of general care services. Adults with ID/DD from communities of color are more likely to live with family members and less likely to get healthcare. In general, people with ID/DD face challenges in locating primary care physicians and other providers while also having higher rates of obesity, low bone density, active tooth decay, and challenges associated with aging parents and guardians, including hearing loss.

Quality Measures: The 1115 waiver still lacks adequate and appropriate measures of care appropriate to people with disabilities, in particular people with HCBS needs. Specific concerns include these:

- The current definition of wellness is still medical; defining it as whether someone is living outside of a medical or institutional setting needs also to include whether someone is living a meaningful life in the setting of their own choosing.

² <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8162-ENG>

- There is no clear definition of care integration. There are contract requirements that speak to care coordination and integration, but no benchmark for attaining care coordination or integration, which thus maintains a separation between medical care and LTSS. If care integration is to occur, we need to be able to measure it.
- There are no measures of quality of care for children and adolescents. Children and adolescents have unique needs within their family and community, yet quality measures do not take into consideration the needs of this population in comparison to adults in the 1115 waiver.

LTSS Community Partners Improvements: We appreciate MassHealth’s ongoing effort to improve the LTSS Community Partners program, including establishing a more accountable structure. From the start DAAHR has supported the CP programs as a means of integrating behavioral health, LTSS, medical care, and social supports. But we urge strong attention to a major power differential between the LTSS CPs and ACOs.

The CP program faced challenges out of the box, including limited buy-in from ACOs, uncertain funding mechanisms that caused the CPs to focus on delivering billable services and not necessarily the services consumers needed, difficulty tracking down consumers, and extensive reporting processes that detracted from service delivery. Even with some midstream changes, attention to independent living, recovery, and addressing the social determinants of health was not always easy, which was compounded by ACOs not recognizing the value of integrating LTSS, flex services, and medical care, a tested means to improve outcomes.

The basic changes as proposed, and ones that may be further developed via discussions with CPs, consumers, family members, and advocates can be most beneficial. As well the model needs to be protected from ACOs that may use their size and leverage to subsume CPs instead of partnering with them and other community-based organizations. DAAHR is committed to working with MassHealth to ensure that ACOs:

- Buy services from community-based organizations whose leadership and staff reflect the populations they serve.
- Do not develop services at the expense of existing community-based services, a strategy that would have a fundamental bias towards medical solutions—the medical model!—and that may also limit choice.
- Work collaboratively with LTSS CPs to create systems that more seamlessly integrate medical and LTSS care planning and care coordination.
- Be accountable to the National Core indicators for Aging and Disabilities so that MassHealth can measure and track performance.

Further changes to benefit LTSS CPs also should include these steps:

- Streamline service authorization processes: consumers with LTSS often need a particular service in a timely way, whether it's homemaking or DME. The latter benefit has been reported to be an especially serious problem, with no need to detail how delayed provision or repairs of wheelchairs or like equipment impairs health and independence. The abundance of involved parties itself is a barrier: LTSS care coordinator, ACO, PCP, and DME vendor.
- Support more understanding within ACOs of the role of the LTSS care coordinators and establish stable points of connection for CPs. Misunderstanding of the CP role, inconsistent communication, and variable contact persons delay and even may deter service provision. Additionally, it will be the care coordinator who may most effectively convey key concerns, ideally in conjunction with consumers, of enrollee choice, control, and dignity of risk, vital things not necessarily in the operational models of health plans and providers. Thus giving the CPs the assessment role is a strong positive. Giving more consideration to other means of embedding the care coordinators in the care models is encouraged. One CP has noted that CHA's work with LTSS CPs provides a solid example for best practices.
- Support continued LTSS CP work with children. Services and independent living modeling can be highly beneficial for the consumer and, not insignificantly, the family.
- Focus on the integration of recovery and peers in the model. Not all persons with BH needs will be served by BH CPs, as mental health conditions may not be a primary disability or be apparent until involvement with an LTSS CP. But this does not negate but instead enforces the need for the peer recovery model to be part of ACOs and LTSS CPs operational model.

Because the BH Community Partners programs function more like health homes and are more easily integrated into the ACO system, we did not focus comments on the BH CPs.

Other Waiver Proposal Elements: Parts of the 1115 proposal we wish to cite for general support while acknowledging that the specific content may receive important comment from others include the expansion of the Community Supports Program; the expansion of the Flexible Services program; and services for justice-involved individuals. The experience of the state's ten independent living centers underscores the critical connection between health stability and housing— which along with nutrition is probably the most significant SDOH. The CSP for homeless persons and the tenancy preservation program are much needed initiatives. We will emphasize that all housing initiatives must include disability accessibility within their scope and that nutrition initiatives be fully encompassing of meal accommodations for those with various needs (such as, among others, reduced sodium, gluten free, low sugar content, and liquified food composition).

We also noted the reference to the successful Disability Access initiative and encourage strong consideration of the request by advocates that MassHealth define medical diagnostic

equipment to ensure that medical facilities are providing persons with disabilities adequate medical care. Setting a clear standard of what is considered accessible is vital in capturing whether or not a provider is accessible. Focusing on providers obtaining appropriate equipment opens the door to addressing training, education, and privacy rights. Towards this end adoption of the definition advanced by the US Access Board is strongly encouraged.

Adequate emphasis on oral health remains elusive. We urge MassHealth to take more proactive steps to integrate oral health into the care planning and care implementation processes undertaken by ACOs.

We also wish to strongly highlight the ongoing need for a more comprehensive approach to integrating LTSS, mental health services, and substance use disorder services for persons with dual diagnoses who may also have ADL or IADL needs.³ The 1115 waiver take steps, but further work needs to be done— Massachusetts is amidst a serious mental health and substance use crisis.

It is imperative that ACOs increase their actions to address the needs of these populations in an integrated manner. And to do so requires trust. Persons with mental health diagnoses and substance use disorder have high levels of distrust of managed care systems resulting from experiences of bias by medical providers and biased MCO policies.⁴ The 1115 waiver does not provide a clear roadmap for establishing trust and relationship between providers and people with dual diagnoses. Such a roadmap is desperately needed.

Research is emerging that shows persons with dual diagnosis may not self-identify as having a physical disability or a need for assistance with ADLs or IADLs. In addition, some in BIPOC communities often don't self-identify as persons with disabilities because of stigma both within their own community and in response to bias by larger systems that have long been expressions of the control exercised by white leadership.⁵

Finally, two we wish to comment on, as done previously, are QALYs and establishment of an implementation Council for ACOs.

³ <http://www.georgetownpoverty.org/wp-content/uploads/2019/07/GCPI-ESOI-MHA-Behavioral-Health-Report-online-20190731.pdf>

⁴ <https://www.chcf.org/wp-content/uploads/2021/08/InTheirOwnWordsFragmentedCareMentalIllnessSUD.pdf>
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8112046/pdf/13722_2021_Article_235.pdf

⁵ <https://www.aaihs.org/disability-whats-black-people-got-to-do-with-it-angel-love-miles/>

Quality Adjusted Life Years (QALYS): We also strongly ask that MassHealth affirmatively reject in their 1115 Waiver application any use of the Quality Adjusted Life Year (QALY), or any other measure which assigns weights to the lives of individuals based on their disability status, throughout the programs which this waiver supports. This measure and others like it have already been explicitly barred or rejected as discriminatory against people with disabilities by the Affordable Care Act, the National Council on Disability, the U.S. Department of Justice (relative to the State of Oregon’s request to use QALYs in their own state’s Medicaid program), and our own state’s COVID-19 Crisis Standards of Care. President Biden also indicated during the election campaign that he felt this metric discriminated against people with disabilities, and national-level disability rights organizations are presently asking for a federal ban. Given that federal regulators already found that the use of measures that deprioritize individuals with disabilities for treatment likely violated federal antidiscrimination law in the context of state crisis standards of care, we would urge MassHealth to affirmatively reject the use of such metrics and publicly confirm its belief in the principle that the lives of all Massachusetts residents are of equal value.

Establish an 1115 Waiver Implementation Council: We raised this need many times prior to and subsequent to the rollout of DSRIP. While the DSRIC has been an important means of input, the meetings are not public and, most important, don’t offer an avenue for consumer concerns comparable to how they are regularly represented at the One Care Implementation Council. DAAHR worked closely with MassHealth to design the One Care IC and hopes to similarly collaborate to establish a council for the ACOs and MCOs. We also support public understanding and information on the work of the various ACO consumer advisory committees is essential.

Thank you for consideration of these comments.

Sincerely,

Dennis Heaphy, DAAHR co-chair, Disability Policy Consortium
Bill Henning, DAAHR co-chair, Boston Center for Independent Living

From: Rodrigues, Dona <Dona.Rodrigues@bmc.org>
Sent: Wednesday, August 25, 2021 5:55 PM
To: 1115 Waiver Comments (EHS) <1115WaiverComments@mass.gov>
Subject: Comments on 1115 demonstration extension request

Good Day

I would like to comment and support extension on "1115" proposal to support extension of post partum services.

As a health care provider and Director of our hospital based community doula program we see many women with racial health disparities ,especially in our underserved brown and black communities.

Many of these women are not seeking post partum care during their 6 week period due to many factors in their lives. This causes many poor outcomes which usually occur during the latter part of the post partum period.

With extension of partum benefits many women would have improved health . This would be an excellent tool to start to decrease maternal health disparities.

Thank you,
Dona Rodrigues, CNM MPH
Staff Midwife
Director Birth Sisters Program
Boston Medical Center

This electronic transmission may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, please notify me immediately as use of this information is strictly prohibited.

I hope this is the right place to leave comments.

I support the comments submitted by the Mass League of Community Health Centers. Thank you.

Heidi Nelson, FACHE

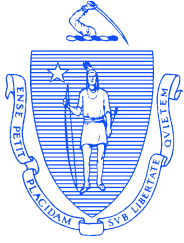
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Restoring Health. Rebuilding Lives.



The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Youth Services

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MARYLOU SUDDERS
Secretary

PETER J. FORBES
Commissioner

617-727-7575
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www.mass.gov

September 20, 2021

Marylou Sudders, Secretary
Executive Office of Health and Human Services
Commonwealth of Massachusetts
One Ashburton Place
Boston, Massachusetts 02108

Dear Secretary Sudders,

The Department of Youth Services (“the Department” or “DYS”) is the Massachusetts juvenile justice agency charged with serving youth, between the ages 12 and 20 who are committed as juvenile delinquents or youthful offenders and detained youth awaiting judicial action. All DYS programs address the unique educational, psychological and health needs of youth in our care and custody across a continuum of supervision and services. This continuum includes 19 residential programs located in hardware secure facilities located throughout the state. Detained and committed youth who are served in these hardware secure residential facilities are currently excluded under MIEP.

Many of the youth come to us with significant health issues with 21% suffering from asthma, 15.5% with food allergies, 16.5% are obese, 12.5% diagnosed with a mental illness, 26% with vision and dental needs, and 33% diagnosed with ADHD. Approximately 632 youth were covered by state-only cost in calendar year 2020 because of MIEP.

The MassHealth proposal to provide uninterrupted Medicaid coverage to MassHealth-eligible youth while they are in the DYS hardware secure facilities would decrease disruption of benefits and prevent youth from “falling through the cracks” after release to the community, increase continuity of care, improve transitions to and from hardware secure facilities, and enhance access to healthcare services. With 70% of the DYS detained and committed population composed of youth of color, MassHealth’s proposal has the potential to address numerous health equity concerns as well.

The Department supports the MIEP 1115 Waiver request. CMS approval of the MIEP 1115 Waiver request would ensure that youth will have continuous and timely access to coordinated care that is not only consistent with but can also exceed the MassHealth community health care standards.

Very truly yours,

Peter J. Forbes
Commissioner



September 20, 2021

Acting Assistant Secretary Amanda Cassel Kraft
Gary Sing, Director, Delivery System Investment and Social Services Integration
Stephanie Buckler, Deputy Director of Social Services Integration
Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation
MassHealth
Via email

Re: Comments on 1115 Demonstration Extension Request

Dear Acting Assistant Secretary Cassel Kraft, Mr. Sing, Ms. Buckler, and Mr. Mahalingam-Dhingra,

On behalf of the Food is Medicine Massachusetts coalition (FIMMA), we are grateful for the opportunity to comment on MassHealth's recently released 1115 Demonstration Extension Request and the proposals it includes regarding the Flexible Services Program (FSP).

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. Over 40% of FIMMA member organizations are community-based nutrition service providers who either currently participate in the FSP or are interested in doing so in the future. Current FSP participants include Community Servings, Project Bread, Just Roots, Mill City Grows, and About Fresh who collectively hold 20 contracts with Accountable Care Organization (ACO) partners which together provide nutrition services to over 5,000 MassHealth members across the state.

Overall, FIMMA is extremely supportive of MassHealth's vision for the next iteration of the FSP. We especially commend MassHealth for proposing to allow provision of nutrition services at the household-level, lengthening the postpartum eligibility timeframe, and expanding the scope of allowable uses to include support for child care. These are critical, substantial changes that will expand the ability of the FSP to meet the real needs of MassHealth members.

FIMMA also recognizes that the next waiver period is crucial to the success of the FSP. Over the next five years, MassHealth, ACOs, and Social Service Organizations (SSOs), will have the opportunity to expand, refine, and evaluate flexible services to inform the future of the program. We therefore urge MassHealth to take the following additional actions as part of its Extension Request to maximize the impact of the FSP in this critical window:

- **Establish infrastructure needed to support and expand SSO participation in the FSP;**
- **Strategically expand the FSP evaluation strategy to maximize learnings;**
- **Expand FSP eligibility to be more inclusive of pediatric populations; and**
- **Provide additional detail regarding the MassHealth's vision for establishing long-term sustainable funding for the FSP.**



Based on the experiences of FIMMA members involved in the FSP, these issues are of utmost importance. We therefore encourage MassHealth to build on the advancements currently outlined in the Extension Request to strengthen the FSP for ACO and SSO participants, to deepen MassHealth’s commitment to prevention, and to fortify pathways for providing nutrition services beyond the next waiver period. Additional detail on each of these recommendations is provided below:

I. Establish infrastructure needed to support and expand SSO participation in the FSP

Infrastructure funding and support have proven to be vital to the success of the FSP. ACOs and SSOs alike have attested to the value of the SSO Prep Fund and have expressed gratitude for the spaces that MassHealth created to navigate new partnerships and systems.¹ Yet, many ACOs and SSOs have relayed that the FSP onboarding process was cumbersome, expensive, and involved a steep learning curve. In fact, this issue was identified as one of the five key themes in a report by Blue Cross Blue Shield Foundation of Massachusetts’ (BCBSMA) Massachusetts Medicaid Policy Institute, the Center for Health Care Strategies, and John Snow, Inc. which analyzed data from 34 FSP stakeholder interviews. In the report, the authors conclude that the “[FSP] is promising, but relationships between Accountable Care Organizations and Social Service Organizations could benefit from more structure.”²

FIMMA therefore urges MassHealth to take the following actions to provide the funding, structure, and technical assistance needed to promote successful ACO-SSO partnerships over the next waiver period:

Recommendation 1: Continue the SSO Prep Fund

The SSO Prep Fund proved to be a lifeline for SSOs looking to participate in the FSP. Nearly all FSP nutrition service providers benefitted from the grant program. FIMMA members specifically used the funds to increase their staffing capacity and build technological systems that allowed them to partner with ACOs. The Prep Fund was especially essential for smaller SSOs, which provide critical services and have deep relationships with community members yet often lack the financial cushion needed to prepare for FSP participation. “We couldn’t have built our API without outside support; if not for the Prep Funds, we would have needed support from elsewhere, which may have been difficult to secure,” said one FIMMA member. Findings of the BCBSMA report echo the value of the Prep Fund but emphasize the need for more support. All SSOs interviewed noted that the Prep Fund, “helped with specific infrastructure needs,” however, “more financial and/or

¹ Kaye N. Massachusetts Fosters Partnerships Between Medicaid Accountable Care and Community-Based Organizations to Improve Health Outcomes. National Academy of State Health Policy. March 2021; pg. 10. Available from: <https://www.nashp.org/wp-content/uploads/2021/03/MA-case-study-3-11-2021.pdf>.

² Houston R, Lloyd J, Crumley D, Matulis R, Keehn A, and Cozier N. The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success. Massachusetts Medicaid Policy Institute, Center for Health Care Strategies, and John Snow, Inc. May 2021; pg. 3. Available from: https://www.bluecrossmafoundation.org/sites/g/files/cspwhs2101/files/2021-05/ACO_Qual-Assess_FullReport_Final_0.pdf.

technical assistance was needed to get SSOs where they needed to be to fully engage in the program.”³

Considering that the FSP is still nascent, now is not the time to abandon supports like the SSO Prep Fund. The resources the Prep Funds provide are critical for onboarding new SSOs and expanding the scope of nutrition organizations able to participate. Additionally, ACO partners have begun to expand the breadth and depth of partnerships. FIMMA members have cited that this creates additional infrastructure needs. One participating SSO has said, “we’re learning that the initial investment in our technology was essential but not sufficient. With each new partner, there are additional licenses and set-up fees to join our technology portal.” Another nutrition service provider similarly noted that scaling will require ongoing financial support from a source like the SSO Prep Fund to continue to adapt their systems to work across diverse platforms with a variety of partners to meet differing needs with data security confidence. By continuing the SSO Prep Fund, MassHealth can provide the supports needed to complete these concrete scaling efforts, thereby expanding the reach and impact of the FSP.

Recommendation 2: Enhance Technical Assistance

ACOs and SSOs have also expressed gratitude for the learning collaborative meetings, facilitated by Health Resources in Action, which allowed stakeholders to share experiences, touch-base on lessons learned, and receive helpful information from experts. FIMMA members have noted that the collaborative meetings were extremely useful for developing relationships between SSOs and ACOs. One participating SSO who is a FIMMA member shared just how beneficial the collaborative meetings were for their organization:

“I was introduced to the people within the various SSOs who were working on flex and was then able to have follow up conversations that ranged from details of our software to program evaluation to best practices for working with different ACO partners. It really began to build a network that I could call on when questions arose.”

Though these meetings were helpful, many stakeholders have still noted having felt as though they were navigating a new system with limited guidance. One FIMMA member shared that, “integrating into the health care system was messy, requiring everyone to reinvent the wheel over and over again with no set of instructions.” For example, confusion around data sharing was common, creating barriers to program implementation. As noted in the BCBSMA report, the launch of one ACO’s FSP was “significantly delayed by the need to research these requirements, implement the steps to ensure compliance, and conduct a separate technology review required by the ACO before data could be exchanged.”⁴

³ Houston R, Lloyd J, Crumley D, Matulis R, Keehn A, and Cozier N. The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success. Massachusetts Medicaid Policy Institute, Center for Health Care Strategies, and John Snow, Inc. May 2021; pg. 10. Available from:

https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2021-05/ACO_Qual-Assess_FullReport_Final_0.pdf.

⁴ Houston R, Lloyd J, Crumley D, Matulis R, Keehn A, and Cozier N. The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success. Massachusetts Medicaid Policy Institute, Center for Health Care Strategies, and John Snow, Inc. May 2021; pg. 10. Available from:

The need for technical assistance on topics such as contracting, HIPAA, IT, and data is a recurring theme across reports that have examined the FSP up to this point,⁵ and remains a core request from nutrition organizations. FIMMA therefore urges MassHealth to include support for technical assistance in its Extension Request in order to assist SSOs and ACOs as they look to onboard or scale flexible services partnerships over the next waiver period. In implementing these supports, FIMMA recommends that MassHealth—at a minimum—create a centralized repository or toolkit of lessons learned/best practices and templates of important documents and forms for ACOs and SSOs. We recommend exploring the Managed Care Technical Center of New York as a model of a training, consultation, and education resource center.⁶

Recommendation 3: Explore Strategies to Improve Technological Interoperability

Technological interoperability was one of the biggest challenges for SSOs launching flexible services programming and continues to be a major concern. Generally speaking, each new ACO partnership has required SSOs to create additional data systems to receive referrals and allow for data sharing. It is expensive and inefficient to continue to create technological bridges for each new ACO system. For example, one SSO in the state estimates that it would cost between \$525,000 - \$1 million to fully integrate their data systems with their ACO partners.

These technological burdens are often cited by FIMMA members, and well-documented in reports examining the FSP.

- **BCBSMA:** In its report, BCBSMA noted that interviewees often had to enter the same data into different programs due to the lack of technological interoperability and that “numerous interviewees expressed a desire for MassHealth to create a single, standardized data-sharing system in place across the Commonwealth that ACOs, CPs, and SSOs could access as needed.”⁷
- **NASHP:** Similarly, NASHP’s report states, “ACOs and CBOs are looking to an electronic platform that would enable medical providers and CBOs to easily

https://www.bluecrossmafoundation.org/sites/g/files/cspwhs2101/files/2021-05/ACO_Qual-Assess_FullReport_Final_0.pdf

⁵ Kaye N. Massachusetts Fosters Partnerships Between Medicaid Accountable Care and Community-Based Organizations to Improve Health Outcomes. National Academy of State Health Policy. March 2021; pg. 9. Available from:

<https://www.nashp.org/wp-content/uploads/2021/03/MA-case-study-3-11-2021.pdf>; Sheff A, Vangeli A, Ribble M, Korycinski R, Ramachandran L, Siegrist T. Addressing Health-Related Social Needs: A Report on MassHealth Accountable Care Organization and Community-Based Organization Collaboration. Health Care For All. October 2019; pg. 3. Available from: https://36eh4c5otxj1b3ekp2bd3fk1-wpengine.netdna-ssl.com/wp-content/uploads/2020/10/hcfa_report_on_aco-cbo_collaboration_2019_2.pdf.

⁶ The Community Technical Assistance Center of New York (CTAC) and the Managed Care Technical Assistance Center of New York (MCTAC). Available from: <https://ctacny.org/about-us>.

⁷ Houston R, Lloyd J, Crumley D, Matulis R, Keehn A, and Cozier N. The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success. Massachusetts Medicaid Policy Institute, Center for Health Care Strategies, and John Snow, Inc. May 2021; pg. 17. Available from:

https://www.bluecrossmafoundation.org/sites/g/files/cspwhs2101/files/2021-05/ACO_Qual-Assess_FullReport_Final_0.pdf

exchange referrals, including ‘closing the loop’ to ensure that the medical providers learn the results of the referral.”⁸

- **Independent Evaluation Interim Report:** Lastly, the recently released Interim Report for the current MassHealth Demonstration Waiver Extension summarizes this issue through a direct quote from a participating organization:

“When you look at information sharing from an infrastructure or foundational perspective, one of the practical challenges we face as a CP is working with 15, 16 different ACOs, and because of the way the numbers game is right now, you’ll often have a care coordinator who ultimately needs that information but is servicing a dozen or so ACOs.”⁹

FIMMA member experience aligns with the findings of these reports. Like the authors of the reports, we recommend that MassHealth take action through the waiver extension to address the barriers presented by technological interoperability. Specifically, in the long-term, MassHealth should explore opportunities to standardize and promote interoperability.¹⁰ In the short-term, MassHealth should provide resources and guidance to improve data sharing between organizations. As the health care system continues to explore addressing health-related social needs through partnerships with CBOs, technological interoperability will remain a costly and imbalanced barrier for SSOs. We therefore believe it is time for MassHealth to seriously explore solutions to address this issue.

II. Strategically expand the FSP evaluation strategy to maximize learnings

MassHealth’s goal to be data-driven reads prominently in the Extension Request, especially with the inclusion of an evaluation plan to assess each goal proposed within the demonstration.¹¹ FIMMA supports MassHealth’s data-driven approach and thoughtfulness in balancing quantitative and qualitative evaluation methods. Given the critical role evaluation will ultimately play in determining the future of the FSP, we urge MassHealth to use the Extension Request to specifically and strategically enhance flexible services evaluation.

⁸ Kaye N. Massachusetts Fosters Partnerships Between Medicaid Accountable Care and Community-Based Organizations to Improve Health Outcomes. National Academy of State Health Policy. March 2021; pg. 10. Available from: <https://www.nashp.org/wp-content/uploads/2021/03/MA-case-study-3-11-2021.pdf>

⁹ Draft Independent Evaluation Interim Report Massachusetts Medicaid 1115 Demonstration Extension 2017-2022. Commonwealth Medicine Research and Evaluation Unit and Department of Population and Quantitative Health Sciences at the University of Massachusetts Medical School. August 2021; pg. 103. Available from: <https://www.mass.gov/doc/1115-demonstration-interim-evaluation-report/download>.

¹⁰ The Interim Report recommends that in the long-run, “MassHealth should seek opportunities to standardize health and social information exchange and promote interoperability.” See Draft Independent Evaluation Interim Report Massachusetts Medicaid 1115 Demonstration Extension 2017-2022. Commonwealth Medicine Research and Evaluation Unit and Department of Population and Quantitative Health Sciences at the University of Massachusetts Medical School. August 2021; pg. 103. Available from: <https://www.mass.gov/doc/1115-demonstration-interim-evaluation-report/download>.

¹¹ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 90-93. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.



Thus far, the FSP evaluation strategy has prioritized assessing the program’s impact on health care costs and utilization, two specific and meaningful indicators that both determine overall success for the demonstration and allow for cross-program and cross-institutional comparison. Notably, preliminary results indicate that the FSP has been successful in these arenas. One ACO reported that they reduced total cost of care by nearly \$11,000 more for members participating in the FSP compared to eligible members not participating.¹² Similarly, data showed remarkable reductions in emergency department visits for FSP participants.¹³

MassHealth’s current FSP Protocol document outlines two additional evaluation requirements for ACOs participating in the FSP. ACOs must report on:

- At least one health outcome measure (such as hemoglobin A1c) and
- At least one indicator of change in members’ risk factors or a program implementation/process measure.¹⁴

These reporting requirements have also proven useful. For example, by evaluating the impact of providing nutrition and housing supports on hemoglobin A1c, one ACO was able to demonstrate that the FSP was associated with improved diabetes management since the program resulted in both an average reduction of hemoglobin A1c levels and decreased the number of members experiencing uncontrolled type-2 diabetes.¹⁵

However, while illustrative of impact at the program-or-ACO level, the flexibility of the requirements surrounding health outcomes and implementation/process measures has made it challenging to compare impacts across programs or ACOs. Additionally, the current evaluation framework may not address certain priority questions for the next waiver period. To address these issues, FIMMA recommends that MassHealth take the following actions:

Recommendation 4: Enhance FSP Evaluation Alignment Across ACOs

ACOs have expressed a desire for enhanced guidance and coordination related to FSP evaluation. The broad evaluation requirements outlined by MassHealth have resulted in great variability in health outcome and implementation/process measures across ACOs. To explore this issue, FIMMA’s Research Task Force convened FSP stakeholders to discuss and compare evaluation plans. The discussion found that sometimes, when ACOs were assessing the same health metric, there were even slight changes in approach. For example, in the Research Task Force evaluation discussion, we learned that organizations measuring the

¹² Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 55. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

¹³ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 56. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

¹⁴ Performance Year 3-5 (PY3-PY5) Delivery System Reform Incentive Payment (DSRIP) Flexible Services (FS) Program Guidance Document for MassHealth Accountable Care Organizations and MassHealth Community Partners. August 2020; pg. 62. Available from: <https://www.mass.gov/doc/flexible-services-guidance-document/download>.

¹⁵ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 55. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

impact of programs on mental health often used different screeners, making data comparison across groups difficult. Similarly, diabetes control may be evaluated based on the percent reduction in HbA1c, the average HbA1c, or the % of members with HbA1c </>9%. Implementation and process measures captured tended to differ even more, spanning referral processes, partnership characteristics, and technology barriers.

MassHealth should offer specifications for key standardized outcomes of interest so that data can be compared across partnerships for both health and implementation/process measures. Guidance informing process measures may be particularly useful in assessing the broad value of nutrition services beyond ROI. Beyond those key metrics, MassHealth could suggest – and provide support for – that ACOs capture changes in patient churn, primary care engagement, and specific program quality measures. By providing such guidance, MassHealth can better ensure that the FSP achieves its fundamental goal of establishing a robust set of data that can be compared across institutions and illustrate system-wide outcomes to guide future decision-making.

Recommendation 5: Seize Opportunities to Build the Evidence-Base for Providing Nutrition Services at the Household-level

As discussed below, FIMMA is highly supportive of the expansion of nutrition services to the household-level, as doing so will better respond to the needs of MassHealth members. However, the current evaluation framework may not capture the impact of this crucial change. Given the importance of this question, we recommend that MassHealth specifically call for its examination as part of the FSP evaluation framework.

III. Expand FSP eligibility to be more inclusive of pediatric populations

FIMMA applauds all three changes MassHealth has proposed in the demonstration Extension Request regarding scope of services and eligibility for the FSP. We are particularly pleased that MassHealth is proposing to allow nutrition supports to extend to a MassHealth member’s household based on the SNAP definition of a household. This change brings the FSP into better alignment with both the practical experience of Massachusetts nutrition service providers and current research on program design. One study analyzing the impact of household size on fruit and vegetable intake with produce vouchers found that household size dramatically reduced fruit and vegetable intake when using produce vouchers. The study found that the difference in the voucher effect between a household of 1 person versus a household of 8 people was about 0.8 cups per day. Study authors therefore recommended that “subsidies for food purchases should be adjusted for household size because food is shared across the household.”¹⁶ Our coalition enthusiastically agrees with MassHealth that “this approach would maximize the impact of the nutritional supports for the

¹⁶ White JS, Vasconcelos G, Harding M, Carroll MM, Gardner CD, Basu S, et al. Heterogeneity in the Effects of Food Vouchers on Nutrition Among Low-Income Adults: A Quantile Regression Analysis. *American Journal of Health Promotion*. 2021 Feb;35(2):279-283. doi: 10.1177/0890117120952991. Epub 2020 Sep 3.



individual member, and would also significantly simplify program implementation.”¹⁷ We therefore strongly support this critical change.

FIMMA similarly commends MassHealth’s inclusion of childcare (while accessing nutrition or housing services) as an allowable use for FSP funding and MassHealth’s extension of FSP eligibility for pregnant individuals from 60 days to 12 months postpartum. These changes illustrate MassHealth’s attention to creating a person-centered program that responds to the practical needs of families across the state. Lastly, we appreciate that MassHealth has valued flexibility in the delivery of services and “meeting members where they are” by strengthening telehealth and other electronic service delivery.¹⁸ We recommend that this strategy carries over to the FSP as well.

Overall, FIMMA has also been impressed by MassHealth’s attention to the unique needs of children throughout the extension request. However, FIMMA continues to urge MassHealth to further amend FSP eligibility to be more inclusive of pediatric populations.

Recommendation 6: Amend Health Needs-Based Criteria for Children

In addition to allowing the provision of nutrition services to the household, MassHealth has proposed enhanced care coordination support services for children with rising, moderate, and high medical complexities and has proposed providing “preventative behavioral health services to youth who screen positive for behavioral health symptoms, but who do not meet the clinical threshold for diagnosis and treatment.”¹⁹ The coalition encourages MassHealth to also consider the unique needs of children by adjusting the health needs-based criteria of the FSP for this population as well. In line with the proposed expansion of FSP eligibility criteria to serve postpartum members for 12 months, we urge MassHealth to include among its FSP eligibility criteria, which states “members must meet at least one health needs-based criteria (e.g., behavioral health need or repeated emergency department use) and have at least one risk factor (e.g., homelessness)²⁰,” the flexibility required to improve FSP accessibility for a rising, moderate, and high risk pediatric population. Evidence demonstrates that, for children, social risk factors alone are associated with adverse health

¹⁷ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 57. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

¹⁸ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 37. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

¹⁹ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 47. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

²⁰ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 58. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

outcomes and increased health services utilization.^{21,22,23} Requiring a health needs-based criteria *and* a risk factor is therefore too onerous to advance the goal of improving accessibility to the FSP for pediatric populations. Thus, we recommend FSP eligibility criteria for this population include *either* a health need *or* a risk factor. We believe that this will bring our state one step closer to addressing health disparities as the pediatric population ages.

IV. Provide additional detail regarding the MassHealth’s vision for establishing long-term sustainable funding for the FSP

Finally, FIMMA applauds MassHealth for proposing to continue the FSP which has quickly become an indispensable program in the Commonwealth. We also applaud the amount of funding MassHealth is proposing to allocate to the FSP throughout the next waiver period. Adequate FSP funding in the waiver will expand access to vital nutrition and housing services for many Massachusetts residents over the next five years. However, we continue to urge MassHealth to outline a pathway to transition the FSP away from reliance on waiver savings/set aside funds and towards sustainable funding pathways.

Recommendation 7: Develop Sustainable Pathways to Support Flexible Services Beyond the Next Waiver

To support long-term sustainability, we encourage MassHealth to begin to develop pathways to support flexible services beyond the next waiver cycle. States such as New York and California are taking innovative steps to utilize ‘in lieu of’ services authority to cover health-related social needs interventions. Similarly, Oregon has incorporated payment for HRSN interventions into the capitation rates for its Coordinated Care Organizations based on regulations governing “activities that improve health care quality.” The nutrition and housing services provided through the waiver-dependent FSP warrant long-term integration into MassHealth programs. We therefore encourage MassHealth to examine approaches used by other states to create sustainable funding streams that protect access to these vital supports.

Finally, while FIMMA is particularly focused on the continuation and refinement of the FSP, we also applaud MassHealth’s broader efforts to advance access to care, improve care coordination, and reduce disparities through the waiver process. FIMMA is especially supportive of MassHealth’s attention to health equity throughout the Extension Request. We appreciate the proposed three tiered approach of pay-for-reporting, pay-for-performance, and incentivizing process on reducing

²¹ Bovell-Ammon A, Mansilla A, Poblacion A, Rateau L, Heeren T, Cook JT, Zhang T, Ettinger de Cuba S, and Sandel MT. Housing Intervention For Medically Complex Families Associated With Improved Family Health: Pilot Randomized Trial. *Health Affairs*. 39, NO. 4 (2020): 613–62.

²² Drennen CR, Coleman SM, Ettinger de Cuba S, et al. Food Insecurity, Health, and Development in Children Under Age Four Years. *Pediatrics*. 2019;144(4): e20190824.

²³ Ettinger de Cuba S, Casey PH, Cutts D, Heeren TC, Coleman S, Bovell-Ammon AR, Frank DA, and Cook JT. Household food insecurity positively associated with increased hospital charges for infants. *Journal of Applied Research on Children: Informing Policy for Children at Risk*. 2018. Vol. 9 : Iss. 1 , Article 8. Available at: <https://digitalcommons.library.tmc.edu/childrenatrisk/vol9/iss1/8>.



health disparities.²⁴ Dedicating \$190 million²⁵ across ACO-participating hospital and non-state-owned hospital classes for these incentives is an essential first step, yet we encourage MassHealth to go beyond imposing an incentive structure to ensure greater health equity accountability.

Thank you for the opportunity to provide feedback on the 1115 Demonstration Extension Request. If there are any questions regarding these recommendations, please contact Kristin Sukys (ksukys@law.harvard.edu) and Katie Garfield (kgarfield@law.harvard.edu). We look forward to deepening our conversations with MassHealth in pursuit of our shared long-term vision.

Sincerely,

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.

Organizations

About Fresh

Adam Shyevitch, Chief Program Officer

American Heart Association

Allyson Perron Drag, Government Relations Director

Boston Children's Hospital

Alex Frey, Project Manager, Dept. of Accountable Care and Clinical Integration

Boston Public Health Commission

Mary Bovenzi, Director, Chronic Disease Prevention and Control Division

CareQuest Institute for Oral Health

Michael Monopoli, Vice President for Grant Strategy

Center for Health Law and Policy

Innovation of Harvard Law School
Katie Garfield, Clinical Instructor

Community Servings

Jean Terranova, Director of Food and Health Policy

EatWell Meal Kits

Dan Wexler, CEO

²⁴ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 20. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

²⁵ Section 1115 Demonstration Project Extension Request. Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid. August 2021; pg. 49. Available from: <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.



**The Food Bank of Western
Massachusetts**

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Health Care Without Harm

Emma Sirois, National Director, Healthy
Food in Health Care

Just Roots

Jessica O'Neill, Executive Director

**Massachusetts Food System
Collaborative**

Winton Pitcoff, Director

Project Bread

Jennifer Obadia, Senior Director of Health
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UMass Memorial Medical Center

Kimberly Reckert, Community Health
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Grow Food Northampton

Alisa Klein, Executive Director

In The Vine Ministries

Apostle Dr. Orlena McQueen, Outreach
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Marie-France Hivert, MD

Associate Professor
Department of Population Medicine
Harvard Medical School

Matoaca Hardy-Fletcher

Chef

Meredith Goff CNM

Retired Nurse Midwife

**Individual title information given for identification purposes only.*

I'm John Roberts DNP, ANP-BC, a nurse practitioner in continual practice for more than 30 years as a primary care nurse practitioner, and now also the director of the Harbor Health postgraduate nurse practitioner residency program for new nurse practitioners committed to practice careers in community health centers (CHCs). Harbor Health operates five community health centers in Dorchester, Plymouth, Hyannis, and Dennis as well as 2 PACE programs in Mattapan and Brockton.

CHCs provide care disproportionately to people who are low-income or uninsured. Approximately 42 percent of our patients identify as a racial or ethnic minority. Many live in areas with few providers who accept MassHealth. We provide care to all, regardless of ability to pay.

A key point to make is that primary care is the gateway to, and often the only source of care for folks with substance use & mental health disorders. Our patients include people with physical and mental disabilities, individuals with complex medical needs, chronic pain, dual/triple-diagnosis individuals (those with co-existing medical, psychiatric, and/or addictions) and folks whose care is frequently compromised by lack of stable, food, housing, transportation, employment, literacy challenges, structural racism, and other social determinants of health. These are folks who disproportionately experience healthcare disparities. We provide access that can, in part, address this health equity problem, particularly for people with substance use & mental health disorders. At our five community health centers, Harbor provides medical, behavioral health, dental, and social services.

Harbor Health established the 1st postgraduate nurse practitioner residency program in Boston and 2nd in MA because we recognize that nurse practitioners benefit immensely from a year of postgraduate residency training specifically in caring for the complex patients seen in community health centers, and that this period of close support and mentoring boosts confidence and comfort in practice, improving retention. We were fortunate to have funding thru DSRIP, that recognizes that without expert primary care providers, CHCs can't move forward. NPs are ideal PCPs for our patient population and remain a primary means of access to care for persons with substance use and mental health disorders.

Our second resident cohort completed their PGY1 year in August of 2021. One resident has remained at our Boston Health Centers and the second resident has gone to work for another FQHC in a different location. Our initial resident cohort (2019-2020) have worked their second year in our Plymouth site and have chosen to continue practice at this site. Their presence has been key in Plymouth as both are waived to prescribe Suboxone for treatment of opiate use disorder, a critical need at all of our sites, especially in Plymouth. Addictions treatment is one of the specialty rotations that our residents participate in, and all residents have attained their waivers thus far. This is a program priority. We have just begun training our third resident cohort. This has all been possible because of DSRIP funding.

Residents function as primary care providers, mentored by experienced preceptors, developing expertise caring for the complex, multi-problem patients served by CHCs. We have been impressed by the overwhelmingly high quality of the residency applicants. We see this as a strategy to improve both recruitment and retention and to ensure that our new colleagues develop the skills, knowledge, expertise, and confidence in a supportive environment that will help prevent burnout and keep them practicing in CHCs for their career. This has been the experience in other NP residency programs since first launched in 2007.

In a recent article in the journal Health Affairs, Auerbach and colleagues considered how health care delivery is likely to be affected by the increasing numbers of NPs and PAs. They forecast that between

2016 & 2030, NPs projected to be practicing in the US will increase by 6.8 % per year, faster than comparative rates for physicians (1.1%) and PAs (4.3%).

Post-graduate NP residency training has been demonstrated to be an effective recruitment and retention tool for nurse practitioners. It provides valuable additional training for NPs to better serve health centers' many culturally diverse and clinically complex patients. Residents are precepted by experienced nurse practitioners and physicians. Additionally, they attend medical specialty rotations in cardiology, infectious diseases, office-based treatment of addictions, pulmonology, neurology, orthopedics, women's health, behavioral health, and elderly care. They are able to participate in other care experiences such as with our clinical pharmacists, our WIC program, and our food pantry. We know new NPs who want to practice with underserved populations are seeking postgraduate NP residency programs—if we can recruit them for our program, we have a much better chance of retaining them in practice afterwards.

As a matter of health equity, the people we serve deserve care by expert providers such as those developed by nurse practitioner residency programs. It is vital that workforce development programs such as those funded under DSRIP be sustained. Thank you for the opportunity to offer my comments.



John Roberts DNP, ANP-BC

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September 20, 2021

EOHHS

Office of Medicaid

ATTN: 115 Demonstration Comments

One Ashburton Place Boston, MA 02108

To Whom It May Concern:

The Home Care Alliance of MA has appreciated the opportunity to participate on the MassHealth's 1115 waiver renewal Advisory Committee. We believe the Commonwealth has an opportunity to build on what we have learned over the past years and to improve services to the MassHealth community in new and different ways. We offer these comments on behalf of our close to 100 member agencies who are providers of a variety of home-based services to the MassHealth population.

A general comment is that the waiver renewal and dedication of resources is very hospital centric despite what we believe is a sincere interest on all involved parties to keep this population healthy and in the community. The Home Care Alliance of MA would like to see a much stronger commitment throughout the waiver to investments in community based long term care services and supports and a recognition that such a commitment is essential to achieving gains in preventable acute hospitalizations and addressing the challenges associated with social determinants of health in this population. The waiver renewal is a critical time to redesign the stagnant MassHealth home health program benefit and model new ways of using care at home to address the waiver's goals.

Below are some specific comments on ways that we believe that this could be addressed in the waiver renewal.

Principle: Advancing health equity, with a focus on health-related social needs

The proposal suggests that \$500 million will be set aside for hospitals to address health inequities and strengthening the commitment of ACOS on tracking equity issues. But the fact is that hospitals are the least equipped when treating a sick person to try to assess what is facing a person once they leave the controlled environment of the hospital. To truly address SDoH, (including safety in the home, food security, transportation, family and social supports etc), requires eyes in the home. We believe the demonstration waiver should be considering redirecting some these funds into home based care models or creating models for the ACOS is using home care agencies to screen for, and address these issues. Many agencies, including private home care agencies, already include such

assessments in their work, but the waiver needs to make these types of home based SDOH assessments common practice for MassHealth members.

In waiver opportunities, the proposal mentions that: “Hispanic and non-Hispanic Black MA residents have asthma hospitalization rates 3.5x higher than non-Hispanic White residents.” This is an example of another area where assessing and addressing the home environment is a critical component for improving outcomes. Home care expertise could and should be tapped to address preventable admissions and funding made available.

Principle: Advancing health equity, with a focus on maternal health

HCA of MA applauds the waiver team for this important expansion of maternal health benefits as part of its plans around health equity advancement. This is again an area that we would like to see a commitment in the waiver application to involving home health care agencies in the implementation. For many years in the not so distant past, visiting nurse associations were heavily involved in providing maternal child care to high risk, young families. Although this program was particularly successful in educating new mothers on nutrition and general new born care, especially relative to failure to thrive, MassHealth reimbursement simply failed to keep pace with what it cost to deliver this service. Mothers with limited access to transportation or other support mechanisms were left alone in those critical weeks post delivery. The waiver expansion provides an opportunity to recreate a successful new born Mom Care At Home program.

Community Partners and Case Management

- Continue and refine the Behavioral Health and Long-Term Services and Supports Community Partners (CP) program, while transitioning the program to sustainable financing and a more accountable
- Streamline care coordination to ensure members have a single accountable point of contact, including by requiring ACOs to proactively identify and engage high and rising-risk members; and, to offer care coordination when needed to address holistic needs, including behavioral health, long-term services and supports, and health-related social needs.

Despite providing significant amounts of home health to high risk clients, many with behavioral health issues, our member agencies have at limited to no interaction with the behavioral health or LTSS community partners. In some ways, we see the above two bullets from the waiver documents at odds. We have seen patients confused about who is making decisions about their care needs, especially if there are multiple case managers involved. We strongly support the concept of a single point of contact being a case manager at the ACO.

Thank you for consideration of these comments.

Patricia M Kelleher
Executive Director
Home Care Alliance of MA
www.thinkhomecare.org



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hcfama.org

September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to 1115-Comments@mass.gov

Re: MassHealth Section 1115 Demonstration Waiver Extension Request

Dear Acting Assistant Secretary Cassel Kraft,

On behalf of Health Care For All (HCFA), thank you for the opportunity to comment on MassHealth's 1115 waiver extension request. HCFA greatly appreciates MassHealth's thoughtful and comprehensive work in drafting the waiver renewal. MassHealth's goals for the waiver proposal align with HCFA's objectives for the program – advancing health equity; addressing health-related social needs; expanding access and improving care; making reforms and investments in primary care, behavioral health and pediatric care; supporting the safety net; and simplifying the delivery system for members.

MassHealth's waiver proposal builds upon decades of coverage expansions and aims to improve the care experience for MassHealth members, with a clear focus on health equity. HCFA supports the overarching framework and the majority of policies MassHealth puts forth in the waiver renewal. We ask you to consider HCFA's comments as you finalize the Commonwealth's 1115 waiver proposal for submission to the Centers for Medicare and Medicaid Services (CMS). We look forward to working with MassHealth on implementation of the waiver extension. As important it is to get the underlying policy right, it is also critical to ensure that the policy, programmatic, and operational details meet our collective vision of ensuring equitable, quality, patient and family-centered care and supports.

Delivery System & Accountable Care Organizations

Oral Health

HCFA is pleased to see that the waiver proposal takes an important new step toward oral health integration. Oral health care should not be siloed from other forms of care. Importantly, the current waiver includes a pediatric oral health quality measure to begin to move toward further integration, and the waiver uses a different mechanism to bring integration into a new phase. Specifically, we are excited that the waiver proposal includes a requirement for primary care practices in the sub-capitation program to conduct oral health needs screenings and provide follow-up referrals to dental services as part of the core, baseline requirements for participation in the program. This is a critical shift that could leverage primary care workflows to greatly increase the engagement of MassHealth members in oral health care.

As more guidance and contracts are issued to implement the waiver, we would like to see additional steps taken to further integrate oral health care, including requiring oral health provider representation in ACO governance structures and committees and integration of oral health into aspects of general care coordination, including through staff trainings. We also hope to see opportunities to improve the oral health provider search tool to show those taking new patients, and we would be interested to discuss potential efforts to advance the use of tele-dentistry to increase access to oral health care.

Health Related Social Needs

We appreciate MassHealth's focus on health equity and health related social needs (HRSNs). We believe that maintaining and expanding the commitment to addressing HSRNs of MassHealth members through the Flexible Services Program, primary care coordination requirements, and expansion of housing support programs has the ability to transform the health care delivery system and the lives of the members MassHealth serves to help them get and stay healthy.

Specifically, we are extremely pleased to see several key policies on addressing HRSNs included in the waiver proposal including:

- a strong commitment to the Flexible Services Program (FSP), including an investment of \$40 million per year to address housing and nutrition needs of members, which represents a larger share of overall waiver funding (13%) compared to the current waiver (8%);
- the ability to provide family-level nutrition supports under FSP – a critical change to enable better household food security given the evidence that food supports provided to one member are likely shared with the entire household, diminishing their effectiveness if not provided at the family level;
- inclusion of a requirement to not only screen for social needs like food and housing insecurity, but to provide follow-up navigation to help members connect to supports as part of the new primary care sub-capitation program;
- expanded access to housing supports through the Community Support Program for individuals experiencing homelessness who do not meet the federal definition for chronically homeless, and those facing eviction related to disability status such as a behavioral health disorder; and
- increased access to FSP for pregnant and postpartum women, children, and families, including inclusion of childcare coverage to facilitate access to services.

As MassHealth continues to provide additional details on the programs outlined in the waiver proposal in the months to come, there are several areas where we hope to see specific program designs adopted. These include:

- using contractual requirements or other mechanisms to set a minimum population and/or spend for each ACO on FSP, to ensure each ACO is ensuring access to these critical supports for their members at a sufficient scale;
- FSP evaluation methodology that accounts for medium to long-term impact, especially for children;
- caution on standardization of Flex Services so as not to stifle innovation and experimentation;
- details on adequacy of primary care sub-capitation payments that support HRSN navigation supports and practice transformation; and
- ensuring sufficient staffing including community health workers (CHWs).

There is also a need for additional transparency and public reporting of data related to social needs screening, referrals, and connection to social services, such as the number and percentage of members

screened for HRSNs by ACO. The need for additional public reporting of ACO-specific performance also goes beyond HRSN related work and to overall financial and quality performance that should be made available to the public.

Health Equity

We appreciate MassHealth’s commitment to health equity as a core pillar of the waiver proposal. In addition to integrating a focus on health equity into various aspects of the waiver, the financial investment and clear structure of the health equity incentive program is a strong signal of the centrality of this work. Specifically, we are pleased to see the ambitious goals for demographic data collection including race and ethnicity, performance stratification by key demographic subgroups, and reduction in performance disparities, as part of the \$190 million per year investment in health equity incentive payments to support these goals.

One area where we would like to see the current waiver proposal modified is with regard to the financial incentive structure for the health equity incentive program. Progress in collecting demographic data has been unacceptably slow and is hindering the ability of ACOs, MassHealth, consumers, and the public to understand and act to improve health equity. Using incentive payments (upside risk) to improve demographic data collection and stratification is necessary but not sufficient to ensure badly-needed system-wide reform. It is crucial that ACOs also bear downside risk for not meeting standards related to subcomponents of the health equity incentive program – data collection (subcomponent one) and stratified reporting (subcomponent two) no later than year two of the waiver period. The use of upside risk for ACOs that meet higher standards and demonstrate progress in reducing identified inequities (subcomponent three) seems to be an appropriate approach.

In addition, as further guidance is provided and the programs under the waiver are implemented, we hope to see further details that will strengthen the commitment to equity through the establishment of infrastructure to address health disparities, for example, health equity committees, strategic plans, health equity and anti-racism staff trainings.

Pediatric Care

HCFA is extremely pleased that MassHealth includes improving pediatric care as one its core goals for the waiver renewal, which is clearly woven throughout the proposal. Children and youth make up nearly 40% of MassHealth’s membership and as such warrant specific policies, programs and financial investments that meet their unique needs. Many of our recommendations in this section are most relevant to implementation, but we hope they are also informative for the final submission of the waiver proposal to CMS.

Primary Care Reforms

HCFA greatly appreciates MassHealth’s intention to increase investment in primary care and supports the overall framework of the primary care sub-capitation program. We are especially pleased that MassHealth includes specific expectations for providers who serve children, adolescent and families with a focus on team-based care – inclusive of clinician and non-clinician staff, integrated behavioral health, and care coordination. This structure has the potential to significantly improve families’ access to and experience of care; support prevention and early intervention in physical health, behavioral health, and HRSNs; and reduce inequities.

MassHealth should ensure that pediatric care is appropriately valued in development of capitated rates and any remaining fee-for-service payments. Pediatric care often focuses on promotion, prevention and

early intervention. For example, MassHealth’s new forward-thinking policy to allow coverage and payment for short-term behavioral health services without a diagnosis must be adequately considered in the rate development process. At the same time, we hear from providers that they are seeing more serious and acute pediatric behavioral health needs as the COVID-19 pandemic continues. MassHealth should account for the complexity of behavioral health interventions in developing reimbursement rates for primary care, including the new sub-capitation program. This policy should also be applied across the behavioral health care continuum. More holistically, rates must account for and support the care delivery expectations included in the primary care sub-capitation program, accounting not only for differences in pediatric care and team members, but also to adequately support non-clinician professionals such as CHWs and family partners, as well as comprehensive care coordination.

Non-Clinician Professionals

HCFA would like to emphasize our support recognizing the integral role of non-clinician professionals, such as CHWs, family partners, and other peers, who have uniquely vital roles in the health care system, particularly for behavioral health. CHWs as a broad designation often come from the communities they serve and help build trust between underserved communities and health care providers. Family partners are themselves caregivers of children with behavioral health needs who combine family-centered supports based on their lived experience navigating services and systems. CHWs, family partners and peers help families access services and empower caregivers to advocate for their children’s needs. They often come from diverse racial and ethnic backgrounds and understand the social, cultural and linguistic needs. CHWs, family partners and peers are essential to helping families access and engage in care, advancing behavioral health integration, reducing disparities, and improving health outcomes. As described above, we ask MassHealth to ensure that the primary care sub-capitation rate provide adequate resources for primary care practices to sustain valuable non-clinician team members.

Care Coordination

Currently, many families either have no or little assistance with care coordination or too many care coordinators. Both situations put the burden on families to navigate the complexity of the health care, social services and educational systems. We support MassHealth’s efforts to simplify and streamline care coordination for members, while leaving room for innovation and flexibility for providers to work with families to meet their individualized needs. The majority of children receive most of their care and care coordination through primary care. Primary care practices should be held to high standards for family-centered care coordination and compensated adequately to meet these standards. For those children with the most complex needs, we support the creation of a Targeted Case Management program, with the expectation that the designated care coordination entity – based on family preference – coordinate services across the health, educational, social services and state agency sectors.

Specific to behavioral health, we strongly support EOHHS’ efforts to promote integrated behavioral health care and increase behavioral health access through the Behavioral Health Roadmap. We request that MassHealth build in specific expectations for care coordination among all entities providing children’s behavioral health services, including but not limited to, primary care (especially the new sub-capitation program), Community Service Agencies that provide Children’s Behavioral Health Initiative (CBHI) services, the new Community Behavioral Health Centers (CBHCs) and youth Crisis Stabilization Services, community-based outpatient behavioral health providers, and more acute levels of care (e.g., Partial Hospitalization programs, inpatient, Community-Based Acute Treatment). We acknowledge that for most families, care coordination is done through primary care. While closed-loop referrals and coordination with the Children’s Behavioral Health Initiative (CBHI) is a current expectation for ACOs,

this is rarely done successfully. We recommend that it be strengthened under the primary care reforms and the Roadmap.

Good pediatric care necessitates coordination both within the health care system and outside the health care system, most notably with schools, childcare and related child-serving entities. As children return to school after a tumultuous academic year during the pandemic – and upon the waiver approval, finish out the school year – the Commonwealth has the opportunity to think about how to more thoughtfully foster collaboration between the health care and education sectors.

It is also worth noting that care coordination can be the most challenging for children and youth who receive services from multiple systems and agencies. As stated in the waiver document, MassHealth aims to more intentionally work across agencies, particularly with the Department of Children and Families (DCF) services. We support efforts to ensure that children engaged with DCF, who are among the most vulnerable youth in the Commonwealth, can benefit from improvements in care delivery and disparities reduction envisioned in the waiver proposal.

Quality & Accountability

Accountability mechanisms are necessary to ensure that ACOs and primary care providers participating in the sub-capitation program are meeting care delivery expectations and that enrollees are not denied care. HCFA asks MassHealth to consider adding meaningful, family-centered pediatric-specific metrics to its ACO and primary care measure slate, such as screening follow-up (including caregiver screenings) and effectiveness of integrated behavioral health. We also understand there are long-standing efforts in the Commonwealth to align quality metrics across payers.

Behavioral Health

In addition to the above comments regarding behavioral health integration and care coordination, HCFA supports the following elements of the waiver proposal and related policies, with recommendations for each:

- *Behavioral health network:* We support efforts to strengthen and streamline MassHealth’s behavioral health network in a way that meets the following principles:
 - ensures continuity of care;
 - broadens available network providers;
 - improves access for underserved populations, such as children and youth, including young children; people with co-occurring intellectual, developmental, or other disabilities; Black, Indigenous, and other People of Color; LGBTQ+ people (especially LGBTQ+ youth, whose behavioral health has been disproportionately affected by COVID-19); people with language access needs; and people living in parts of the state with limited capacity;
 - includes robust consumer protections; and
 - complies with state and federal parity laws.
- *Fee-for Service Enhancements:* We are pleased to see that MassHealth proposes to expand coverage of independent clinicians and diversionary services to enrollees who utilize the fee-for-service network, increasing the availability of the types of behavioral health providers available to this population, including psychologists, independent social workers and community-based intensive services.
- *Workforce development:* The current behavioral health workforce does not nearly have the capacity to meet the need for current services nor the important additional access points envisioned through the Behavioral Health Roadmap. MassHealth’s proposed loan repayment

program can help contribute to increasing system capacity and must be paired with other reforms to not only recruit but also retain clinicians and create opportunities to advance in behavioral health careers. Additional levers that MassHealth has identified and started to initiate – and private insurers must follow to have impact – include rate increases, administrative simplification and team-based care inclusive of peers. In addition, we are hopeful that this effort will attract providers who can serve diverse populations and a mix of child/adolescent and adult clinicians.

Eligibility & Benefits

CommonHealth

HCFA enthusiastically supports MassHealth’s proposed changes to the CommonHealth program for adult applicants. The changes to eligibility will make the program more accessible to a vulnerable population and extend coverage to many that have been unable to get comprehensive coverage. Updating the eligibility requirements for adults between 21 and 64 years old to remove both the deductible and work requirement allows adults with disabilities to have more stable coverage. By removing the work requirement for individuals with disabilities, more individuals may choose to work. Having the security of being able to qualify for MassHealth regardless of current work status provides members with consistent coverage and may actually allow them to work more when their health allows for it.

For many years, HCFA’s consumer HelpLine has worked with Massachusetts residents with disabilities seeking comprehensive coverage who have not been able to benefit from the CommonHealth program because of the one-time deductible or work requirement. The proposed changes will allow adult applicants, like our HelpLine callers, who have fallen through the cracks to receive comprehensive MassHealth coverage that can help with all their health care needs, including long-term services and supports, regardless of their current work status. This change will also streamline the eligibility determinations. Currently, the need to first meet or waive the deductible before MassHealth makes an income-based premium determination requires a clunky workaround, resulting in longer wait times for applicants and administrative burden for MassHealth eligibility workers. Further, the proposed pathway for members over age 65 to maintain coverage if they have been enrolled in CommonHealth for ten years will allow seniors the ability to retire without fear of losing their coverage and the benefits that have helped enable them to live and work in the community.

Retroactive Coverage

HCFA supports extending three-month retroactive coverage to pregnant individuals and children. We appreciate this as the first step to extending retroactive coverage to a vulnerable population and hope to see retroactive coverage extended to all MassHealth applicants. Full retroactive coverage has the potential to reduce medical debt that may prevent low-income residents from seeking important follow-up care and mitigate practical barriers that may have led to the lack of coverage to begin with.

Continuous Eligibility

12-Month Continuous Eligibility for Formerly Incarcerated and Covering Certain MassHealth Services During Incarceration

HCFA supports 12-month continuous eligibility for formerly incarcerated Massachusetts residents and the bold proposal that MassHealth cover certain services for individuals while they are incarcerated. The vast majority of incarcerated people are eligible for MassHealth before and after incarceration. Many

justice-involved individuals also struggle with mental health and/or substance use conditions. As MassHealth cites in its waiver proposal, the opioid-related overdose death rate is 120 times higher for formerly incarcerated individuals, with 50% of all deaths among this population opioid-related.¹ Extending MassHealth coverage for eligible individuals while in jails in prisons, and during the transition out of these facilities, promotes continuity of care and better health outcomes for the justice-involved population. HCFA recommends that MassHealth set up an advisory committee made up of health care providers, advocacy groups, and formerly incarcerated people in addition to the coordinating council of criminal justice officials in order to evaluate the implementation of MassHealth coverage during incarceration.

24-Month Continuous Eligibility for Homeless Members

HCFA supports 24-month continuous eligibility for homeless individuals and appreciates this practical yet forward-thinking approach to maintain coverage for a population at high risk of churn. Maintaining coverage for homeless members can help keep them engaged in care, improve health outcomes, and increase opportunities for assistance in gaining stable housing.

12-Month Continuous Eligibility for Children

While MassHealth has made considerable efforts in the past several years to address coverage gaps, families still experience this problem. In alignment with the other continuous eligibility proposals in the waiver, as referenced above, HCFA urges MassHealth to also consider filing a State Plan Amendment for 12-month continuous eligibility for children. Currently, 27 states have continuous eligibility for children enrolled in the Children's Health Insurance Program (CHIP) and 25 states have it for Medicaid. Twenty-four states have continuous eligibility for children in both their CHIP and Medicaid programs.² Continuous eligibility would improve continuity of care, reduce administrative burden, improve family experience, foster health equity, and provide an essential foundation for delivery system reforms.

Maternal Health

HCFA applauds MassHealth for prioritizing maternal health equity. As we have previously commented, HCFA strongly supports MassHealth's pending 1115 waiver amendment to extend postpartum coverage from 60 days to 12 months for all pregnant and postpartum members regardless of immigration status. We are pleased to see additional maternal health policies in the 1115 waiver extension proposal, including coverage for doulas and enhanced care coordination for high-risk pregnancies.

Doulas are certified non-medical professionals who provide continuous physical and emotional support to a birthing person before, during and shortly after childbirth. Doula-led care has been identified as a promising model that improves birth, breastfeeding and maternal health outcomes. These improvements are most pronounced for People of Color, immigrants and low-income birthing people. In

¹ Massachusetts Department of Public Health, Data Brief An Assessment of Opioid-Related Overdoses in Massachusetts 2011-2015, August 2017. Available at: <https://www.mass.gov/files/documents/2017/08/31/data-brief-chapter-55-aug-2017.pdf>.

² "Continuous Eligibility for Medicaid and CHIP Coverage," Medicaid.gov, <https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html>.

addition, doula-led care saves more health care dollars than the doula programs cost and reduces health inequities especially for at-risk and underserved populations.³

HCFA is grateful for MassHealth's hard work and openness to stakeholder feedback throughout the development of the 1115 waiver extension proposal. We look forward to continued collaboration to implement policies that prioritize health equity and improve access to coverage, care and support for HRSNs. Please do not hesitate to reach out with any questions or further discussion. Thank you for your time and consideration of these comments.

Sincerely,



Amy Rosenthal
Executive Director

Cc: Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation
Mohammad Dar, MD, Senior Medical Director
Clara Filice, MD, Associate Medical Director for Payment & Care Delivery Innovation
Kate Ginnis, Senior Director, Child, Youth & Family Policy and Programs
Ryan Schwarz, MD, Director of Policy for Accountable Care
Martha Farlow, Deputy Director, Policy, MassHealth

³ Commonwealth Fund, "Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity," March 2021. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity>.



Hilltown Community Health Center

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September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
1 Ashburton Place
Boston, MA 02108

Re: Comments on Demonstration Extension Request [Submitted via email to: 1115-Comments@mass.gov]

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of Hilltown Community Health Center (HCHC), thank you for the opportunity to provide comments on the 1115 MassHealth Demonstration ("Waiver") Extension Request. Established in 1950, HCHC is the only provider of any of its services in the rural Hilltowns west of the Connecticut River, serving almost 10,000 patients annually. We provide medical, dental, behavioral health, and eye care services, as well as a wide range of community services for families and individuals.

HCHC is in full agreement with the Mass League's comments on the key issues of payment/primary care capitation, health equity incentives, workforce, and 340B. Specifically, and of particular importance to our health center are the following issues:

- **Payment:** We are very supportive of the shift to payment mechanisms that will increase our ability to provide integrated care. We need, however, to have a better understanding of how these new payment methodologies would interact with the PPS payment methodology for FQHCs. We would need significantly more information to offer our full support.
- **Equity:** HCHC is committed, as are all FQHCs, to health equity and access. We currently collect patient information on race, ethnicity, income, sexual orientation and gender identity, and other data critical to understanding the barriers that our patients face in the health care system. We are committed to working with our ACO, C3, to improving and expanding this data collection, identifying and monitoring disparities, and/or reducing inequities. It is important for FQHCs to be able to design our own interventions to remedy health inequities – health centers have more experience and expertise in responding to the needs of these communities than most of the rest of the health care system, given our history.
- **Workforce:** As I testified in the MassHealth listening session on September 9, 2021, workforce development and support is a critically important part of any FQHC's ability to serve its community. Primary care loan repayment and support for frontline staff like medical assistants, dental assistants, and front desk staff should be a top priority in any effort to serve the MassHealth patients with accessible, high-quality care.

Thank you for the opportunity to provide feedback about the 1115 waiver demonstration request and to share how the waiver has and will impact our health center. We look forward to continuing our work with MassHealth to provide high-quality, comprehensive care to patients.

Respectfully,

Eliza B. Lake, CEO

I am writing to express my thoughts on the 1115 Extension Request. Please consider the health of all of us, and accept:

- The MIEP Initiative proposal (beginning at the bottom of page 59)
- proposed behavioral healthcare workforce loan repayment program (pages 45-46)
- Health equity performance measures and incentive payments (p.48)
- Incentive payments related to data quality and completeness (p.49)
- Expansion of the Flexible Services Program that can help pay for food and housing stability costs like rent (p.56-59)
- Coverage for childcare costs for members while they are participating in Flexible Services Program related activities and appointments (p.57)

We appreciate all of your hard work to keep MA healthy!

Kathleen Herr-Zaya, PhD

**Deb Wilson, President & CEO, Lawrence General Hospital
Comments on the Medicaid Waiver**

Safety Net Provider Payment

Lawrence General seeks a substantially higher safety net provider payment than the proposed 2022 flat funding amount of \$11.47M annually, in order to sustain vital health care services for the Greater Lawrence community.

With a Medicaid payor mix of 28-30% of GPSR, and the 2nd lowest commercial insurance rates for independent hospitals, the safety net provider payment provides essential funding that sustains key community services. No other payment provided through the waiver provides a comparable opportunity to mitigate the structural deficit Lawrence General faces as a high Medicaid hospital whose shortfalls in Medicaid cost reimbursement are three times the current safety net provider payment.

Annual declines in safety net payments with a growing proportion of it at risk is one factor that contributes to the hospital's \$15M annual reimbursement deficit and the threat to services in the Commonwealth's largest community of color.

In 2022, the hospital will receive a safety net payment that is **\$5.3M and 36% less** than it received in FY17.

(\$11.47M in 2022 – minus - 20% withheld = \$9.12M vs \$14.43M in 2017)

While CMS approved a \$15.9M annual DSTI payment in the prior waiver, EOHHS provided the opportunity for the Hospital to receive \$14.4M a year for 5 years ending 2017. During the current 5-year waiver period the safety net payment has been reduced from \$13.2M in FY18 to \$11.47 in 2022. That \$11.47 is 72% of the CMS approved \$15.9M 2017.

We respectfully request that EOHHS propose a safety net provider payment base at the FY17 CMS approved level of \$15.9M in the prior waiver, adjusted for inflation of 4.5% in FY23 and adjusted each year of the 5 year waiver ending in 2028.

ACO RISK

Lawrence General is a member of a Model A ACO partnership that has had deficits in all but one of six risk categories in 2018, 2019 and 2020 for each of the three performance years. Cumulative losses were \$17.5M over the past three years. Given the challenges in establishing a PMPM that accurately reflects the population as well as the consistent losses, in spite of a medical trend of only 2%, we respectfully request that the safety net provider portion at risk be limited to no more than 10%.

DISABILITY and RACIAL AND ETHNIC DISPARITIES FUNDING

The current disability incentive payment is between \$2.5 and \$3M annually. We would like to achieve reductions in racial and ethnic disparities and embrace this is a key priority. It is not clear however, if there will be considerably higher funding to achieve this. We believe 3x the current disability funding would provide resources needed to capture new measures and make progress.

If gains in reducing disparities is defined by reference group compared to MassHealth HEDIS performance measures, we will require substantially more in funding than the current disability funding. Lack of access to programs in our region and new focused areas of effort make this a unique challenge, particularly in light of our financial constraints.

Capturing racial and ethnic data has proven challenging when self-reported CDC options are captured for covid immunization sign-up, and work to build capacity to provide high integrity data would be required. For example, more people identified as white residents of Lawrence on their covid immunization sign-up than the census data indicate resides in Lawrence.

Please extend coverage to the incarcerated so that folks have access to health care inside and when released.

To the EOHHS:

I have known and know dozens of people who received little and substandard "health care" while incarcerated in Massachusetts' prisons and jails. It is harmful to them and costly to the Commonwealth because their health deteriorates resulting in the need for greater and more expensive care. When people are released, as most people are, if they are in ill-health it is impossible for them to find work which can result in homelessness and even worse health. Once they are released formerly incarcerated people need comprehensive, affordable health care coverage. Enabling this health care coverage as is proposed by the Massachusetts Medicaid Waiver would stop this counterproductive, costly and harmful cycle which benefits no one.

--

Lois Ahrens

[The Real Cost of Prisons Project](#)

[The Real Cost of Prisons Project on Facebook](#)

I am writing in support of the Medicaid Extension Waiver, in order to provide health care to all incarcerated people in Massachusetts, both during incarceration and after. Our incarcerated population is comprised of some of the most marginalized people in Massachusetts, and doing what we can to improve their health is what is best for them and for public safety.

Louellyn Lambros
Scituate, MA

Date:

9/17/2021

To:

Masshealth demonstration project team

Re:

CHC 1115 Waiver Renewal Request Key Issue Comment

From:

Kiame Mahaniah, CEO, Lynn Community Health Center

269 Union Street, Lynn, MA 01901

kmahaniah@lchcnet.org

As evidenced by my participation in a call with CMS earlier this year and by the blog that I began in July 2021, I am quite supportive of Masshealth's 1115 waiver request. From a social justice perspective, moving on the continuum from fee-for-service to value-based care is the bet for us to achieve our mission of supporting our community and our individual patients. Particularly in its focus on those experiencing homelessness, on integrating Behavioral Health and Primary care while including Substance Use Disorder Treatment and its placement of care for the historically disenfranchised at the center of the effort, I -and by extension the LCHC leadership team and the Board of Directors- laud Masshealth.

Unavoidably in any complex process with multiple stakeholders, there some issues that could be better handled.

Health equity:

Along with several others in past and present leadership of community health center, I had the honor of serving on the Health Equity Task Force. Those few months were incredibly eye-opening for me. As a leader of a social-justice organization, I thought I understood unfairness and the consequence of power dynamics. Those hearings confirmed how little I truly knew of the challenges our patients, our communities and the institution that serve them face.

I have no argument with hospitals needing extra funding, especially to move their processes to focus on racial equity. But to create one exclusive pathway for hospitals (getting funding directly) while melding the health center pathway within the ACO structure surprised me. Are both sets of institutions not embedded in ACOs? Why not create the same process for both?

I can almost guarantee that ACO leaders are not in rush to become the gatekeepers of racially equitable programs. The strength of FQHC lies in our incredibly intimate connection with our communities. What equity needs are present in Lynn will be incredibly different than the ones faced by Hilltown Community Health Center in Western Massachusetts. To expect C3 to be better able to devise grant or RFPs than what we could ourselves design is misguided at best. In Lynn, our focus would likely be the growing numbers of Black and Brown suffering from overdoses, from homelessness and housing insecurity, the amazing digital divide and in the growing disparity between our Latinx population preferring English as compared to our Latinx population preferring Spanish. I am certain that certain

health centers will share some of these initiatives, but they will undoubtedly have their own local permutations.

In addition, the health center leadership undoubtedly provides the most racially and ethnically diverse group of health care leaders in Massachusetts. To require them, in the name of advancing racial equity in health, to go through a structure mostly dominated by traditional power structures, seems philosophically inconsistent.

I support the Mass League of Community Health Center's recommendation for Masshealth to invest directly in health centers, just as it is doing for hospitals.

Please don't hesitate to contact me for any further information,

Kiame Mahaniah, MD, MBA

Kiame Mahaniah, MD, MBA

He/his pronouns
Chief Executive Officer
Lynn Community Health Center
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September 14, 2021

Amanda Cassel Kraft
Acting Assistant Secretary, MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

On behalf of a hospital Coalition that includes Baystate Health, Berkshire Health System, Southcoast Health, and Wellforce, we are pleased to submit our comments on Massachusetts' 1115 waiver renewal application. Our Coalition member hospital systems serve 130,508¹ ACO participants and represent 76 percent of the Massachusetts Medicaid Group 2 Acute Care Hospitals. Over the last several months, our Coalition has worked diligently to collaborate with EOHHS to inform the development of its 1115 waiver renewal application and looks forward to continuing to work together through the formal comment period for this application. We have worked with our partners at the Massachusetts Hospital Association (MHA), which has been instrumental in helping to shape the conversations around the future of the health care delivery system in this state. While we submit these comments on behalf of our Coalition, we are also fully supportive of MHA's work, particularly around an increased hospital assessment.

Hospitals have worked tirelessly to help make Massachusetts' ACO model a success under the current waiver, partnering with community providers and other stakeholders. As the state has moved forward with its waiver renewal efforts, our Coalition members have participated eagerly in the various EOHHS stakeholder forums where you have shared your goals and strategies for the extension of the 1115 Demonstration waiver for the next five-year period. We would like to extend our thanks to EOHHS for the inclusiveness of this process.

The Coalition members are broadly supportive of the elements EOHHS included in its waiver renewal, including continued advancement of the Accountable Care Organization (ACO) model, sustainable support for the Commonwealth's safety net, and work to reduce health disparities in the Commonwealth. The waiver renewal is an important next step in advancing Massachusetts' health care delivery system, and one that will continue to position Massachusetts as a thought leader in the delivery of value-based, integrated care. In general, the renewal application makes important changes to make the role of ACOs and health systems more central to the Medicaid delivery system, while concurrently increasing and strengthening expectations. The Coalition applauds EOHHS' support for reducing health disparities in its waiver renewal and appreciates the extent to which this funding is directed toward hospitals with a high volume of Medicaid patients. The Coalition supports moving away from the current subcontracting approach to behavioral health services. The Coalition agrees that ACOs should function as the lead entity for care coordination, as this updated arrangement is likely to improve communication across various domains of care. The Coalition also supports the standardization of clinical standards in the Community Partners Program.

However, our Coalition maintains that these program enhancements and reforms must be supported by commensurate increases in funding to the safety net hospitals that drive and support these programs, and we are concerned that the safety net funding described in the 1115 renewal application will be inadequate to support our efforts to implement many of the changes described in the waiver

¹ As of June 2020

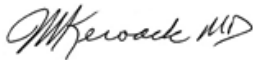
application. While the Coalition supports the EOHHS' goal to maintain the Medicaid safety net and is supportive and appreciative of the proposed increased safety net funding included in the 1115 waiver renewal application, our Coalition members believe EOHHS must do more to support Medicaid Group 2 acute care hospitals. The current MassHealth Medicaid hospital supplemental safety net payments are highly concentrated in favor of Group 1 hospital systems (which includes the Cambridge Health Alliance), which receive a 23 percent add on to their Medicaid payments equal to \$238 million compared to a four percent add on for Group 2 hospital systems, despite both groups having a substantially similar amount of Medicaid business.

In the 1115 waiver renewal, MassHealth proposes increasing the Group 2 Medicaid hospital supplemental safety net funding to \$40 million and the number of eligible Group 2 hospital systems to 17. This increase does not address the significant gap between the Group 1 and Group 2 hospital systems. Without addressing the Group 2 hospital systems funding imbalance, it will be difficult for the Group 2 hospital systems to continue sustained investment and transformation in the MassHealth delivery system contemplated by EOHHS through the waiver renewal period and will further exacerbate the inequities found in the current Massachusetts health care delivery system.

The Coalition requests EOHHS include in its 1115 waiver renewal additional safety net funding for Group 2 hospital systems beyond the MassHealth proposed \$40 million included in the waiver proposal. At EOHHS's request, our Coalition developed a formula-based methodology, using unbiased metrics and data to calculate the additional Group 2 supplemental payment amount request. This supplemental safety net funding will allow our safety net hospital systems to continue the reforms begun under the current 1115 waiver, as well as to provide the enhanced level of service and support envisioned in Massachusetts' 1115 waiver renewal application.

We appreciate the opportunity to provide these comments and look forward to continued collaboration with EOHHS as it submits its 1115 waiver renewal application.

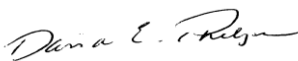
Sincerely,



Mark A. Keroack, MD, MPH
President & CEO, Baystate Health



Keith A. Hovan
President & CEO, Southcoast Health



David E. Phelps
President & CEO, Berkshire Health Systems



Michael Dandorff,
President and CEO, Wellforce

cc: Marylou Sudders, Secretary, Health and Human Services



**We ensure quality, comprehensive
health care for all.**

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September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
1 Ashburton Place
Boston, MA 02108

Re: Comments on Demonstration Extension Request

[Submitted via email to: 1115-Comments@mass.gov]

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of Manet Community Health Center, thank you Acting Assistant Secretary for the opportunity to provide comments on the 1115 MassHealth Demonstration ("Waiver") Extension Request.

Manet Community Health Center, Inc. (Manet) is a 501(c) (3) not-for-profit Federally Qualified Health Center (FQHC) dedicated to providing preventive, primary and non-emergent urgent care to all, regardless of financial circumstance or health insurance coverage status. Manet has been serving the community since 1979 and has three locations in Quincy, one in Hull and one in Taunton. In 2020, Manet opened its Community Outreach and Prevention Services office in Quincy and, in July of 2021, the health center opened a new practice site in Attleboro.

Accredited by The Joint Commission, Manet's practice sites in Quincy, Hull and Taunton are recognized as a Level 3 Patient Centered Medical Home by the National Committee for Quality Assurance (NQCA) (2014 Standards) and are PCMH Prime certified, recognizing Manet's achievement in integrating behavioral health.

Manet's delivers care to more than 20,202 patients in over 74,963 unduplicated annual visits (2020 UDS data), provides services that are reflective of the languages and cultures of the communities it serves and offers a full array of services and programs for infants, children, adolescents, adults, and seniors.

More than 75% of Manet's patients are at or below 200% of the Federal Poverty Level with 70% of our patients relying on Medicare/Medicaid or Health Safety Net.

Manet is and independent FQHC and has a primary affiliation with Boston Medical Center Health System and is part of the Boston Accountable Care Organization, Inc. (BACO), BMC HealthNet Plan Community Alliance.

Manet is aligned and supportive of the Mass League’s comments on the paramount issues of payment/primary care capitation, health equity incentives, workforce, and 340B.

Each are important matters for Manet and the patients and the communities we are privileged to serve, yet to highlight the importance of just two, please:

❖ **Workforce**

The life force of the health center are our Providers—primary care, addiction, and behavioral health. From Quincy, Hull, Taunton to Attleboro, Manet collaborates with eight (8) hospitals and health systems. Currently, Manet has not operated a NP Residency program, yet the vitality and impact of the Student Loan Repayment program is substantial for newer career providers. This program combined with the teaching community and mentorship has helped to develop, retain and inspire a new and next generation not only of safety-net providers but provider leaders of the future. Additionally, Manet’s providers could not be the *best version of themselves* without Care Team Investment and development. Support for the staff they work shoulder-to-shoulder with on behalf of our patients can have lasting and readily measurable impacts.

❖ **340B**

The 340B savings program is truly watershed to the vitality of the health center and the services and offering Manet can provide to improve health access and health outcomes. As detailed in our *340B program policy*, Manet justly utilizes 340B Savings toward the following costs: Community health improvement services. Further, Manet employs the 340B savings toward the following: Personnel and consultancy supports helping connect patients to care and Medical, Behavioral Health, Vision and Nutrition service; and, outreach and enrollment and access specialists; and support toward capital building projects with direct impact to patients served.

Acting Assistant Secretary, we are grateful for this opportunity to provide feedback about the 1115 waiver demonstration request. Manet, dedicate in service to our communities, and existing to care for existing and new patients---only in partnership with MassHealth looks forward collaboratively and optimistically as a provider of comprehensive, quality, equitable, accessible primary, and behavioral health care.

Respectfully,



Cynthia H. Sierra
Chief Executive Officer

*Massachusetts
Association of
Behavioral
Health Systems*

115 Mill Street
Belmont, MA 02478
Phone: 617-855-3520

Marcia Fowler
Chairman

David Matteodo
Executive Director

Members:

AdCare Hospital
Arbour Hospital
Bournewood Hospital
Fuller Hospital
McLean Hospital
Southcoast Behavioral Health
Steward Health Care System

Associate Members:

Anna Jaques Hospital
Austen Riggs Center
Bayridge Hospital
Baystate Health System
Berkshire Health Systems
Beth Israel Deaconess
B.I. Deaconess/Plymouth
Brigham and Faulkner Hospital
Brockton Hospital
Cambridge Health Alliance
Cape Cod Hospital
Children's Hospital
Cooley Dickinson Hospital
Emerson Hospital
Franciscan Children's
Gosnold on Cape Cod
Harrington Memorial Hospital
Haverhill Pavilion Hospital
Henry Heywood Hospital
Holyoke Medical Center
Hospital for Behavioral Medicine
HRI Hospital
Marlborough Hospital
Mass General Hospital
MelroseWakefield Healthcare
Metro West Medical Center
MiraVista Behavioral Health
Mount Auburn Hospital
Newton Wellesley Hospital
Noble Hospital
North Shore Medical Center
Pembroke Hospital
Recovery Centers of America
St. Vincent Hospital
Sunrise Detox Centers
TaraVista Behavioral Health
Tufts Medical Center
U Mass Memorial Health Care
Walden Behavioral Care
Westborough Behavioral Hospital

**Comments to the Executive Office of Health and Human Service
Re: Comments on the 1115 Demonstration Extension Request
Presented by: David Matteodo, Executive Director
Massachusetts Association of Behavioral Health Systems
September 20, 2021**

On behalf of the Massachusetts Association of Behavioral Health Systems (MABHS), I appreciate the opportunity to offer these comments to the Executive Office of Health and Human Services regarding the MassHealth 1115 Demonstration Extension Request. The MABHS is a statewide organization that represents 47 inpatient mental health and substance use facilities throughout Massachusetts. Our facilities admit over 60,000 patients annually and provide the majority of inpatient behavioral health services in the state.

First, we would like to note our appreciation for the many years of MassHealth support in its Medicaid Waivers for the use of IMDs (Institutions for Mental Disease). Since the early 1990's MassHealth has utilized freestanding inpatient psychiatric hospitals for mental health services. On a given day in Massachusetts there are hundreds of MassHealth adults cared for in psychiatric hospitals. It has been helpful to patients by giving them better access and the Emergency Department Boarding situation would be far worse if these hospitals were not used. It has also been helpful to MassHealth and its MCOs and Behavioral Health Management firms by giving them a more robust and competitive Inpatient Network. And finally, it has been good for the hospitals by allowing them to service a large population of public patients.

We understand that MassHealth has a request already submitted to CMS to fully utilize the IMDs. We further understand that MassHealth would continue this full utilization of the IMDs in the upcoming Demonstration Request if the current request is approved. We hope CMS quickly approves the MassHealth request and stand ready to assist if needed.

MABHS also supports the principles in the MassHealth Roadmap for Behavioral Health Reform. Given the overwhelming demands for inpatient psychiatric care in Massachusetts anything MassHealth can do to provide the most appropriate settings for its clients is a very positive step. Also, a very positive initiative is the integration of primary and behavioral care as contemplated in the MassHealth request. We look forward to hearing more details and working with MassHealth and other constituencies on implementation of these very promising proposals.

MABHS would also request that the Behavioral Health Workforce initiative in the Extension request include an ability for individuals who benefit by the financial support for their Student Loans be extended to inpatient Behavioral Health facilities. The current request requires a commitment to work for four years in Community Settings. This MassHealth request should be expanded to inpatient Behavioral Health facilities which also are having unprecedented levels of workforce shortages to the point of hundreds of beds being unavailable due to these shortages. Please amend the request to include inpatient Behavioral Health facilities as an option for the four-year commitment.

In summary, we strongly support MassHealth's IMD request and the principles for the MassHealth Roadmap and integration of primary and behavioral care. We also hope you will amend the Workforce Initiative to include inpatient facilities. We look forward to next steps. Thank you for your consideration of these comments.



Danna E. Mauch, PhD
President and CEO

Ambassador (ret.) Barry B. White
Chairperson of MAMH Board of Directors

September 20, 2021

Ms. Amanda Cassel Kraft
Assistant Secretary for MassHealth
MA Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: MassHealth Section 1115 Demonstration Waiver Renewal

Dear Assistant Secretary Cassel Kraft,

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for your commitment to ensuring that the needs of people with behavioral health conditions and their families are considered in MassHealth's Section 1115 Demonstration Waiver Renewal. We appreciate the opportunity to provide you with written comments and thank you and your team for including MAMH in the stakeholder engagement and work group process recently completed in preparation for filing the waiver renewal.

Formed over a century ago, MAMH is dedicated to promoting mental health and well being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated track record of furthering its mission by convening stakeholders across the behavioral health and public health communities; disseminating emerging knowledge; and providing subject matter expertise to inform public policy, service delivery, and payment methodologies.

Behavioral health needs have increased substantially during the COVID-19 pandemic and are anticipated to persist in the months and years to come. In an online survey conducted by the MA Department of Public Health (DPH) between September and November 2020, one in three Massachusetts adults reported 15 or more poor mental health days in the past month. The groups reporting the highest rates of poor mental health were respondents of transgender experience, non-binary respondents, and respondents questioning their gender identity; LGBTQ+ respondents; multiracial, American Indian/Alaska Native, and Hispanic/Latinx respondents; younger respondents; respondents with low income <\$35k; and those with lower educational attainment. Youth have been hit particularly hard by the pandemic. Almost half of all youth in Massachusetts (48%) reported feeling sad or hopeless almost every day for two or more weeks in a row. This is 21% higher than data from 2017.¹

Along with the Executive Office of Health and Human Services' (EOHHS') Roadmap for Behavioral Health Reform,

¹ Massachusetts Department of Public Health (DPH). COVID-19 Community Impact Survey (CCIS). 8 September 2021. Available at: <https://www.mass.gov/doc/covid-19-community-impact-survey-ccis-preliminary-analysis-results-full-report/download>.

the 1115 waiver renewal presents a timely opportunity to improve behavioral health care access throughout the continuum – from promotion and prevention through acute inpatient treatment. Please consider these comments as you finalize the waiver proposal and implement complementary changes through other policy vehicles.

Integrated Behavioral Health in Pediatric Primary Care

As an Executive member of the Children’s Mental Health Campaign (CMHC), MAMH supports the full comments submitted by the Campaign in regard to MassHealth’s Section 1115 Demonstration Waiver Renewal. I specifically want to highlight the comments related to the prioritization of integrated behavioral health. I was pleased to see specific expectations and requirements related to children, youth and families, as well as an emphasis on team-based care that includes behavioral health clinicians and family partners, peers and community health workers on the care team; and specific care delivery expectations for children, youth and families. I am optimistic that these features of the proposed primary care sub-capitation program will enhance care for children and families enrolled in Accountable Care Organizations (ACOs), increasing the opportunity for early intervention and potentially relieve some pressure on the specialty behavioral health system. The 1115 waiver should enable more opportunities for pediatric practices and community behavioral health clinics to provide promotion, prevention, and early intervention services to families. The CMHC enthusiastically supports MassHealth’s recent guidance allowing for coverage and payment for up to six behavioral health visits without a diagnosis for enrollees under the age of 21, within the pediatric primary care, community behavioral health, and/or school settings.

Adequate Rates for Behavioral Health Services

Despite passage of parity legislation at both the state and federal levels, coverage and access to mental health and substance use services remain more restrictive than coverage and access to physical health services. In November 2019, a landmark 2017 Milliman Research Report was replicated and again found disparities in reimbursement rates (proxies for network adequacy and provider fee level NQTLs) for behavioral health providers in comparison to medical/surgical providers. In fact, the 2019 study found widening disparities in provider reimbursement (behavioral health provider reimbursement was found to be even lower compared to their professional peers paid for physical health treatments).^{2,3}

I recognize that MassHealth reimburses most behavioral health services at better rates than those offered by private insurers. However, to solve the thorny workforce and associated access issues in behavioral health care we need to address the relative rate inequities with other health care services. In order to realize the potential of MassHealth’s Section 1115 Demonstration Waiver in expanding access to a continuum of quality behavioral health services, providers of behavioral health care must be reimbursed at adequate rates. For instance, in regard to integrated behavioral health in primary care, the primary care sub-capitation payment must be sufficient, including properly valuing primary care, the behavioral health clinician, and non-clinician team members. In particular, reimbursement rates must be reflective of the requisite staffing needs, especially of those roles that have previously been largely unreimbursed, including family partners, peer professionals, and community health workers. In addition, while rates for physical health care are often adjusted for complexity, this is not often the case for behavioral health. In both the integrated primary care setting and in behavioral health care more generally, reimbursement should also account for complexity. The COVID-19 pandemic has only increased the need for more complex and acute conditions that require more time-intensive and complicated interventions and often coordination among multiple providers and different levels of care.

² Melek SP, Perlman D, Davenport S. *Milliman Research Report: Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates*. Commissioned by Mental Health Treatment and Research Institute, LLC, a nonprofit subsidiary of The Bowman Family Foundation, December 2017.

³ Melek SP, Davenport S, Gray TJ. *Milliman Research Report: Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement Rates*. Commissioned by Mental Health Treatment and Research Institute, LLC, a nonprofit subsidiary of The Bowman Family Foundation, November 2019.

Exception to the Federal Medicaid Inmate Exclusion Policy (MIEP)

I applaud the Commonwealth in its effort to seek an exception to the federal Medicaid Inmate Exclusion Policy (MIEP). The MIEP denies states from accessing Medicaid funds to cover the costs of medical, mental health, and substance use care for incarcerated individuals, except for the cost of hospitalization for 24 hours or longer. Massachusetts prisons and jails are burdened by the need to provide mental health and substance use services to large numbers of incarcerated individuals. As of the end of 2020, 38% of male prisoners and 70% of female prisoners in Massachusetts prisons had an open mental health case.⁴ The MA Department of Correction (DOC) serves approximately 6,305 men and 190 women prisoners.⁵ As of May 2021, another 5,773 persons were held in Massachusetts county jails,⁶ and a 2015 national survey found that the rate of serious psychological distress is substantially higher for adult jail inmates than for adult state prison inmates.⁷

Most of these prisoners likely would be eligible for Medicaid were they in the community.⁸ Massachusetts has expanded adult enrollment to 133% of the Federal Poverty Level and covers ages 19 and 20 up to 150% of that level. Most prisoners would fall into this category; the median incomes of incarcerated people prior to incarceration “are dramatically concentrated at the lowest ends of the national income distribution.”⁹

An exclusion from the MIEP would save money for several reasons: 1) ongoing treatment reduces the need for more expensive mental health services; 2) maintaining prisoner health keeps prison costs down;¹⁰ and 3) treatment and better re-entry services reduce recidivism.¹¹ EOHHS’s proposal has the potential to improve the quality of care. Although prisoners have a constitutional right to health care, that care often is not comparable in quality to care offered in the community. With respect to mental health care, prisoners may not have access to timely delivery of medication, talk therapy, and other treatment alternatives. They may be denied access to needed care intentionally or unintentionally. They also suffer from lack of continuity of care as they move from the community to carceral facilities and back to the community. An exclusion would help address the existing racial disparity in the Massachusetts correctional system. BIPOC individuals are disproportionately represented in the Commonwealth’s carceral facilities.

I applaud the effort to cover mental health and substance use care for the entirety of the incarceration period and appreciate the attention to the first and last 90 days. Early days of detention present mental health and substance

⁴ <https://www.mass.gov/service-details/quick-statistics>.

⁵ *Id.* (Sept. 2021 data).

⁶ <https://www.mass.gov/lists/county-population-reports#fy2021-county-population-reports> (May 2021 County Population Report).

⁷ <https://healthpolicy.usc.edu/wp-content/uploads/2018/07/MA-Facts-and-Figures.pdf> at 25 (15% of state prison inmates had serious psychological distress versus 26% of jail inmates).

⁸ <https://www.medicaid.gov/state-overviews/stateprofile.html?state=massachusetts>. As of April 2021, the state’s Medicaid enrollment was at 1,573,872. <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

⁹ <https://www.prisonpolicy.org/reports/income.html>. Black prisoners earned less than the average incomes of all racial and ethnic groups. *Id.*

¹⁰ One program highlighting the fiscal benefits of keeping people with mental health issues out of carceral facilities is the Stepping Up Initiative. <https://www.naco.org/resources/signature-projects/stepping-initiative>.

¹¹ According to Mass. DOC’s most recent data, the one-year recidivism rate, including technical violations of parole or probation, for those released from DOC custody in 2016 was 17%. <https://www.mass.gov/doc/one-year-recidivism-rates-2016-release-cohort/download>. According to a 2016 CSG Justice Center report, the one-year re-incarceration rate for the Mass. Houses of Correction was 22%, the two-year rate was 35% and the three-year rate was 44%. <http://massinc.org/wp-content/uploads/2016/07/MA-Interim-Report-3-Slide-Deck.pdf> at 25.

use challenges and will require close oversight. The period of transition back to the community is also critical. MassHealth should consider extending the planning period for discharge to 180 days.

Likewise, MassHealth should develop means to ascertain not only the services offered but also the services actually delivered in carceral settings. It is important to recognize and address obstacles to service delivery that are unique to prison settings (such as security concerns, barriers to private treatment settings, lack of therapeutic environments, lack of freedom of movement, and difficulties connecting with family members and other supports, need for high numbers of culturally competent providers).

I am pleased to learn that MassHealth intends to focus on ensuring that behavioral health services are not only available but are also of high quality. To that end, MassHealth should develop multiple measures of access to and quality of services, including surveys and other means to incorporate, on an ongoing basis, the opinions of prisoners. MassHealth should also continue to consult advocates as they work to develop ways to review quality. Data collection stratified by race/ethnicity, disability status, and LGBTQ+ prisoners will help ensure that some of the most vulnerable prisoners are receiving quality services. MassHealth should rely upon external oversight to ensure quality on an ongoing basis.

Moreover, a focus on suicide prevention is paramount. MassHealth should address prevention in a holistic way in these settings, looking at environmental factors, individual factors, services, policies, and practices. Particular attention should be given to addressing suicide for at-risk categories of prisoners (such as prisoners with substance use conditions, newly admitted prisoners, and prisoners on mental health watch).

Related, MassHealth should anticipate issues with the delivery of services to prisoners held in special settings including mental health watch, medical units, and restrictive housing and similarly isolating and/or disciplinary conditions. MassHealth should encourage access to the outdoors and to exercise facilities.

Finally, MassHealth should give the young adult prisoner population (in all settings) special attention during planning, considering particularly the relationship between health care and other goals including: 1) access to educational and special educational services; 2) reunification with family and other supports; 3) pursuit of other transitional and young adult services.

Thank you for the opportunity to submit comments on MassHealth's Section 1115 Demonstration Waiver Renewal and for MassHealth's leadership to improve access to behavioral health care. Should you have questions, would like additional information, or if MAMH can serve as a resource to your critical work please don't hesitate to contact me at dannamauch@mamh.org.

Sincerely,



Danna Mauch, PhD
President and CEO



September 20, 2021

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

Amanda Cassel Kraft, Acting Assistant Secretary
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: MAHP Response to Draft Section 1115 Demonstration Waiver Extension Request

Dear Secretary Sudders and Assistant Secretary Cassel Kraft:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 16 member health plans that provide coverage to nearly 3 million Massachusetts residents, 2 behavioral health organizations, and the 5 Medicaid managed care organizations (MCOs), I am writing to provide our feedback on the 1115 Demonstration Waiver Extension Request, released on August 18, 2021. We appreciate the public process by which MassHealth engaged stakeholders and thank you for the opportunity to participate and offer our perspectives on these important topics.

The five Medicaid MCOs, who, working with their Accountable Care Partnership Plan (ACPP) partners, provide coverage to close to 800,000 Medicaid members, are deeply committed to the program and to the communities that they serve. The MCOs have been long-standing and committed partners with the state, providing high quality, innovative, and affordable coverage for MassHealth members and, more recently, working closely with their provider partners and community partners to implement the ACO program.

The integrated partnerships formed between the MCOs and their ACPP partners provide significant value to the members they serve, their contracted providers, and the state. Integration between the MCO and provider is at the core of each ACPP, providing comprehensive wrap-around care and coverage for the state's Medicaid population. Through these partnerships, MCOs provide the critical infrastructure to support the ACPP model, such as care coordination services, care management programs, network development and management, member services, and implementation of the community partners program. These initiatives would have been developed and implemented by and at the expense of the state or individual providers. Instead, the MCO partnership enables participation in the ACPP by providers that may not have had the resources or capability to participate without an MCO partner.

As you finalize the waiver extension request, we respectfully request that you consider the points outlined below:

Ensuring Strong and Sustainable MCO and ACPP Programs

The Section 1115 Waiver must ensure that there is a strong and central role for the MCOs, in partnership with their ACPP partners, and with the state going forward. Fundamental to securing such a role is to ensure that the program is appropriately funded to support the long-term sustainability of the MCO and ACPP programs with actuarially sound rates and adequately funded programs and services that further the quality

improvement and care coordination goals of the program. The ACPP model works by leveraging the strengths, capabilities, and expertise of the respective partners. Continuing these partnerships will provide value to members and to the state by improving quality and outcomes, addressing health equity, and lowering costs.

As MassHealth prepares to issue a new procurement, it is vital that there be no variation in financing mechanisms or programmatic design between the ACPPs and the Primary Care ACOs that results in a financial advantage for Primary Care ACOs. At the outset of the program there were features of the ACPP and Primary Care ACO programs that made the field uneven, due to distinctions in the risk adjustment model and other measures aimed at limiting the risk exposure for Primary Care ACOs. This resulted in better overall financial performance by the Primary Care ACOs. MassHealth addressed these concerns and worked with the ACO community to improve the ACPP financial model. We appreciate your willingness to make these changes and ask that as you develop the procurement for the ACO programs as part of the Waiver Extension, there be no variation between the ACPP ACOs and the Primary Care ACOs that results in a financial advantage for Primary Care ACOs.

We remain concerned with conclusions made by the state regarding the comparison between ACPPs' and Primary Care ACOs' administrative costs and the overall value of each program to the state. MassHealth has claimed that ACPPs have higher administrative costs than Primary Care ACOs, yet similar medical cost and quality performance. Based on this analysis, MassHealth has stated its intention to set additional requirements for the ACPPs, such as care delivery, innovation, and integration standards. Since ACPPs have and will continue to perform more administrative functions than Primary Care ACOs, it makes sense for the administrative component to have been higher for the ACPPs and to remain higher going forward, to reflect the different expectations for each model.

Significant differences exist between the two programs that require some level of normalization before making any financial or "value" comparisons between the two ACO models. By virtue of the program, the ACPPs are taking insurance risk whereas the Primary ACOs are not. Furthermore, MCOs work collaboratively with their ACO partners to provide core managed care functions, including member services, care management and disease management programs, data and information to help support providers, program integrity initiatives, and quality improvement programs. While these programs are harder to quantify, they need to be properly reflected when evaluating the economic value of the ACPP programs. We have attached an independent analysis from Milliman that outlines our concerns in greater detail and the additional clarification needed, including data on the normalization between Model A and Model B, consideration of additional savings achieved after FFY2019, and any other differences between Model A and Model B that may affect this comparison.

Based on our analysis of MassHealth data, the state's comparison between the two models and subsequent proposal to seek additional financial efficiency adjustments for ACPPs to bring the two models into "cost parity" for MassHealth, fails to fully capture the value ACPPs added in RY19. Using actual medical spend data, we find that had ACPPs instead been Primary Care ACOs, MassHealth would have spent \$145 million more in risk sharing to offset losses. Furthermore, when taking RY19 risk sharing into consideration, ACPPs were actually lower cost than Primary Care ACOs by 1.3%. Looking ahead to RY21, it is far more likely that the ACPPs and Primary Care ACOs will be closer in costs and value than the analysis shared by MassHealth suggests. Policy decisions that favor Primary Care ACOs over ACPPs will result in a reduction in scale for the ACPPs, reducing the ability of ACPPs to minimize administrative costs across members. The correlated shift in population will lead to higher administrative costs as a percentage of cost of care and could reduce benefits and services that improve care and outcomes for members.

We look forward to continuing our work with our ACPP partners to provide important benefits, services, and supports for the populations we serve. Adequate and sustainable funding that reflects the value that MCOs bring as payers to the ACPP program will help ensure the long-term sustainability of the MCOs and ACPPs and enable us to build upon the successes achieved as we enter the next Waiver period.

DSRIP and Flexible Services

The DSRIP program 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. DSRIP funding has supported the development of critical programs for members, such as the provision of patient-centered support after an inpatient stay and resources to link members with needed social resources when identified in primary care.

We are supportive of MassHealth's proposal transitioning DSRIP into base funding to support primary care, care coordination, and health-related social needs; however, continued and sustainable funding is essential to maintaining these programs and ensuring that we build on existing successes. It is, therefore, important that administrative funding be sufficient to support ACPP oversight of these programs, including the Community Partners program, and that the state allow continued flexibility in oversight.

In addition, we are hopeful that the MCOs can play a significant role in advancing the state's health equity goals, particularly with regard to data collection and reporting on measures. The ACPPs are uniquely positioned to collect data on race, ethnicity, language, disability status, sexual orientation and gender identity, and to act on that data to help close health disparities.

Pharmacy Policy

Uniform Prescription Drug Formulary

We appreciate the opportunity we had to meet with you regarding the direction that MassHealth is taking vis-à-vis the Medicaid Pharmacy Program. This collaborative discussion enabled us to come to the table with solutions that meet MassHealth's goals and retain the ability of the MCOs and ACPPs to work with their pharmacy benefit managers (PBMs) to provide whole-person, equitable, and high-quality care. By retaining the pharmacy benefit within the MCOs and ACPPs, the ACPPs can maintain their existing clinical programs, customer service, and data and analytical tools that provide tremendous value to members, providers, and to the state, which are aligned with the integrated system of coverage of care that the state prioritizes. Retaining the pharmacy benefit within the MCOs enables us to continue providing whole-person, wraparound care and coverage for MassHealth members into the next Waiver period.

This model has allowed MCOs to estimate pharmacy costs, manage pharmacy trends and ensure seamless integration of medical and pharmacy services that allow Massachusetts to operate a sustainable Medicaid program. Carving-in benefits consumers through unique clinical programs, member services and care management, driven by the MCOs' access to real time data and analytic tools to provide for and address member needs. MCOs and PBMs have developed clinical programs to monitor medication adherence, established programs to prevent misuse and overutilization, and continue to offer support 7 days a week to address member needs with access to both out-of-state and specialty pharmacies.

We support MassHealth's decision to move to a Uniform Preferred Drug List (UPDL), which will help the state attain its goals without disruption to members and providers, or requiring substantial investment of time and resources to replicate the data, customer service, data and analytical tools, and clinical programs that the MCOs provide today. The UPDL preserves the comprehensive clinical programs and support services established by MCOs and ACOs that ensure real-time problem solving, help to avoid gaps in treatment and improve quality and outcomes, and help members manage chronic diseases.

We urge the state to consider the following principles as we move forward with implementation of the UPDL and into the new Waiver period:

- Implementation of the UPDL should follow a structured process that includes a reasonable timeline for implementation, ensures a smooth transition, and minimizes member disruption,
- Implementation planning must include timeline recommendations, which are critical for ensuring the success of the program and to ensure a smooth transition that minimizes member disruption,
- Implementation should prioritize the member experience and ensure continuity of care,

- Changes to the MCO/ACPP capitation payments to reflect the UPDL should be transparent, actuarially sound, achievable for the MCOs/ACPPs, and not put the MCOs at risk for insolvency,

340B Program Changes

We are concerned, however, with the state's proposed changes to the 340B program and have several questions related to their impact across the ACO program, including how this change will impact ACPPs relative to Primary Care ACOs. We also would like to better understand how MassHealth will develop the MCO and ACO rates to reflect these changes, and whether there will need to be any additional reporting or data collection by the MCOs and ACOs.

As we wait for greater clarity on these important questions, we are deeply concerned with MassHealth's statement in the Draft Waiver that the current 340B construct creates an unequal incentive to join the ACPP ACO program over the Primary Care ACO program. As stated above, we have strong concerns with MassHealth developing policies that seek to incentivize participation in one ACO model over another. It would be helpful to have a better understanding of MassHealth's overarching policy goals for this change to help evaluate whether there are alternative goals beyond incentivizing participation in one model over another.

Behavioral Health Policy

MAHP and our member health plans are supportive of the state's goals for reforming the behavioral health care delivery system, as outlined in the Waiver Policy documents and the Administration's Roadmap to Behavioral Health Reform. We support redesigning the behavioral health delivery system in a way that ensures members have access to the services that they need, when they need them, and that there is no wrong door to getting care. We further support the development of a more integrated and coordinated behavioral health care delivery system that prioritizes adherence to best practices, minimizes variation in practice, and improves the overall quality of care for patients.

During the current waiver period, MCOs and their ACPP partners implemented programs and services that leverage the MCO's or their Behavioral Health Organization's analytic tools and data to improve access to and quality of behavioral healthcare. MCOs and their ACPP partners have implemented a wide range of programs and initiatives to improve access to care for members in need of behavioral health services, including those that:

- Reduce boarding in the emergency departments,
- Establish collaborative structures with the ACOs and other providers for better targeted outcomes,
- Ensure access to community-based treatments and supports,
- Connect members to food, housing, and other resources to help alleviate pressures that pose barriers to treatment.

MCOs additionally have entered into alternative payment contracts with their ACO partners to implement innovative programs for members to integrate behavioral health into primary care to ensure access to comprehensive behavioral health care programs and services. Some of the MCOs have considerable expertise that allows them to tailor approaches to behavioral health and primary care integration based on the primary care settings' needs. To assist and improve member and provider services, MCOs have implemented steps to streamline referral workflows across providers, health plans and ACOs, and have developed resources and guides to support primary care providers with behavioral health integration and members. Each ACO population is unique, therefore, flexibility for the MCOs and ACOs to customize programs to address needs of the individual ACOs and member population is critical as we move into the next waiver period.

While we continue to believe that granting the MCOs the flexibility they need to innovate and customize programs to meet their members where they are, there are places where standardization and simplification make sense. Therefore, we offered robust recommendations that meet the goals outlined by the state for standardization and simplification of administrative requirements, such as: credentialing and provider

integrity requirements and measures to address fraud waste and abuse; provider networks, quality improvement, and implementing new benefits and services, as recommended by the Administration's Roadmap. We further believe that opportunities exist to ensure successful, efficient, and timely implementation of behavioral health policy changes going forward.

We look forward to working with you on the implementation of policies that balance standardization and further enable continued flexibility for us to innovate and develop customized programs and services that meet the specific needs of the populations we serve. Finally, the investments that will be made in behavioral health should come in the form of increased provider rates across the Medicaid program, avoiding placing the MCOs and ACPPs in the position of expanding their networks and risking financial penalties for paying reimbursement rates that are higher than the fee-for-service rates.

Impact of MCOs and ACPPs on the Community

The MCOs are committed to the members and communities they serve and are proud to have built programs with their ACPP partners that provide comprehensive, whole-person care to some of the state's most vulnerable residents. To help illustrate the impact of their important work, attached to these comments are 56 letters in support of the MCOs and their ACPP partners signed by 217 individuals, including:

- 54 letters signed by organizations, including community partners, ACOs, and labor unions,
- 1 letter signed by 29 mayors, and
- 1 letter signed by 32 Massachusetts State Senators and 102 Massachusetts State Representatives.

The participating organizations wrote in support for all five MCOs and ACPPs, highlighting the value these programs bring to the work the organizations do to support members of their communities in delivering comprehensive, equitable, and affordable care to those most in need including:

- Prioritizing personalized outreach,
- Providing culturally competent care management,
- Distributing pandemic supports,
- Connecting residents to community resources,
- Administering behavioral and physical care,
- Taking a holistic approach to caring for clients, and
- Taking steps to address social determinants of health.

Also included is a link to a series of 12 videos featuring each of the MAHP MCOs and several of their ACO partners. Through interviews with providers, community partners, and health plan and ACO staff, the videos highlight the many ways the MCO/ACO partnership provides whole-person care for their members, including:

- *Addressing vaccine hesitancy by confronting historical inequities in care* – Boston Medical Center HealthNet Plan and Boston Accountable Care Organization tailored COVID-19 outreach for their members of color to acknowledge and address mistrust.
- *Building community relationships to provide culturally competent services to members right where they live* – Tufts Health Plan partners with Quincy Asian Resources, Inc. to provide linguistically and culturally competent services for their members, including programs encouraging healthy behaviors and diabetes prevention and management and programs to access fresh produce through the SNAP benefit.
- *Caring for the homeless during the COVID-19 pandemic* – AllWays Health Partners and their My Care Family ACO partners worked together to ensure homeless individuals had safe housing and access to comprehensive health care, helping to mitigate the spread of COVID-19 and care for some of the state's most vulnerable citizens.

- *Creating a safe environment for families* – Health New England and their BeHealthy ACO partners support families struggling with trauma and domestic violence by connecting members to important resources like shelter services and counseling.
- *Integrating behavioral health, physical health, and complex social needs* – Fallon Health’s clinical team comprised of social workers, physicians, nurses, and navigators, supports their ACO partners with comprehensive data to help reimagine what care can look like for members dealing with substance use disorders, behavioral health challenges, and medical conditions.

The MCO/ACO Partnership video series can be viewed here: <https://www.mahp.com/a-different-way-to-care-for-people/>

Finally, we have attached a white paper that details the many ways that MAHP MCOs have taken action to advance health equity and address racial and ethnic health disparities. From data collection and analysis to advancing culturally and linguistically appropriate resources to addressing social determinants of health, the MCOs are committed to promoting health equity for all members.

We thank for you for the opportunity to provide you with these comments and for the opportunity to work collaboratively with you and your staff on these important issues.

Sincerely,



Lora M. Pellegrini
President & CEO



OnPoint: Issue Brief

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Written by Lynda Jackson

Massachusetts Medicaid Managed Care Organizations Address Racial and Ethnic Health Disparities and Take Action to Advance Health Equity

The COVID-19 pandemic has brought to the forefront the long-standing racial and ethnic disparities that exist in health care. Over the past year, we have witnessed the harm that inequities have caused to communities of color and vulnerable populations, not only in Massachusetts but also across the country. Data from across the U.S. has shown that racial and ethnic minority groups such as Latinx, Blacks, and indigenous communities have been infected, hospitalized, and died from COVID-19 at much higher rates than Whites have.

In Massachusetts, Hispanic and Black residents, respectively, are about 4.3 and 2.7 times more likely than Whites to be infected with COVID-19, and 1.7 and 2.3 times more likely to be hospitalized from the virus. As of June 30, 2020, Hispanic and Black residents, respectively, had 1.6 and 2.1 times higher age-adjusted COVID-19 mortality rates than white residents.¹

The disparate impact of COVID-19 has been attributed in part to disparities in preexisting conditions such as hypertension, diabetes, heart disease, and obesity that make individuals more vulnerable to poorer outcomes when they are infected. As noted in the National Health Survey, non-Hispanic Blacks are 30 percent more likely to be obese, 40 percent more likely to have hypertension, and 60 percent more likely to have diabetes than non-Hispanic Whites.² But studies are showing that structural differences that relate to social determinants of health have also played a key role in the disproportionate impacts of COVID-19 in communities of color and vulnerable populations. For example, many racial and ethnic minority families live in more densely populated areas and in multigenerational housing, which has made them more susceptible to COVID-19 infections. In 2018, the Pew Research Center reported that nearly 29 percent of Asians (including Pacific Islanders), 27 percent of Hispanics, and 26 percent of Blacks lived in multigenerational housing, compared to 16 percent of Whites.³

Health disparities refer to differences in health and health care, such as a higher burden of illness, injury, disability, or mortality experienced by one group relative to another, driven by social and economic inequities.

Health inequities cause health disparities. They are the structural or institutional patterns that ultimately result in health disparities.

Massachusetts Medicaid Health Plans' Commitment to Health Equity

The plans that participate in the state's Medicaid program enroll MassHealth members in accountable care partnership plan organizations (ACOs) and managed care organizations (MCOs). These organizations serve an important role in addressing the health inequities that impact many of their members. Out of the MassHealth enrollees who report race/ethnicity, 40 percent identify as other than White, and 16.8 percent speak a language other than English.⁴ MCOs have demonstrated a long-standing commitment to serving these diverse populations; managing the physical, social, and emotional needs of their members; and addressing racial and ethnic health disparities. Below are some examples of successful actions taken by MCOs with their ACO partners to advance health equity.

Actions Massachusetts Medicaid MCOs Are Taking to Address Racial and Ethnic Disparities and to Advance Health Equity

DATA COLLECTION AND ANALYSIS

MCOs recognize the importance of collecting and analyzing data on the race, ethnicity, and language (REL) of their members and of assessing racial and ethnic differences in utilization or health outcomes. This is the first step in identifying disparities and effectively targeting interventions that are culturally and linguistically appropriate and help families connect with social services. MCOs receive initial REL data from MassHealth's enrollment files. As this information is not always complete, some of the MCOs supplement it with additional information they collect directly from members through initial member outreach, welcome calls, member survey responses, health assessments, and care management interactions they have with members.

Some MCOs stratify quality data by race and ethnicity to help identify health disparities in care and potential areas of improvement. For example:

- **AllWays Health Partners** selects large population-based metrics for cancer and diabetes screenings and stratifies results by race, ethnicity, age, and gender to identify disparities and to develop potential improvement activities. Improvement projects include sending gap-in-care reminders through text messaging campaigns in Spanish to Latinx members identified with these chronic conditions and reminding them of diabetes eye exams and cancer screenings. The text messages include hyperlinks to direct members to websites with educational materials to help them control their conditions. Also, health coaches review responses received from members through these campaigns and refer them to appropriate care management services. They are in the process of implementing a pilot remote monitoring program for Latino and Black members with hypertension and diabetes to help them manage these conditions at home.
- **BMC HealthNet Plan** reviews data related to care management outcomes and analyzes subpopulations through a health equity lens focused on race and ethnicity to ensure there is equitable impact on the patients served through care management.
- **Fallon Health** convened a Health Equity Committee that is focused on addressing disparities among its members by identifying and prioritizing current barriers. One of the areas of focus will be utilizing available REL data to support their goal of making the delivery of high-quality health care more equitable for all their members.
- **Tufts Health Plan** tries to collect members' REL data when they first sign up with the plan. Their Member Services representatives collect REL data during their welcome calls with members. To better understand and serve them, they ask about their preferred language and ethnic background. In addition, they collect social determinants of health and sexual orientation and gender identity data. This data is used to identify health disparities and to support efforts to address bias in data analytics, regulatory requirements, and quality programs. Using available data, Tufts Health Plan expands services and benefits based on cultural and linguistic needs.

LANGUAGE AND CULTURAL COMPETENCY

MCOs understand that they represent a very diverse membership, and they have taken extensive action to provide linguistically and culturally appropriate services to their members. To address barriers to care, they collect data on preferred language and cultural considerations that may impact their members' health care decisions. All the MCOs' member services departments are staffed with bilingual and multicultural representatives and have access to translation services that provide members with real-time translation support and websites in multiple languages.

Member communications materials are prepared in a culturally and linguistically appropriate manner and are available in Spanish and on demand for many other languages. Below are examples of additional actions some health plans take to provide language and cultural competency:

- **Health New England** engages their ACO partners in the review of communications materials to ensure the content aligns with the needs of the communities they serve. They have hired interpreters and racially diverse health center staff to work at the health centers that are part of their *BeHealthy Partnership ACO* to provide a cultural understanding of the diverse populations they serve.

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- **Tufts Health Plan** invested in *ConsejoSano*, a leading digital short message service (SMS) solution to engage culturally diverse populations in navigating their health care coverage and benefits. The services have been implemented across public programs to increase member engagement by using multicultural SMS text technology. By meeting members where they are in their cultural preferences, Tufts Health Plan is able to build trust with members by using ConsejoSano's white-label approach to identify additional health equity needs that can be addressed through care coordination teams.

MEMBER ENGAGEMENT

MCOs place a strong focus on understanding the populations they serve and engaging with them to promote activities that improve their health outcomes and result in healthier communities. They take concrete actions to understand their diverse members and engage them in their health outcomes. Member engagement activities include patient family advisory councils, outreach by integrated care teams, and patient education programs focused on addressing health disparities.

Patient and Family Advisory Council meetings allow a diverse group of patients and family members to regularly meet to advise their providers about challenges they face, identify gaps in services, and recommend ways to close these gaps. The MCOs and their ACO partners host patient and family advisory council monthly meetings that provide a forum for members and their families to share ideas and make recommendations on ways to improve member experience and access to care. The meetings provide an opportunity to collect feedback from members on support and services important to the delivery of person-centered quality care and to make plans to communicate upcoming changes to their programs. For example, during the pandemic, **Health New England** used their culturally and linguistically diverse advisory council meetings to hear about members' concerns about COVID-19 vaccines and to offer educational information on vaccines.

Integrated Care Teams provide outreach to members and engage them in care management that provides targeted and intensive support to help them access mental health care, addiction treatment, and chronic disease management care, often involving daily communication with members. The MCOs hire care management staff with diverse backgrounds and experiences shared with their members. This supports member engagement and helps inform program initiatives that meet the specific needs of the populations they serve.

During the COVID-19 pandemic, the MCOs escalated efforts to ensure members had the resources they needed. Understanding that many of their members stopped seeing their health care providers out of fear of contracting the virus, **BMC HealthNet Plan** identified high-risk members and scheduled virtual, comprehensive health assessments. The initiative identified barriers to care and allowed their staff to make referrals for care management, conduct medication reconciliations, and apprise the respective health care providers of the efforts and outcomes.

Patient Education Programs increase knowledge of access to care and treatment decisions, and MCOs have targeted education at members in communities of color. They maintain close relationships with the communities they serve. **BMC HealthNet Plan** community outreach staff attend community cultural events throughout Massachusetts to work with locally based community organizations and provider groups to educate members on health issues. Some of the cultural events include the Haitian Housing Fair, the Quincy Asian Resources Community Banquet, the Dudley Street Neighborhood Initiative Multicultural Festival, Whittier Community Health Center Haitian Heritage and Hispanic Heritage events, and Codman Square block parties.

During the pandemic, the MCOs focused on educating their members on COVID-19 prevention, testing, and vaccination efforts. In addition to reaching out to members through newsletters and social media, **Health New England** promoted town halls and webinars that were multicultural and multilingual, and **BMC HealthNet Plan** staff created a Q&A document specifically focused on addressing COVID-19 vaccine hesitancy among people of color.

Also, MCOs have implemented specific programs to engage members in health care related issues such as maternal mortality, diabetes, and mental health that have revealed disparities. Examples include:

- **AllWays Health Partners** developed interventions to raise awareness among Latino, Black, and African American members of the importance of taking medications and seeing a licensed mental health counselor. They communicate with members through text messages, available in Spanish, to encourage health and wellness in key clinical focus areas, such as asthma and diabetes. They hold community wide health fairs, where diabetes care managers provide diabetes education to members in the community to teach them how to manage their condition and to promote healthy eating habits.
- **Health New England** has instituted the “Women’s Health Network,” a community health worker model program for breast and cervical cancer screening and navigation, which targets low-income African American, Latina, and Muslim women, and they will be instituting a specific high-risk maternity program that will focus on addressing disparities in maternal morbidity.
- **Tufts Health Plan** created a doula program for expecting at-risk mothers to offer their members support leading up to, during, and after birth. The doulas help with vital nonmedical needs crucial to the health of infants, like family education, household organization, and general support. The impact of doula support improves birth outcomes and maternal health, while providing additional opportunities for member outreach and support on social needs and other health challenges.

PROVIDER ENGAGEMENT

MCOs believe that collaboration with providers is critical to helping them address racial and ethnic health disparities, and they share a commitment to work with their ACO provider partners to deliver high-quality health care for members in need.

- **AllWays Health Partners** works collaboratively with their ACO primary care providers, behavioral health community partners, and Lawrence General Hospital on a joint multi visit patient initiative to address patients with high emergency room and hospital utilization. The program aims to understand and address a patient’s unique social determinants of health, which often drive utilization. There are systems in place to ensure that follow-up care is arranged, social needs such as food insecurity are addressed, and referrals to community-based organizations are followed up on. This is done through regularly scheduled multidisciplinary meetings, where care pathways are determined and documented for each patient and added to electronic medical records as appropriate. Additionally, care managers are assigned to ensure accountability for follow-up on members’ needs.
- **BMC HealthNet Plan** holds interdisciplinary care team meetings with providers at many of their complex care management sites. Integrated behavioral health teams and primary care providers meet to discuss specific plans of care for patients in complex care management programs. They work together to address the patients’ needs and to improve their engagement in care. The ACO strategy team regularly presents progress on ACO quality metrics and works with the clinic sites in strategies to address gaps in quality metrics. Complex care management staff support outreach for patients who have quality gaps in order to facilitate their engagement with providers.
- **Fallon Health** works with their ACO partner (*Berkshire Fallon Health Collaborative*) to address substance use disorder in the populations they serve. They leverage data to identify effective care models and develop care coordination strategies.
- **Health New England’s** ACO *Be Healthy Partnership* is led by committees that have provider and health plan representation. They routinely meet with provider leaders to share data and formulate strategies for care. They have delegated care management to the health centers where their staff are integrated with providers. Also, they have offered *Healing Racism and Cultural Humility* training to leaders and clinical staff to create shared language and knowledge of racial health inequities.
- **Tufts Health Plan** engages with community health centers and has recently collaborated with the Bowdoin Street Health Center, the Martha Elliot Health Center, and the Cambridge Health Alliance to offer food vouchers for patients, support mobile markets and community events such as back-to-school and holiday donations, offer cooking demonstrations, and provide doula referrals to their members.

SOCIAL DETERMINANTS OF HEALTH – Building Strong Community Partnerships

MCOs recognize the intrinsic connection between social determinants and health and have established partnerships with community-based organizations (CBOs) to address social needs such as food access, employment, and housing, which have a profound impact on the health and well-being of their members.

Food Access Programs:

- **AllWays Health Partners** has partnered with [Community Servings](#), an organization that delivers medically tailored, nutritious meals to chronically ill members with complex conditions. In 2020, during the height of the pandemic, they expanded this partnership to support members who fall into high-risk categories for COVID-19, including those who tested positive or were under quarantine, at no cost to members.
- **BMC HealthNet Plan** partnered with two Massachusetts-based CBOs and implemented a flex services program to provide food and nutrition support to ACO patients. This includes food delivery, financial assistance to supplement what members receive from the Supplemental Nutrition Assistance Program, education on diet and nutrition, and culturally appropriate food options.
- **Fallon Health** has facilitated partnerships with statewide and regional organizations focused on food security and works jointly with their ACO partners to develop programs that address food access issues among the populations they serve.
- **Health New England**, in partnership with [Revitalize Community Development Corporation](#), will be launching a flexible services program called Food & Nutrition Rx Delivery, which aims to provide members who have diabetes and gestational diabetes with an intensive 10-week food delivery and nutrition support program.
- **Tufts Health Plan** partnered with Good Measures, a company that combines the expertise of a registered dietitian with a digital platform to help individuals make positive changes in eating and exercise behavior. It provides culturally tailored meal libraries and multilingual access. In addition, they offer food voucher programs at many local food pantries.

Housing Programs:

- **AllWays Health Partners** has partnered with [HomeStart](#) — an organization that helps with eviction prevention, assistance finding permanent housing, and stabilization — and with [Women’s Lunch Place](#), a day shelter community that provides nutritious food and individualized services for women who are experiencing homelessness or poverty.
- **BMC HealthNet Plan** has partnered with two housing authorities to prioritize access to housing for their most clinically vulnerable members and to advocate at the state and city levels for policies that address homelessness. Additionally, they provide housing navigation support to help members who have Section 8 vouchers access units, and they provide legal advocacy and navigation for those that are at risk for eviction.
- **Fallon Health** is working actively with its ACO partners and regional housing agencies in Pittsfield, Lowell, and Worcester to launch innovative programs using available flexible dollars that contribute to housing stability.
- **Health New England** has partnered with the Mental Health Association to offer their complex behavioral health members housing navigation and placement services to help find stable, permanent housing for these patients.
- **Tufts Health Plan** developed a pilot program to address housing needs for members, using a tiered approach designed to triage housing needs with the appropriate community or housing resource. This effort in collaboration with care management and care coordination teams is intended to prioritize housing needs for those at the highest risk and to help develop a formal referral process for all members.

Other Programs

- **Health New England** developed the *BeHealthy Medical-Legal Partnership* with [Community Legal Aid](#), through which an attorney augments their health center care teams and provides legal assistance and representation in housing and domestic violence cases.
- **Tufts Health Plan** has a partnership with Union Capital Boston (UCB), an organization whose mission is to transform social capital into opportunity by rewarding community engagement, and with Bowdoin Street Health Center to encourage patients to join UCB's platform so they are able to engage in their communities to drive change and to learn about resources and programs available to them.

COVID-19 PROGRAMS

In the wake of the COVID-19 pandemic, the MCOs recognized their role in addressing the inequities and quickly implemented programs to address COVID-19-related disparities, with a focus on mitigation, testing, and vaccination efforts.

To mitigate the spread of the coronavirus, the MCOs conducted routine symptom screenings for members in care management programs. They worked with their ACO partners to locate at-risk patients, conducted culturally and linguistically sensitive needs assessments, and delivered on those needs by providing supplies to members and linkages to pharmacy delivery services.

The MCOs promoted the Center for Disease Control and Prevention's "Stop the Spread" campaign and participated in initiatives to increase access to COVID-19 testing for traditionally underserved populations, working with community partners to make testing highly accessible to their members.

To increase access to vaccinations, the MCOs have implemented campaigns that include targeted outreach for vaccine education in multiple languages and scheduling in the communities most impacted by COVID-19. They have partnered with their ACOs and have engaged their workforce and faith and community leaders from multiple cultural backgrounds to educate their members on the safety and efficacy of COVID-19 vaccines. Through phone calls, texts, social media platforms, and messages on Latino radio stations, they have communicated with members in English and Spanish to provide education, assistance with appointment scheduling, and coordination of transportation for members to and from vaccine appointments. Some of the MCOs also stood up mobile vaccination clinics in "hot spot" communities, where the vaccines were made available to vulnerable members, and they provided visits to homebound members.

MAHP'S ACTIONS TO PROMOTE HEALTH EQUITY AND INCLUSION

At the end of 2020, the Massachusetts Association of Health Plans (MAHP) announced two important initiatives to help combat social and racial disparities that persist in the delivery of health care services and within the health care workforce.

The first initiative authorizes MAHP to sponsor a broad-based research study to identify how access to telehealth services during the COVID-19 pandemic has differed based on race, ethnicity, and socioeconomic factors and how the health care sector can work together to eliminate identified barriers to equitable access. The second initiative supports employment opportunities for low-income communities and communities of color in health care through a workforce development compact. Both initiatives were based on recommendations from a MAHP subcommittee that was formed to examine how MAHP member health plans could address health care related disparities and broader social inequities.

TELEHEALTH RESEARCH STUDY

The 18-month telehealth study, led by researchers from the Department of Population Medicine at the Harvard Pilgrim Health Care Institute, aims to be the most timely and comprehensive evaluation of potential socioeconomic, racial, and ethnic disparities in telehealth usage in Massachusetts to date since the onset of the COVID-19 pandemic. The study will combine analyses of health care claims data from Medicaid, Commercial and Medicare members with qualitative interviews with members, providers, and health officials in communities with disproportionately low rates of telemedicine use. This study will build upon recent work led by the Massachusetts Attorney General's Office by looking expansively at access and use rates and identifying actionable implementation steps across the health care sector.

A preliminary report, scheduled to be released in September, will measure telehealth usage rates before and since the COVID-19 pandemic and will examine differences by insurance, socioeconomic status, race, and ethnicity. The preliminary report will also review activities that health plans have taken to enable access to telehealth services and will outline ways to improve the robustness of demographic data in the health plan setting. The final report, tentatively scheduled to be released in July 2022, will measure interval changes in telehealth usage rates and equity, identify communities with low rates of digital access and telehealth usage rates, and outline actionable steps to promote and sustain health equity.

WORKPLACE EQUITY AND INCLUSION

MAHP member plans, including our MCOs, are committed to increasing diverse representation among their leaders and workforce, educating them on health equity and racial justice, and taking steps to diversify and educate their leaders and their entire workforce. They have signed the [MAHP Compact for Diversity and Inclusion in Health Care Workforce Development](#), committing to promoting a culture of diversity and inclusion across their organizations, supporting workforce diversity in health professions through creation of a pipeline to employment, and developing and increasing opportunities for diverse candidates through targeted entry-level health care jobs.

Below are some examples of workforce equity and inclusion efforts that have been implemented at each of the MCOs:

- **AllWays Health Partners** — Provide systemwide anti-racism training, *United Against Racism*, for leaders. Also participating in the Department of Transitional Assistance Health Care Training Internship program, where diverse candidates gain professional/employment skills in health care to help create a pipeline for employment opportunities.
- **BMC HealthNet Plan** — Provide cultural competence training for all staff. The plan also has a Diversity, Equity, and Inclusion Committee that focuses on increasing employee awareness and support for other cultures, languages, and abilities. In addition, complex care management staff host monthly training programs for staff on social determinants of health, such as criminal justice, housing, food security, mental health services, and addiction treatment.
- **Fallon Health** — Employees receive education and training in implicit biases and social and structural determinants of health, and they are encouraged to participate in forums on health equity.
- **Health New England** — Provide *Healing Racism and Cultural Humility* training to leaders and clinical staff to create shared language and knowledge of racial health inequities. They offer a series, *Leading with Dignity*, as well as *Think Again*, a training that supports individuals, organizations, and communities to enact social justice principles in their life and works to enhance skills to support trans people in the community.
- **Tufts Health Plan** — To increase representation of people of color (POC), they created a diverse slate policy, which requires the inclusion of POC in the hiring process for all positions of manager and above. They also offer cultural competence courses and anti-racism training to all their employees.

Conclusion

COVID-19 has affected everyone in the Commonwealth, but it has disproportionately impacted racial and ethnic minority communities, who make up a large number of Medicaid members in Massachusetts. Our MCOs are undertaking effective initiatives to address the existing health disparities, support the communities impacted, and protect the health of these populations. They are focusing on data collection and analysis to help identify the disparities, using preferred languages for communicating with members, and promoting cultural competency within their organizations through training. Through targeted outreach and culturally sensitive approaches, they are communicating with members and engaging providers in this effort. They continue to build quality relationships with trusted local and community-based organizations to improve social determinants of health. The MCOs are committed to engaging in actions to create a more equitable society and health care system for the members and the communities they serve throughout the Commonwealth.

We'd like to acknowledge and thank individuals at the MCOs that submitted content for this issue and our team of reviewers: Christie Bik, Sarah Chiaramida, Arthur Edwards, Lisa Hatfield, Ann Chamberlin LaBelle, Elizabeth Leahy, Adam Martignetti, Preeti Nakrani, Lora Pellegrini, Nikki Sonwane, and John Sullivan.

Footnotes

1. Massachusetts Office of the Attorney General, Building Toward Racial Justice and Equity in Health: A Call to Action (Boston, Massachusetts, Nov. 2020), <https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download>
2. U.S. Department of Health and Human Services Office of Minority Health, Heart Disease and African Americans, www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19/
3. Cohn, D’Vera, and Jeffrey S. Passel, Record 64 Million Americans Live in Multigenerational Households, Pew Research Center, July 27, 2020, www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households/
4. Blue Cross Blue Shield Foundation Massachusetts, Massachusetts Medicaid Policy Institute, Manatt Health, Health Care for All, Faces of MassHealth: Chart Pack https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2020-09/BCBSF_FacesofMassHealth_ChartPack_Final.pdf

Dear Governor Baker,

We are writing to express our strong support for the five Medicaid Managed Care Organizations (MCOs), AllWays Health Partners, Boston Medical Center HealthNet Plan (BMCHP), Fallon Health, Health New England, and Tufts Public Plans, as the Commonwealth renews its Medicaid Section 1115 Demonstration Waiver. These MCOs work in collaboration with their Accountable Care Partnership Plan (ACPP) partners to care for the majority of our Medicaid constituents, with BMCHP and Tufts operating in the traditional MCO state-wide program.

Our health care system is at a turning point. It is more important than ever before to sustain and strengthen those systems that are working to provide high quality care, services, and supports for MassHealth enrollees during this unprecedented time. The current 1115 Waiver has done a good job promoting integrated, coordinated care, and meeting our most vulnerable residents where they are and the MCOs and ACPP plans have been committed partners with the state in responding to the challenges brought on by the pandemic over the last year. The MCOs and ACPP plans have been an essential part of this program, and we wanted to take this opportunity to urge you to continue to support these organizations in the new Waiver period by building appropriate, equitable and sustainable funding into the program going forward.

Coordination between federal, state, and local health entities was vital during the past year in leveraging various resources and institutions to support our residents. For critically underserved and disadvantaged communities in the Commonwealth, the MCO and ACPP programs are critical partners in ensuring access to care and proactively addressing social determinants of health such as housing and food insecurity. Through a unique position at the intersection of hyperlocal care - simultaneously working with street-outreach-focused Community Partner (CP) organizations and with larger system-based ACO partners - the MCO program is one of the most vital in our state health care system.

The MCO program connects at-risk residents to lifesaving supports and services and cuts costs for the health care system as a whole by reducing unnecessary hospitalizations and emergency room visits. As one of the few programs effectively targeting and serving our most vulnerable populations, it is crucial to maintain and bolster the MCO program.

MCOs are particularly impactful in the behavioral health space. The pandemic laid bare a massive mental health crisis throughout the Commonwealth that hospitals alone are incapable of fully addressing. MCOs' flexibility, reach, and partnership with CPs make them invaluable partners to primary care and ACO care management services, and vital supports to patients who need mental and behavioral health services. The availability of innovative health care services and other supports through the MCO and ACPP programs has been essential to the Commonwealth's low-income and disadvantaged communities, especially during the COVID-19 pandemic. Integrated and coordinated health care delivery has provided demonstrable results across our communities and systems.

We appreciate the opportunity to participate in the conversation regarding the priorities for the next Section 1115 Waiver and offer our strong support for a robust Model A MCO program. We are in constant pursuit of a more just and equitable health care system. This involves fixing what is broken, but also upholding what is proven to work. Amid incredible levels of pandemic-induced disruption to our health care system, now is not the time to disrupt programs that work and serve our hardest-hit communities. It is therefore critical that the Section 1115 Waiver renewal include equitable and sustainable funding and support for the managed care and ACPP programs and ensure that the funding mechanisms in place to support these programs are not disadvantaged when compared to other models within the Medicaid program.

We look forward to continuing to work together to provide critical support to MassHealth members.

Sincerely,

State Senator Harriette Chandler
First Worcester District

State Representative Paul Donato
35th Middlesex District

State Senator Michael J. Barrett
Third Middlesex District

State Senator James B. Eldridge
Middlesex and Worcester District

State Senator Joseph A. Boncore
First Suffolk and Middlesex District

State Senator Ryan C. Fattman
Worcester and Norfolk District

State Senator Michael D. Brady
Second Plymouth and Bristol District

State Senator Paul R. Feeney
Bristol and Norfolk District

State Senator Nick Collins
First Suffolk District

State Senator Barry R. Finegold
Second Essex and Middlesex

State Senator Brendan P. Crighton
Third Essex District

State Senator Anne M. Gobi
Worcester, Hampden, Hampshire and Middlesex District

State Senator John J. Cronin
Worcester and Middlesex District

State Senator Adam Gomez
Hampden District

State Senator Sal N. DiDomenico
Middlesex and Suffolk District

State Senator Adam G. Hinds
Berkshire, Hampshire, Franklin and Hampden District

State Senator Diana DiZoglio
First Essex District

State Senator Patricia D. Jehlen
Second Middlesex District

State Senator John F. Keenan
Norfolk and Plymouth District

State Senator Edward J. Kennedy
First Middlesex District

State Senator Eric P. Lesser
First Hampden and Hampshire District

State Senator Jason M. Lewis
Fifth Middlesex District

State Senator Joan B. Lovely
Second Essex District

State Senator Mark C. Montigny
Second Bristol and Plymouth

State Senator Michael O. Moore
Second Worcester District

State Senator Susan L. Moran
Plymouth and Barnstable District

State Senator Patrick O'Connor
Plymouth and Norfolk District

State Senator Marc R. Pacheco
First Plymouth and Bristol District

State Senator Becca L. Rausch
Norfolk, Bristol and Middlesex

State Senator Michael F. Rush
Norfolk and Suffolk District

State Senator Bruce E. Tarr
First Essex and Middlesex

State Senator Walter F. Timilty
Norfolk, Bristol and Plymouth District

State Senator John C. Velis
Second Hampden and Hampshire District

State Representative James Arciero
2nd Middlesex District

State Representative Brian Ashe
2nd Hampden District

State Representative Bruce Ayers
1st Norfolk District

State Representative Christine Barber
34th Middlesex District

State Representative John Barrett
1st Berkshire District

State Representative F. Jay Barrows
1st Bristol District

State Representative Antonio Cabral
13th Bristol District

State Representative Dan Cahill
10th Essex District

State Representative Peter Capano
11th Essex District

State Representative Gerard Cassidy
9th Plymouth District

State Representative Tackey Chan
2nd Norfolk District

State Representative Michelle Ciccolo
15th Middlesex District

State Representative Mike Connolly
26th Middlesex District

State Representative Rob Consalvo
14th Suffolk District

State Representative Edward Coppinger
10th Suffolk District

State Representative Michael Day
31st Middlesex District

State Representative Marjorie Decker
25th Middlesex District

State Representative David DeCoste
5th Plymouth District

State Representative Marcos Devers
16th Essex District

State Representative Kip Diggs
2nd Barnstable District

State Representative Carol Doherty
3rd Bristol District

State Representative Daniel Donahue
16th Worcester District

State Representative Michelle DuBois
10th Plymouth District

State Representative Patricia Duffy
5th Hampden District

State Representative Lori Ehrlich
8th Essex District

State Representative Tricia Farley-Bouvier
3rd Berkshire District

State Representative Kimberly Ferguson
1st Worcester District

State Representative Ann-Margaret Ferrante
5th Essex District

State Representative Michael Finn
6th Hampden District

State Representative Brandy Fluker Oakley
12th Suffolk District

State Representative Paul Frost
7th Worcester District

State Representative Sean Garballey
23rd Middlesex District

State Representative Denise Garlick
13th Norfolk District

State Representative Coleen Garry
36th Middlesex District

State Representative Carmine Gentile
13th Middlesex District

State Representative Jessica Giannino
16th Suffolk District

State Representative Susan Gifford
2nd Plymouth District

State Representative Carlos González
10th Hampden District

State Representative Kenneth Gordon
21st Middlesex District

State Representative Tami Gouveia
14th Middlesex District

State Representative Patricia Haddad
5th Bristol District

State Representative Richard Haggerty
30th Middlesex District

State Representative Jim Hawkins
2nd Bristol District

State Representative Natalie Higgins
4th Worcester District

State Representative Bradford Hill
4th Essex District

State Representative Russell Holmes
6th Suffolk District

State Representative Kevin Honan
17th Suffolk District

State Representative Vanna Howard
17th Middlesex District

State Representative Daniel Hunt
13th Suffolk District

State Representative Bradley Jones
20th Middlesex District

State Representative Hannah Kane
11th Worcester District

State Representative Kay Khan
11th Middlesex District

State Representative Patrick Kearney
4th Plymouth District

State Representative James Kelcourse
1st Essex District

State Representative Meghan Kilcoyne
12th Worcester District

State Representative Kathleen LaNatra
12th Plymouth District

State Representative David LeBoeuf
17th Worcester District

State Representative Jack Patrick Lewis
7th Middlesex District

State Representative Jay Livingstone
8th Suffolk District

State Representative Adrian Madaro
1st Suffolk District

State Representative Liz Malia
11th Suffolk District

State Representative Christopher Markey
9th Bristol District

State Representative Joseph McGonagle, Jr.
28th Middlesex District

State Representative Paul McMurtry
11th Norfolk District

State Representative Joan Meschino
3rd Plymouth District

State Representative Christina Minicucci
14th Essex District

State Representative Liz Miranda
5th Suffolk District

State Representative Lenny Mirra
2nd Essex District

State Representative Rady Mom
18th Middlesex District

State Representative Frank Moran
17th Essex District

State Representative David Muradian
9th Worcester District

State Representative Mathew Muratore
1st Plymouth District

State Representative Tram Nguyen
18th Essex District

State Representative James O'Day
14th Worcester District

State Representative Jacob R. Oliveira
7th Hampden District

State Representative Steven Owens
29th Middlesex District

State Representative Jerry Parisella
6th Essex District

State Representative Alice Peisch
14th Norfolk District

State Representative Edward Philips
8th Norfolk District

State Representative David Robertson
19th Middlesex District

State Representative Jeffrey Roy
10th Norfolk District

State Representative Daniel Ryan
2nd Suffolk District

State Representative Lindsay Sabadosa
1st Hampshire District

State Representative Jon Santiago
9th Suffolk District

State Representative Adam Scanlon
14th Bristol District

State Representative Paul Schmid
8th Bristol District

State Representative Danillo Sena
37th Middlesex District

State Representative Alan Silvia
37th Middlesex District

State Representative Michael Soter
8th Worcester District

State Representative Thomas Stanley
9th Middlesex District

State Representative Paul Tucker
7th Essex District

State Representative Jeff Turco
19th Suffolk District

State Representative Steven Ultrino
33rd Middlesex District

State Representative Erika Uytterhoeven
27th Middlesex District

State Representative Andres Vargas
3rd Essex District

State Representative David Vieira
3rd Barnstable District

State Representative Tommy Vitolo
15th Norfolk District

State Representative Tom Walsh
12th Essex District

State Representative Susannah Whipps
2nd Franklin District

State Representative Donald Wong
9th Essex District

State Representative Steven Xiarhos
5th Barnstable District

Dear Governor Baker,

It has been a long and devastating year for the Commonwealth and our communities. But it has also been an illuminating year. The different ways the pandemic was experienced across racial, ethnic, and socioeconomic lines demonstrated the importance of locally based programs that do the difficult work of operating on the ground in chronically underserved areas. Programs that prioritize the street outreach and culturally competent care that our residents need are critically important. The five Managed Care Organizations (MCOs), including AllWays Health Partners, Boston Medical Center HealthNet Plan, Fallon Health, Health New England and Tufts Public Plans, work in collaboration with their Accountable Care Partnership Plan (ACPP) partners and prioritize these needs that are essential to the health of our communities. We are writing to strongly encourage you to maintain and strengthen these programs in the next Section 1115 Demonstration Waiver.

The past year clarified the importance of local health care organizations with roots in and connections to the communities in which they operate. MCOs and ACPPs partner with local boards of health, health centers, and providers to administer behavioral and physical care, pandemic supports, and resources that no large external bureaucracy can. MCOs do a tremendous job using their on-the-ground knowledge and resources to serve our most vulnerable residents to address the social determinants of health. Without the ACPP program, and the MCOs in particular, we fear that our cities would lose these vital services.

A key reason for the success of the MCO and ACPP programs is how well-versed their providers and care coordinators are in facilitating access to community-based social and long-term supports and services. These MCOs work in our communities and leverage these resources, networks, and knowledge to provide vital care to their enrollees. The residents served by these programs are our most vulnerable and disadvantaged community members and the MCO and ACPP programs ensure that these individuals and our cities are not left behind. The MCOs and ACPPs are consistently there for our residents, our health care providers, and us.

We share MassHealth's goals of promoting primary care, behavioral health care, and social determinants of health in its next Waiver. The Medicaid program is essential to our ability to serve our highest-risk and most disadvantaged residents. Its innovative programs and dedicated focus to integrated, coordinated care are what our municipalities need most. We look forward to continuing to partner with the State to serve these populations and strengthen our cities in the process. The ACCP program, and particularly the role of MCOs in it, positively altered the health trajectory of so many of our residents. We are therefore strongly encouraging you to ensure that as you renew the 1115 Waiver, these programs are adequately and sustainably funded to ensure that they can continue to deliver innovative programs and services that improve the lives of our residents that they serve.

We thank you for the opportunity to share these comments and look forward to continuing to work together to provide critical support for MassHealth members.

Sincerely,

Mayor Joe Curtatone

City of Somerville

Mayor Joe Petty

City of Worcester

Mayor Nicole LaChapelle

City of Easthampton

Mayor Paul Brodeur

City of Melrose

Mayor Thomas Koch

City of Quincy

Mayor Jon Mitchell

City of New Bedford

Mayor Sumbul Siddiqui

City of Cambridge

Mayor Gary Christenson

City of Malden

Mayor Carlo DeMaria

City of Everett

Mayor Thomas Bernard

City of North Adams

Mayor Breanna Lungo-Koehn

City of Medford

Mayor Brian Arrigo

City of Revere

Acting Mayor Terry Murphy

City of Holyoke

Mayor Stephen DiNatale

City of Fitchburg

Mayor Yvonne Spicer

City of Framingham

Mayor Kim Driscoll

City of Salem

Mayor David Narkewicz

City of Northampton

Mayor Donna Holaday

City of Newburyport

Mayor Thomas McGee

City of Lynn

Mayor Domenic Sarno

City of Springfield

Mayor Linda Tyer

City of Pittsfield

Mayor Robert Sullivan

City of Brockton

Mayor Paul Coogan

City of Fall River

Mayor Cassandra Gove

City of Amesbury

Mayor Roxann Wedegartner

City of Greenfield

Mayor Michael Cahill

City of Beverly

Mayor John Leahy

City of Lowell

Mayor Sefatia Romeo Theken

City of Gloucester

Mayor Neil Perry

City of Methuen

AF About Fresh

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of About Fresh to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that this model be preserved within the MassHealth system.

About Fresh is committed to strengthening communities by getting fresh food to the households that need it most. Through our Fresh Truck and Fresh Connect programs, we are bringing healthier food closer to communities and connecting patients to the food they need to be healthy. We recognize the importance of food and healthcare to be more closely connected, and we work towards seeing a more resilient and equitable health care system.

Our organization has worked directly with BMC HealthNet Plan and their MCO system here in Massachusetts as we work to serve Boston-area patients struggling to access the fresh fruit and vegetables they need to be healthy. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our shoppers but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

Sincerely,



Adam Shyevitch, Chief Program Officer, *About Fresh*

28 April 2021

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Olga Valdman, M.D.
Co-Founder

Elizabeth Ahmadi, Esq.

Bob Bureau, M.Ed., CAGS

Saint Cyr Dimanche

Kwame Gayle

Abigail Mensah, M.Ed.

Patience Noah

Bonnie Walker

Kaska Yawo
*Executive Director &
Co-Founder*

Dear Governor Baker,

I am writing on behalf of African Community Education (ACE) Program to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Tufts Health Plan and their MCO system as we work to serve African refugee and immigrant youth and families across the Commonwealth. The pandemic has shed a glaring light on the inequalities that exist in many of our communities, and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need, but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

African Community Education Program knows how important this work is. Although our primary focus is serving children from all African countries, including refugees, recent immigrants, and children of immigrants, we also recognize that we needed to expand our services to help students' families gain access to services and benefits to better help the children we serve succeed. Ultimately, our vision is a community where African refugees and immigrant youth and families are empowered, self-sufficient, and secure.

Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combatting this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavior health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work Tufts Health Plan has done to support our local communities, our residents, and the overall health and well-being of our region – something we have been invested in building for quite some time. Losing the services offered by Tufts Health Plan and the resources they provide patients directly within their communities would be a blow to our



ACE African Community Education

embracing culture | building community | creating change

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Co-Founder

Elizabeth Ahmadi, Esq.
Bob Bureau, M.Ed., CAGS

Saint Cyr Dimanche

Kwame Gayle

Abigail Mensah, M.Ed.

Patience Noah

Bonnie Walker

Kaska Yawo
*Executive Director &
Co-Founder*

most vulnerable residents – the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

Kaska Yawo
Executive Director





April 26, 2021

The Honorable Charles Baker
Governor
Massachusetts State House
Beacon Street #280
Boston, MA 02133

Dear Governor Baker,

On behalf of BMA TenPoint (BMATP), I provide this letter to express my support for Massachusetts' Managed Care Organizations (MCOs). This network of MCOs which plays an important role in providing comprehensive care to those most in need right within their communities. I write to ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with BMC HealthNet Plan and their MCO system here in Boston as we work to serve low-income children, youth and families. The pandemic has shone the tremendous inequities that exist in many of our communities and has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that works for our residents and helps local providers ensure that the physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

BMATP knows how important this work is. Our mission is to serve as an intermediary organization working in partnership with over 100 nonprofits, churches, and ministries annually to make services delivered to over 10,000 low-income youth and their families more meaningful and effective. We convene resources, acting as a clearinghouse that redistributes funds and technical assistance to build the capacity and strengthen faith and community-based organizations.

BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

2010 Columbus Avenue
Boston, MA 02136

www.BMATenPoint.org

617-445-2737

As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services, but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

Very Truly Yours,

A handwritten signature in blue ink that reads "David Wright". The signature is fluid and cursive, with the first name "David" being more prominent than the last name "Wright".

David Wright
Executive Director

2010 Columbus Avenue
Boston, MA 02136

www.BMATenPoint.org

617-445-2737

Dear Governor Baker,

I am writing on behalf of BMC Transitions of Care and Homelessness to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

BMC Transitions of Care and Homelessness works in partnership with various members of the BMC hospital, shelters, government, and non-profit organizations to serve the homeless populations across the Commonwealth. We continuously work to find ways to better serve and care for those who are most vulnerable and at-risk.

Our organization has worked directly with BMC HealthNet Plan and their MCO system here in as we work to serve the homeless populations. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work BMC HealthNet Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by BMC HealthNet Plan and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

Sincerely,

Deanna J. Faretra, R.N., B.S.N



BOYS & GIRLS CLUB

OF WORCESTER

65 BOYS & GIRLS CLUB WAY, WORCESTER, MA 01610

FOUNDED 1889

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Boys & Girls Club of Worcester to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

Boys & Girls Club of Worcester is one of the largest youth development agencies in Central Massachusetts. We provide mentoring, programs, and services that help youth, especially to those who are in most need. We are committed to serving youth so that they can develop the qualities needed to become responsible citizens and community leaders, through our caring professional staff who forge relationships with our youth members and influence their ability to succeed in life.

Our organization has worked directly with Fallon Health and their MCO system as we work to serve youth in Central Massachusetts. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Fallon Health prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Fallon Health has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Fallon Health, on doing just that.

Sincerely,

Liz Hamilton, MSW
Executive Director

May 11, 2021

Caring Health Center
1049 Main Street
Springfield, MA 01103

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

On behalf of Caring Health Center (CHC), which has provided essential health care services to residents of the Greater Springfield region for over 25 years, I am writing today to request that you and your Administration support the state's Managed Care Organizations (MCOs) and work to preserve this model within the MassHealth system.

These organizations, including Health New England (HNE) and their MCO system, play an important role in providing comprehensive care to those most in need – addressing their physical and behavioral health needs right within their own communities. Expanding access to quality health care to those most underserved in the community is something that we at CHC know a great deal about – because we've spent the last two and a half decades doing just that.

Since 1995, CHC has been an integral part of the Greater Springfield community as it continues to fulfil the mission it was built upon: to provide health care for the ill, to comfort the sick, and to bring the highest level of health care to all. Our team is focused on addressing the cultural, economic, and language needs of our patients in order to truly provide them with the level of care they need and deserve. Today, we employ over 250 and provide affordable, comprehensive medical care to approximately 20,000 patients annually at three sites. We also operate a state-of-the-art pharmacy, run WIC Nutrition Programming for our local families in need, and are the state's largest Refugee Health Assessment provider.

Not only does HNE's MCO system serve many of the clients in need that we see, but they take the same holistic approach to caring for their clients. As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been

invested in building for quite some time. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents.

As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services, but also takes steps to adequately address the social determinants of health.

Losing the services offered by MCOs and the resources they provide within our communities would be a blow to our most vulnerable residents – who are already disproportionately impacted by this pandemic and are at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our experiences with our local MCO and why we know how important it is to protect this system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,



Tania M. Barber, MBA
President and CEO
Caring Health Center

Dear Governor Baker,

I am writing on behalf of Catholic Charities Worcester County to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Massachusetts as we work to serve all of Worcester County residents. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

Catholic Charities Worcester County knows how important this work is. We are committed to strengthening families and serving individuals in need regardless of racial, ethnic, cultural or religious origins, ability to pay, or mental, physical or developmental challenges. Every individual who visits or calls our office completes an assessment that helps us to address immediate needs, and move towards self-sufficiency through food distribution, clothing, housing and utilities, SNAP, MassHealth, Fuel Assistance, and many more.

Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work Tufts Health Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by Tufts Health Plan and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,



Maritza Cedeño

Area Administrator

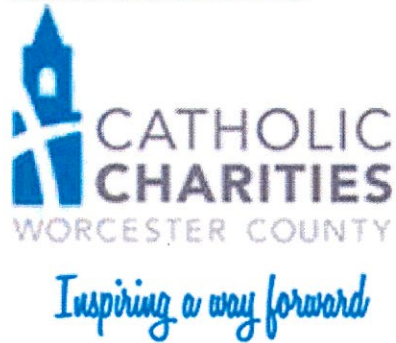
Catholic Charities

196 Mechanic Street

Leominster, MA 01453

978-840-0696

mcedeno@ccworc.org





April 28, 2021

Care Alliance of Western Massachusetts
4 Valley Mill Road
Holyoke, MA 01040

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

On behalf of WestMass Elder Care, the lead agency guiding the Care Alliance of Western Massachusetts (CAWM), I am writing today to express my support of the work the state's Managed Care Organizations (MCOs) do throughout Massachusetts and ask that you and your Administration work to preserve this model within the MassHealth system.

These organizations, including Health New England (HNE) and their MCO system, play an important role in providing comprehensive care to those most in need – addressing their physical and behavioral health needs right within their own communities.

CAWM is a partnership of 3 agencies working together to connect consumers with long-term services and supports. Our partners have spent over four decades working with residents and key allies in communities throughout Berkshire, Franklin, Hampden, Hampshire, and Worcester counties.

We use our deep working knowledge of community resources to help healthcare consumers overcome the impact of social and economic issues. Our team coordinates home and community resources and care across a broad spectrum of health and social services. For decades, we've been focused on strengthening and supporting comprehensive, coordinated, community-based service systems to ensure these critical services are available and accessible to all those in need including our elderly, persons with disabilities (physical or developmental), and those with long-term service and support needs.

Not only does HNE's MCO system serve many of the clients in need that we see, but they take the same holistic approach to caring for their clients. As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. Our organization was built on that notion – that patient-based, comprehensive care is critical because the needs and concerns of each of our patients is unique to their situation.

HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time.

Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

Brenda Denno

Brenda Denno

Care Alliance of Western Massachusetts

WestMass Elder Care



June 11th, 2021

Center for Human Development
332 Birnie Avenue
Springfield, MA 01107

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

On behalf of The Center for Human Development (CHD) and the clients we serve, I am writing today to express my support of the work the state's Managed Care Organizations (MCOs) do throughout Massachusetts and ask that you and your Administration work to preserve this model within the MassHealth system.

These organizations, including Health New England (HNE) and their MCO system, play an important role in providing comprehensive care to those most in need – addressing their physical and behavioral health needs right within their own communities.

CHD provides a broad range of high-quality, community-oriented human services dedicated to promoting, enhancing, and protecting the dignity and welfare of people in need.

Our organization was founded nearly 50 years ago by three young activists looking to address the severe lack of behavioral health services for those in need. Instead of sending people away for help, they brought life-saving services into homes, schools, workplaces, and community centers.

Today, community-based care is the heart and soul of our mission. We offer 80+ programs and services that help people tackle life's toughest problems. Our services include but are not limited to: emotional and behavioral health; addiction services; child development and advocacy; housing, hunger, and family support; youth welfare and court services; and support for those with intellectual and developmental disabilities.

Not only does HNE's MCO system serve many of the clients in need that we see, but they take the same community-based and holistic approach to caring for their clients. As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. We were founded upon a bold, new vision – to bring life-saving social services to people where they live and work. This community-centered approach was novel, but the results were soon clear. Given the opportunity to learn, heal, and grow in familiar surroundings, people flourish. It's a win-win-win for participants, supporters, and the whole community.

Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents - the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,



Ben Craft
Vice President of Community Engagement
Center for Human Development



CITYBLOCK HEALTH
100 Grove Street, Suite 115
Worcester, MA 01605

The Honorable Charles D. Baker
Governor of the Commonwealth of Massachusetts
State House
Boston, MA 02133

April 21, 2021

Dear Governor Baker,

I am writing on behalf of Cityblock Health to express my support for preserving value based care, and the critical role of Massachusetts' Managed Care Organizations (MCO) in delivering it, within the MassHealth system through the upcoming 1115 waiver renewal.

Cityblock Health is a value based provider that unites primary care, behavioral health, and social care for Medicaid enrollees with complex needs to address the root influencers of health. In partnership with Tufts Health Plan, we launched in Massachusetts in March 2020 and currently serve around 2,000 OneCare enrollees with special healthcare needs in Worcester County. Cityblock members have access to integrated care teams, including doctors, nurses, behavioral health specialists, and a Community Health Partner who is there every step of the way.

Through our partnership with Tufts on the OneCare program, we have seen, firsthand, the value of their personalized care management, curated high-value network and provider collaboration, and service coordination across the many services that our medically and socially complex members need. In the past year, Tufts Health Plan has partnered with us and other local organizations to support our community during the Pandemic through educating our members about COVID and supporting access to vaccines, providing critical behavioral and medical care, and much more. They do a tremendous job using on-the-ground knowledge, as well as leveraging organizations like ours that deliver truly community-based care, in serving our most vulnerable residents and addressing social determinants of health.

Further, Tufts supports our local communities, our residents, and the overall health and well-being of our region - something we have collectively been invested in building for quite some time. Losing the services and resources made possible under value based care by Tufts Health Plan and others would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and have historically faced the inequities of racism and systemic oppression in the Commonwealth.

Thank you for the opportunity to share our concerns and comments about the importance of protecting value based care in Massachusetts. Now more than ever, we must continue to focus on maintaining



CITYBLOCK HEALTH
100 Grove Street, Suite 115
Worcester, MA 01605

systems that give people the opportunity to access quality services across the spectrum of care within their own communities, while keeping an eye on creative ways to address the unsustainable healthcare costs we have in the Commonwealth. We look forward to continuing our work with MCOs, like Tufts Health Plan, to do just that.

Sincerely,

A handwritten signature in black ink that reads "Iyah K. Romm".

Iyah K. Romm
CEO
Cityblock Health



The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Cambodian Mutual Assistance Association (CMAA) to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

At CMAA, we aid programs and services to our members to combat key issues that they face daily including contact with government (from adverse experiences in their native land), low proficiency in English, low native language literacy rates, and fear of eviction. We are currently based in Lowell, MA, which is home to the second largest Cambodian refugee population in the US.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Lowell, Massachusetts as we work to serve Cambodian refugees, immigrants, and families. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

Sovanna Pouy
Executive Director

Dear Governor Baker,

I am writing on behalf of ConsejoSano to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Massachusetts to serve culturally diverse populations by offering the only healthcare engagement solution tailored to address the needs of our communities. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

ConsejoSano knows how important this work is. Our mission is to engage culturally diverse populations to take the desired actions to improve health outcomes,, quality measures and financial performance. We are a multidisciplinary group of doctors, medical providers, engineers, health policy experts, visionaries, engagement specialists, and wellness practitioners from across the globe that believe that the combination of data, behavioral science, and a deep understanding of culture can create enormous value and savings for our clients and their patients, members or employees.

Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work Tufts Health Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by Tufts Health Plan and the resources they provide patients directly within their communities would be a blow to our most

vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

A handwritten signature in blue ink, appearing to read "Gary Rosenfield".

Gary Rosenfield

Senior Vice President, Business Development & Strategy at ConsejoSano

Daybreak Shelter

19 Winter St.
978-975-4547

Women's View

582-584 Haverhill St.
978-687-1658

THE PSYCHOLOGICAL CENTER



Pegasus House

482 Lowell St.
978-687-4257

Located in
Lawrence, MA
since 1971

Dear Governor Baker,

I am writing on behalf of The Psychological Center to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with AllWays Health Partners and their MCO system here in the Merrimack Valley as we work to serve homeless men & women. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, AllWays Health Partners prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

AllWays Health Partners has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.



We have seen, firsthand, the important work AllWays Health Partners has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by Your Care Circle and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like AllWays Health Partners, on doing just that.

Sincerely,

Joshua White
Director of the Daybreak Shelter



The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of DPV Transportation to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

DPV is a global company based in Everett, Massachusetts. At DPV, we set out to change every facet of ground transportation, embracing safety and leveraging technology at every step. Beyond transportation, DPV builds opportunities for minority communities and homes for those who need them most in third world countries. With a long, shared history of resilience, DPV drives communities forward.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Massachusetts as we work to serve minority communities, bilingual households, and undocumented families throughout the state. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel Perez". The signature is fluid and cursive, with a large initial "D" and "P".

Daniel Perez
President/CEO
DPV Transportation



April 20th, 2021

Dan Tsai, Assistant Secretary
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Assistant Secretary Tsai:

I am writing on behalf of Eliot Family Resource Center, one of the Community Partner organizations that works with the Medicaid Accountable Care Organizations (“ACOs”) to provide care management and care coordination services to provide support to MassHealth enrollees with significant behavioral health or long-term services. Our organization has partnered closely with Tufts Health Plan since the inception of the program and have worked collaboratively to provide high quality services for the members that we serve. As the state develops its Section 1115 Waiver renewal proposal and priorities for the upcoming Section 1115 Waiver beginning July 2022, we wanted to take this opportunity to offer our strong support for the Model A ACOs and CP programs, share some of our successes with you, and strongly urge you to continue to support the programs in the new Waiver period.

CPs play a key role in the MassHealth program to provide, in collaboration with ACOs, comprehensive care management, care planning, assessments, care coordination, care transition, and health promotion for identified members. These services have been particularly important during the COVID-19 pandemic as we work to ensure that we deliver critical medical, behavioral health, and social needs for MassHealth enrollees. Going forward, it will be more important than ever to reach members, especially those with complex behavioral health needs, disabilities, and chronic illnesses, to ensure that necessary care and services are not delayed.

We wanted to take the opportunity to share our experience working with Tufts Health Plan to serve members in the program and offer examples of success stories, lessons learned, and opportunities for continued support for individuals in the MassHealth program. We would also like to share examples of how we have worked collaboratively with our ACO partner to connect members to services and supports and how we have focused on the impact that COVID-19 has had on our community.

We have no words to express the gratitude we have for the commitment, support and generosity for all Tufts Health Plan has done for our center and our community. Since we opened three years ago Tufts Health Plan became our number one partner for multiple events, including:

- Donations to our back to school events (Backpacks and school supplies).
- Providing reusable grocery bag for food distribution in our food pantry– each week around 500 families receive food donations).
- Donating diapers, wipes and co-hosting community baby showers.
- Donating summer toys, sunblock, sunglasses and other fun items for our children’s events.

- Donating hand sanitizers, mask and other COVID19 prevention items.
- Supporting families during holidays, especially during Thanksgiving.
- Providing financial grants to cover the cost of family events.

Once again, we appreciate the opportunity to participate in the conversation regarding the priorities for the next Section 1115 Waiver and offer our strong support for a robust Model A ACO program and CP program. We share your goals to build upon the successes of the program and strengthen care coordination across the program, to advance health equity, and ensure sustainability and support for our providers. Given the impact that COVID-19 has had on individuals in the Medicaid program and within our communities, now is not the time for significant changes that will disrupt the program. We must focus our efforts on strengthening our programs so that we can provide the necessary care and services that our enrollees need during these most unprecedented times. We look forward to working in partnership with the state to ensure that the program is successful and support the development of a more integrated and coordinated behavioral health care delivery system. We thank you for the opportunity to provide these comments and look forward to continuing to work together to provide critical support for MassHealth members.

Sincerely,

Liliana Patino, M.Ed
Program Director
Eliot Family Resource Center
548 Broadway,
Everett, MA 02149
Lpatino@Eliotchs.org



Executive Director
Andrew Morehouse

Executive Committee
Erica Flores, Esq., President
Skoler, Abbott & Presser, P.C.

William Dávila, Ed.D., MSW, LICSW, 1st
Vice President
The Children's Study Home

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SageFox Consulting Group

David Pinsky
Tighe & Bond (retired)

Bishop Bruce Shaw
New Hope Pentecostal Church

Vasilios Tourloukis
Radiology & Imaging, Inc.

Shannon Yaremchak
Corporation for Public Management

Beth Young
Stop & Shop Supermarket

April 29, 2021

Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon St.
Boston MA 02133

Dear Governor Baker:

I am writing on behalf of The Food Bank of Western Massachusetts to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Health New England (HNE) and their MCO system as we work to feed our neighbors in need and lead the community to end hunger. We provide food to 240 feeding programs throughout the four counties of western Massachusetts. These programs – local food pantries, meal sites, shelters, Mobile Food Banks, and Brown Bag: Food for Elders sites – are on the front line here in our region, providing vital assistance to individuals, families, seniors, children, and people with disabilities (including many veterans) to help them lead healthy and meaningful lives. On average, we serve 101,782 residents monthly.

In order to address this issue head-on, we are not only focused on providing resources to help our partners provide food to people experiencing hunger. We are also dedicated to increasing the capacity at these sites, strengthening the emergency food network in our region, and developing long-term solutions to combat the underlying causes of hunger in our community.

As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for people in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

The mission of The Food Bank of Western Massachusetts is to feed our neighbors in need and lead the community to end hunger.



We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time.

Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

Christina Maxwell
Director of Programs
The Food Bank of Western Massachusetts



Evelyn Friedman
Executive Director & CEO

Johan Lopez
Chair, BOD

April 27, 2021

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Greater Lawrence Community Action Council (GLCAC) to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

At GLCAC, we encourage and promote the improvement of community life in Greater Lawrence with special emphasis on, but not limited to, the initiation of programs in education, social services, child care, health, housing youth employment and related fields. Since its inception, GLCAC has been a consistent partner in working with local, state and federal governments and private agencies in creating opportunities and providing hope for people living in poverty. Currently the GLCAC, Inc, serves over 25,000 clients in a variety of programs and has an annual operating budget of over \$20 million dollars.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Greater Lowell of Massachusetts as we work to serve people from all walks of life. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to

access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,



Evelyn Friedman
Executive Director



May 11, 2021

Good Measures
30 Rowes Wharf, Suite 410
Boston, MA 02110

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

I am writing today to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

As the Vice President of Business Development at Good Measures, I've worked directly with Tufts Health Plan and their MCO system as we help lay important nutritional foundations focused on improving sustainable health outcomes for patients, employers, and insurers.

Good Measures is based on a simple idea – that meeting nutrient needs is the foundation for all healthy living and chronic condition management efforts. Our team – made up of mathematicians, engineers, food and nutrition experts, and organization leaders – offers proven programs that meet people where they are – helping them eat better in a personal, relevant, and actionable way. Good Measures works hand-in-hand with Tufts to bring whole person care to members to improve self-efficacy and healthcare outcomes.

As a local MCO, Tufts prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need, but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. Tufts has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but that also address social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for many years.

Losing the services offered by MCOs and the resources they provide patients within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts, on doing just that.

Sincerely,

Caroline Carney, MS, RDN, LDN
Vice President of Business Development
Good Measures



4/29/2021

The Gray House
22 Sheldon Street
Springfield, MA 01107

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

On behalf of The Gray House in Springfield and the clients we serve, I am writing today to express my support of the work the state's Managed Care Organizations (MCOs) do throughout Massachusetts and ask that you and your Administration work to preserve this model within the MassHealth system.

These organizations, including Health New England (HNE) and their MCO system, play an important role in providing comprehensive care to those most in need – addressing their physical and behavioral health needs right within their own communities.

The Gray House was opened in 1984 by five Sisters of Saint Joseph and one lay-person to expand access to key services that provided for the civic, social, and educational needs of their neighbors in the North End, which is one of the poorest sections of Springfield and the Commonwealth.

Our organization helps over 7,000 unique residents a year meet their immediate needs as we work to address the root causes of poverty. Services include a food assistance program, adult education programming, and after-school and summer youth programming. Like many other organizations, we have seen a huge influx of new people needing services and support during this global health crisis. During the first three months of our curbside food distribution program launched at the beginning of the pandemic, we served over 3,000 households with a total of more than 10,000 household members.

Not only does HNE's MCO system serve many of the clients in need that we see, but they take the same holistic approach to caring for their clients. As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to administer behavioral

and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time.

Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents - the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

A handwritten signature in black ink that reads "Benjamin B. Holt". The signature is written in a cursive, flowing style.

Benjamin B. Holt
Food Program Director
The Gray House



Care Central VNA
& Hospice, Inc.
Healthcare in Your Neighborhood

Healthy Families North Worcester County
(978) 632 1230 ext. 311

34 Pearly Lane Gardner MA 01440
FAX (978) 632.6843

The Honorable Charlie Baker
Governor of Massachusetts
Massachusetts State House,
24 Beacon St.
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of the Healthy Families program at CareCentral VNA to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that you and your Administration work to preserve this model within the MassHealth system.

Tufts Health Plan has been a great partner with us at our Diaper Pantry, donating thousands of diapers over the past several years to help us to serve those families in the north Worcester county region who are diaper insecure. We have also partnered with them to plan and execute a "Community Baby Shower" which is a community resource fair for young parents. It has always been a pleasure to work with the Tufts Health Plan representatives, and we look forward to the opportunity to see their program continue to partner with us and other groups to address important community issues for children and families.

Sincerely,

Karen Culkeen
Healthy Families North Worcester County Program Director



April 26, 2021

The Honorable Charles Baker
Governor
Massachusetts State House
Beacon Street #280
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of HealthFirst Family Care Center/ Women, Infant & Children Supplemental Nutrition Program to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Fall River, Massachusetts as we work to serve the Portuguese, Hispanic, Cambodian, African American and Brazilian Portuguese populations. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

HealthFirst/WIC knows how important this work is. HealthFirst/WIC has always been a resource for people struggling through difficult times, whether unemployed, a single parent or a recent immigrant. We are committed to ensuring easy access for all patients, regardless of language, income or cultural barriers to care. Additionally, federal assistance means you are assured of the highest quality care, and we will continue to greet anyone in need with open arms.

Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a

tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work Tufts Health Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by Tufts Health Plan and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

Chelsie Stephenson

WIC Community Coordinator

HealthFirst Family Care Center



The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Hope House to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

As you know, Hope House Addiction Services (Hope House) is the oldest and one of the largest residential and individualized treatment programs in Massachusetts for adults with substance use disorder. Through our residential treatment program and outpatient treatment center, we work to ensure individuals receive the education and support that they need in order to pursue their life interests with families, employers, and be self-sufficient members of their communities. We also recognize individuals' needs for enhanced services, so we work with licensed clinicians to evaluate for special needs in the areas of housing, medical condition, and job prospects. We appreciate your support, and that of your great team led by Marylou Sudders. We especially appreciate the support we get from the great team at BSAS led by Deirdre Calvert and Lee Kremer.

Our organization has worked directly with BMC, and the BMC HealthNet Plan and their MCO system as we work to serve adults with substance use disorder that come from all walks of life and value the partnerships we share. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Hope House, Inc. 8 Farnham Street, Boston, MA 02119 www.hopehouseboston.org



Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

We especially look forward to supporting the agenda of your team as we work hand in hand to address the pressing and unrelenting needs and challenges of the opioid epidemic.

Sincerely,

A handwritten signature in black ink, appearing to read "Ted Waterman", with a long horizontal flourish extending to the right.

Ted Waterman
President & CEO
Hope House, Inc.



Innovative Care Partners
332 Birnie Avenue
Springfield, MA 01103

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

As one of the state's Community Partners (CP) serving residents throughout the four counties of Western Massachusetts, our team at Innovative Care Partners (ICP) works day in and day out to help our most vulnerable patients access critical medical and behavioral health services within their own communities.

ICP works to support patients – including those with severe mental illness, developmental disabilities, and/or the elderly who have a history of significant medical claims – by coordinating their care and creating individualized plans to make sure the unique and usually complex needs of each patient are being met. We work directly with the patient's medical and community-based service providers, including the state's Managed Care Organizations (MCOs) and their Accountable Care Organization (ACO) plan partners.

These organizations, including Health New England (HNE) and their MCO system, play an important role in providing comprehensive care to those most in need – addressing their physical and behavioral health needs right within their own communities.

ICP was formed by three local organizations in order to ensure the best health outcomes for our region's MassHealth enrollees – the Center for Human Development (CHD), Gandara Center, and ServiceNet. Combined, these three organizations have served our region for nearly 150 years – expanding access to community-based care to those most in need while protecting the dignity and quality of life for all involved, including family members and caregivers providing long-term support and services.

In order to best serve our clients and communities, we work to anticipate the unique needs of each person (including those that are regionally and/or culturally specific), adapt to changing circumstances and situations within our communities, and help leverage resources and partnerships to promote better health and life outcomes for all we serve. As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more.

Our state's most vulnerable residents rely on these services and the MCO have the proven track record of helping to connect those most in need with critical care they need in an easy to access and comprehensive way. Residents served by our state's MCOs have already been disproportionately impacted by the COVID-19 pandemic and are at the highest risk of being left behind as we work toward recovering from this crisis. Any disruption in services or moving away from this organized, comprehensive network of care would be detrimental for our residents and our communities.

Thank you for the opportunity to share our experiences with our local MCO as one of the region's Community Partners. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

A handwritten signature in blue ink that reads "James Goodwin". The signature is fluid and cursive, with the first name "James" being larger and more prominent than the last name "Goodwin".

James Goodwin
President and CEO



INTERFAITH SOCIAL SERVICES

April 28, 2021

Interfaith Social Services
105 Adams Street
Quincy, MA 02169

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Interfaith Social Services in Quincy to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

For several years our organization has worked directly with Boston Medical Center HealthNet Plan (BMCHP) and their MCO system on the South Shore as we work to provide compassionate, client-centered programs to help improve the lives of residents and families in the region through food assistance, mental health services, and emergency assistance. In 2020, we saw 873 new households come to us for food assistance and distributed over 68,000 bags of food through our food pantry – one of the largest in Greater Boston. We provided mental health counseling to over 2,500 people during this year and helped keep over 440 residents and families in their homes through our emergency assistance program.

The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas. Not only do they serve many of the clients in need that we see but they take the same holistic approach to caring for their clients.

As a local MCO, BMCHP prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. BMCHP has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep

understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work MCOs, like BMCHP, have done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMCHP, on doing just that.

Sincerely,



Rick Doane
Executive Director
Interfaith Social Services



April 23, 2021

Just Roots, Inc.
34 Glenbrook Drive, Apt. B
Greenfield, MA 01301

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

I am writing to you today to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization, Just Roots, has worked directly with Health New England (HNE) and their MCO system as we focus on expanding access to healthy, local food by connecting people, land, resources, and know-how to break down barriers to local food access and play a critical role in connecting our healthcare system with locally grown food and resource. Prior to the pandemic the Greater Boston Food Bank and Children's Health Watch published research finding the Massachusetts spends and 2.4 Billion in avoidable healthcare costs directly linked to hunger and diet related illness. Hunger and diet related disease and illness do not exist in a vacuum. The social determinants of health are well documented as core contributors to the overall health of our population and the associated cost of that population. The MCO system plays a critical role in addressing social determinants of health and works to narrow the avoidable healthcare costs we spend today.

We began in 2008 as a grassroots group of concerned citizens looking to promote vegetable gardening and grow food on municipal land in Franklin County. Today, we are a social enterprise that operates the largest SNAP enrolled CSA farm share program in the Commonwealth and effectively connects our healthcare system with local food and resources, leveraging food as medicine, building health, reducing food insecurity and reducing the cost of patient care. We strive to promote cross-disciplinary and mutually beneficial partnerships with area organizations and agencies that collaborate to benefit our community in an inclusive way.

The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas. Not only does HNE's MCO system serve many of the clients in need that we see, but they take the same holistic approach to caring for their clients. HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

A handwritten signature in cursive script that reads "Jessica O'Neill".

Jessica O'Neill
Executive Director
Just Roots



**Mattapan Food and
Fitness Coalition**

mattapanfoodandfit.org
1613 Blue Hill Ave, Suite 307
Mattapan, MA 02126
617-696-2900
mffcweb@gmail.com

Dear Governor Baker,

I am writing on behalf of Mattapan Food and Fitness Coalition (MFFC) to express my support for Massachusetts' Managed Care organizations (MCO), which plays an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration works to preserve this model within the MassHealth system.

Our organization has worked directly with BMC HealthNet Plan and their MCO system here in the Mattapan neighborhood of Boston as we work collaboratively to serve Mattapan residents, organizations and others to work on improving the food and physical activity environments. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

Mattapan Food and Fitness Coalition knows how important this work is. MFFC is a largely volunteer and community based organization in Mattapan designed for making healthy and affordable food, safe and inviting recreational spaces and streets and sidewalks readily accessible to all. Through our focus areas of food access and nutrition, physical activity, youth development, built environment, and community empower, MFFC promotes healthy behaviors through its networks and its partnerships with other organizations including BMC HealthNet Plan. Through these collaborative efforts and using a racial equity lens, we work towards bettering the lives of our residents to decrease health problems like diabetes, heart disease, obesity and other health conditions.

BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work BMC HealthNet Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by BMC HealthNet Plan and

the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

Sincerely,

A handwritten signature in cursive script that reads "Shavelle Olivier".

Shavel'le Olivier
Executive Director, Mattapan Food and Fitness Coalition



The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Merrimack Valley ACO to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

Merrimack Valley ACO in partnership with AllWays Health Partners is one of 16 Accountable Care Organizations statewide—representing 4,500 primary care providers and 850,000 MassHealth patients across the state. Our ACO is called My Care Family, with 40,000 Mass Health members currently. Individual MassHealth members are cared for by My Care Family interdisciplinary teams consisting of nurses, doctors, behavioral health professionals, clinical pharmacists, social service providers, and others impacting community health. These team members work together to ensure that total health needs are met in a member-centric way that results in high quality and efficient care, delivered in cost-appropriate settings for patients and families.

Our organization has worked directly with AllWays Health Partners and their MCO system to serve MassHealth members across the greater Lawrence, Lowell, and Haverhill communities. The pandemic has shone a glaring light on the inequities that exist in many of our communities, particularly in Lawrence where 75% of our members reside, and it has also underscored the importance of locally based programs, operating on the ground in chronically underserved areas.

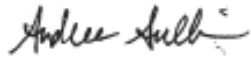
AllWays Health Partners has had a long history, first as Neighborhood Health Plan, providing care and coverage for MassHealth members in the greater Lawrence area. AllWays Health Partners knows our community and has continued its commitment to our region through our ACO partnership. Together we have shared resources and worked on innovative approaches to reduce cost, improve outcomes, address social determinants of health, and support our members during and after both the Columbia Gas explosions and the pandemic. AllWays Health Partners prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied medical and behavioral health needs of the region are being comprehensively addressed. As an experienced MCO with a deep understanding of organizations like ours, AllWays Health Partners has provided important knowledge and resources to support our ACO and benefit the ACO members in our community.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems and safety net providers that serve the needs of Massachusetts' most underserved residents through

strong primary care, robust community hospital and behavioral health services while also taking steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like AllWays Health Partners, with ongoing support from the Commonwealth.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrea Sullivan". The signature is fluid and cursive, with a small flourish at the end.

Andrea Sullivan
Chief Executive Officer

Merrimack Valley ACO
15 Union St., Suite 555
Lawrence, MA 01841
(978) 780-3060



April 22, 2021

Martin Luther King Jr. Family Services
106 Wilbraham Road
Springfield, MA 01109

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Martin Luther King, Jr. Family Services (MLKFS) in Springfield to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Health New England (HNE) and their MCO system as we strive to help our Greater Springfield community become the "beloved community" that Reverend Dr. Martin Luther King, Jr. often referred to in many of his speeches. We take concrete steps to attain this vision through programs that address some of the most pressing needs our underserved and under-resourced community has. With the help of over 100 volunteers, we are able to serve over 650 local residents each and every week – even during the latest health crisis.

Our services include, but are not limited to: after-school literacy programs, a College Readiness Academy, family support and stabilization services, food assistance, and prevention services to address poor health and maintenance of good health. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas. Not only does HNE's MCO system serve many of the clients in need that we see, but they take the same holistic approach to caring for their clients.

As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local

providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time.

Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

Ariana Williams
Director of Public Health Programs
Martin Luther King Jr. Family Services



April 21, 2021

Dear Governor Baker,

I am writing on behalf of Merrimack Valley Community Partner to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with AllWays Health Partners to serve the most vulnerable, at risk members with long term services and support (LTSS) needs who are enrolled under the MCO/CP model of care across the northeast region of the state to help address the inequities that exist within this population. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, AllWays Health Partners prioritizes personalized outreach and culturally competent care management that we know not only works for our members in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable members who rely on it.

Merrimack Valley Community Partner (MVCP) knows how important this work is. MVCP is a LTSS community partner made up of long-standing community-based organizations who have served consumers with LTSS needs across the northeast region. MVCP has an extensive reach within the communities we serve, as well as a deep knowledge of LTSS resources. We also have a long history of working with the health care partners in our community to address the holistic needs of consumers, using a consumer-focused approach to care planning.

AllWays Health Partners has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect members to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable members and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services, but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work AllWays Health Partners has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by AllWays Health Partners

and the resources they provide members directly within their communities would be a blow to our most vulnerable members -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like AllWays Health Partners, on doing just that.

Sincerely,

A handwritten signature in blue ink that reads "Joan Hatem-Roy". The signature is fluid and cursive, with the first name "Joan" being the most prominent.

Joan Hatem-Roy, LICSW
Chief Executive Officer



April 23, 2021

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Old Colony YMCA to express my support for Massachusetts Managed Care Organizations (MCOs), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with the BMC HealthNet Plan and their MCO system here in Southeastern Massachusetts as we work to serve children and families of Brockton, Taunton, East Bridgewater, Middleboro, Easton, Plymouth, and Stoughton. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, the BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

Old Colony YMCA knows how important this work is. We currently serve 31 communities in Southeastern Massachusetts with programs for all ages and abilities, designed to build healthy spirits, minds and bodies. Old Colony Y is one of the largest human service providers in Southeastern Massachusetts, serving over 140,000 children and families. Our community-based programs and services help children and families break destructive patterns and learn to live responsibly.

The BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.



We have seen, firsthand, the important work that the BMC HealthNet Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by the BMC HealthNet Plan and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like the BMC HealthNet Plan, on doing just that.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Vincent J. Marturano'. The signature is fluid and cursive, written in a professional style.

Vincent J. Marturano, MSW, ACSW
President & CEO
Old Colony Y
320 Main Street
Brockton, MA 02301



See beyond. Live beyond.

May 24, 2021

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Open Sky Community Services, Inc. to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing access to comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

Open Sky Community Services Inc is a non-profit headquartered in Worcester that operates over 100 programs serving more than 4,500 individuals each year. As one of the largest human service organizations in Central MA, Open Sky is a leading provider of clinical, community-based and residential services for people with mental health challenges, co-occurring substance use disorders, justice involvement, developmental disabilities, acquired brain injury, autism, homelessness, and other complex challenges. We are the lead agency in the Central Community Health Partnership (CCHP) which provides services in the MassHealth BH and LTSS Community Partner program. Our partnership is comprised of 5 organizations that include LUK Inc, Venture Community Services, AdCare Hospital, Center for Living and Working and Elder Services of Worcester.

CCHP has contract agreements with both statewide MCO entities and seven other ACO organizations. Tufts Health Plan is one of our biggest referral partners and our team has developed a strong integrated relationship with their MCO team and those relationships have resulted in better care and support for residents through Central Massachusetts. The pandemic has shone a glaring light on the inequities that exist in many of our communities, and it has also underscored the importance of local community-based organizations that help individuals and families facing complex challenges.

Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of people in Central Massachusetts are being comprehensively addressed. Tufts Health Plan has partnered with us and other local organizations to deliver behavioral and physical care, distribute pandemic supports, connect

4 Mann Street, Worcester, MA 01602 (508) 755-0333

www.openskycs.org



Alternatives Unlimited, Inc. and The Bridge of Central Mass., Inc. dba Open Sky Community Services





See beyond. Live beyond.

residents to resources, and much more. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and we are pleased to see MassHealth taking steps to make improvements. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health and human service providers that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to address critical social determinants of health such as housing, transportation, food insecurity and more.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on strengthening the local health and human service provider systems that work to remove barriers and give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing to develop our relationship with Tufts Health Plan to do just that.

Sincerely,

A handwritten signature in black ink, appearing to read "Ken Bates".

Ken Bates, President & CEO
Open Sky Community Services Inc.

4 Mann Street, Worcester, MA 01602 (508) 755-0333
www.openskycs.org



Alternatives Unlimited, Inc. and The Bridge of Central Mass., Inc. dba Open Sky Community Services





**PUBLIC HEALTH INSTITUTE
OF WESTERN MASSACHUSETTS**

PARTNERS FOR HEALTH EQUITY

4/27/2021

Public Health Institute of Western Massachusetts
127 State Street, 4th Floor
Springfield, MA 01103

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

As Executive Director of the Public Health Institute of Western Massachusetts (PHIWM), I am writing today to express my support for the state's Managed Care Organizations (MCOs) and to respectfully urge you and your Administration to preserve this model of care within the MassHealth system.

MCOs play a critical role in providing comprehensive care to those most in need – right within their own communities. Our organization has worked directly with Health New England (HNE) and their MCO, which serves residents throughout Western Massachusetts. As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Addressing health equity is a critical component to just about everything we do at PHIWM. Through various services and programs, we work to provide the skills, expertise, and experience necessary to create successful and impactful public health campaigns and sustainable system changes to improve the health and well-being in Western Massachusetts.

In addition to providing key resources for successful campaigns – including coalition building, community-based research, policy development, and data driven services – PHIWM is diligently taking steps to expand health equity and challenge institutional racism. In order to tackle these issues head-on, we work to ensure our efforts shine a light on and help address the structures and institutions that cause health inequities in our communities. With our key partners, we're focused on testing and implementing the solutions and policies to help us breakdown the barriers to equitable health care that too many of our residents and communities face.



**PUBLIC HEALTH INSTITUTE
OF WESTERN MASSACHUSETTS**

PARTNERS FOR HEALTH EQUITY

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of our most underserved residents through primary care and behavioral health services, but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

Jessica Collins
Executive Director
Public Health Institute of Western Massachusetts

Pioneer Valley Pediatrics



5/18/2021

Pioneer Valley Pediatrics
106 Wilbraham Road
Springfield, MA 01109

To: Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

As a pediatrician at Pioneer Valley Pediatrics, which has served the children of Western Massachusetts for over 60 years, I am writing today to express my support for Massachusetts' Managed Care Organizations (MCO) and ask that you and your Administration work to preserve this model within the MassHealth system.

These organizations, including Health New England (HNE) and their MCO system, play an important role in providing comprehensive care to those most in need – including children – addressing their physical and behavioral health needs within their own communities.

Pioneer Valley Pediatrics is led by eight dedicated board certified pediatricians who work together to provide comprehensive pediatric health services to infants, children, and adolescents. PVP was started as a small practice in 1957 by Dr. Leonard H. Plotkin. Over the past fifty plus years, we have grown as a professional practice and we proudly provide high-quality medical care and health promotion services to children and families in central Connecticut and Massachusetts in our offices in Enfield, Connecticut and Longmeadow, Massachusetts.

As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to

administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of practices like ours, in serving our most vulnerable residents and addressing social determinants of health.

In ways that other systems do not, MCOs work to provide access to other critical services that many would not describe as “traditional health care” services – like programming to deal with food insecurity and educational and family support programs. By taking a holistic approach to care, MCOs are actively working to connect patients with a vast array of services and care to build strong foundations for our families and children.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time.

Thank you for the opportunity comment on the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

Dr. Richard Segool, MD, FAAP

CC: Daniel Tsai, Assistant Secretary for MassHealth



Dear Governor Baker,

I am writing on behalf of Quincy Asian Resources, Inc. (QARI) to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Massachusetts as we work to serve immigrants and their families in order to benefit Quincy and its neighboring communities. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

QARI knows how important this work is. Since November 20th, 2001, QARI has established itself as the go-to resource center for Asian and immigrant residents in Quincy. We have developed a broad array of services: multilingual information and referrals, healthcare navigation, enrichment events for elders, adult English education, youth programming, and acclaimed cultural events. QARI is serving immigrant populations in innovative ways that empower individuals through collaborations and partnerships.

Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work Tufts Health Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by Tufts Health Plan and the



resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

A handwritten signature in black ink, which appears to read 'Philip Chong'.

Philip Chong
President & CEO, QARI



Revitalize
Community Development Corporation

Colonial Block Building
1145 Main Street, Suite 107
Springfield, MA 01103
Tel: 413-788-0014
www.RevitalizeCDC.com

To: Governor Charlie Baker
State House, Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

April 26, 2021

Dear Governor Baker,

I am writing on behalf of Revitalize CDC in Springfield to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Health New England (HNE) and their MCO system in our work in the Greater Springfield region. Since 1992, we have worked to perform critical repairs, modification, and rehabilitation on the homes and non-profit facilities of low-income families with children, the elderly, military veterans, and people with special needs. Our emphasis and focus is on making meaningful improvements to homes that help reduce energy use, save money, and create a safe, healthy and sustainable living environment for our residents and the community.

Safe housing is a key step in making sure we're investing in our future and investing in the health and wellbeing of our residents. At Revitalize CDC, we launched a Green and Health Homes Pilot Program with key local health advocates. Our two licensed and certified Healthy Homes Assessors completed assessments and interventions on 57 homes and rental units to eliminate asthma triggers for children and adults suffering from asthma. I am glad to report that this is now an on-going program we are focusing on.

As a local MCO, HNE prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. HNE has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time.

Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like HNE, on doing just that.

Sincerely,

Colleen Loveless
President and CEO
Revitalize Community Development Corporation



A Window into Women's Reproductive Health & Wellness

5/5/2021

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Resilient Sisterhood Project (RSP) to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

Resilient Sisterhood Project, founded in 2012, is an emerging nonprofit based in Boston to raise awareness and empower women and young adults of African descent affected by diseases of the reproductive system through a cultural and social justice lens. We mobilize Black women and immigrant women of African descent to challenge existing medical/social inequities and advocate for health improvements regarding the chronic under-diagnosed and under-treated diseases of the reproductive system that disproportionately affect us. RSP is committed to transforming communities to engage in conversations regarding diseases of the reproductive system that disproportionately affect Black women.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Massachusetts as we work to serve The Greater Boston area – particularly Black women from disadvantaged communities. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute

pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

Lilly Marcelin

Executive Director
Resilient Sisterhood Project
617-590-4003
www.rsphealth.org



60 Congress Street • P.O. Box 1609 • Springfield, MA 01101
(413) 785-4500 • Fax (413) 785-4516
www.shamass.org

June 15, 2021

Governor Charlie Baker
State House
Office of the Governor, Room 280
24 Beacon Street
Boston, MA 02133

Dear Governor Baker,

On behalf of the Springfield Housing Authority, the state's third largest housing authority, and the residents we serve to express my support of the work the state's Managed Care Organizations (MCOs) do throughout Massachusetts and ask that you and your Administration work to preserve this model within the MassHealth system.

These organizations, including Boston Medical Center HealthNet Plan (BMCHP) and their MCO system, play an important role in providing comprehensive care to those most in need – addressing their physical and behavioral health needs right within their own communities.

The Springfield Housing Authority (SHA) works to promote adequate and affordable housing, economic opportunity, and a suitable living environment free from discrimination to those in need. Beyond helping ensure those in need have access to affordable housing, we also work to support educational and vocational programs with the goal of reducing the long-term reliance of residents on public assistance and work to ensure each SHA resident and housing community has the opportunity to achieve their maximum potential.

Not only does BMCHP's MCO system serve many of the clients in need that we serve, but they take the same community-based and holistic approach to caring for their clients. As a local MCO, BMCHP prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed.

Caring for those in need – especially during a global pandemic – is never a one-size-fits-all approach. BMCHP has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. Massachusetts' health care system is not perfect, and many aspects need fixing.

As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serves the needs of Massachusetts' most

underserved residents through primary care and behavioral health services but also takes steps to adequately address the social determinants of health.

We have seen, firsthand, the important work these systems do to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. We were founded upon a bold, new vision – to bring life-saving social services to people where they live and work. This community-centered approach was novel, but the results were soon clear. Given the opportunity to learn, heal, and grow in familiar surroundings, people flourish. It's a win-win-win for participants, supporters, and the whole community.

Losing the services offered by MCOs and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents - the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMCHP, on doing just that.

Sincerely,

Denise R. Jordan
Executive Director
Springfield Housing Authority



The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of South Boston Neighborhood House (The Ollie) to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

South Boston Neighborhood House is the oldest continuously operated community-based, non-profit in South Boston, and has been going strong for 115 years. We provide services to residents of all ages and backgrounds in ways that strengthen the community. Our services include Early Education and Care Preschool, School Age, Education and Career Development Programs, Senior Programs and Family Engagement.

Our organization has worked directly with BMC HealthNet Plan and their MCO system here in South Boston as we work to serve individuals and families of all ages. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

Sincerely,

Carole H. Sullivan Senior Advocate, Director of Senior Programs, Resident Service Coordinator



The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Spectrum Health Systems to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

Spectrum Health Systems, Inc. is a private, nonprofit organization dedicated to improving the lives of individuals impacted by addiction and/or mental health disorders. Over the past 50 years, Spectrum has become known as an industry leader, helping thousands of individuals overcome addiction and reclaim their lives. We offer a continuum of addiction treatment services, including inpatient detoxification, residential rehabilitation, medication-assisted treatment, outpatient counseling and peer recovery support. Additionally, Spectrum operates several residential programs for the Massachusetts Department of Youth Services as well as have state contracts throughout the country to provide specialized programming for criminal offenders with histories of substance abuse.

Our organization has worked directly with Tufts Health Plan and their MCO system as we work to serve all Massachusetts residents. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents

through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sherry A. Ellis', written in a cursive style.

Sherry A. Ellis, LICSW, ACSW

Chief Operating Officer

Office: 774-670-4619

Cell: 508-558-9871

sherry.ellis@spectrumhealthsystems.org

10 Mechanic Street | Worcester, MA 01608



This Is Where It Starts

1095 Main Street
Springfield, MA 01103
(413) 732-5183 Fax: (413) 858-3195
www.startatsquareone.org

Dear Governor Baker,

I am writing on behalf of Square One to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Massachusetts as we work to serve children, families in our communities. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

Square One knows how important this work is. Our vision is to affect meaningful change that results in better lives and more promising futures for children, families and our communities. Square One achieves this vision by raising funds, advocating on behalf of children and families, delivering research-based solutions, and developing needed services that promote education, health, safety, holistic development and self-reliance. As a multi-service organization, every program we deliver and resource we provide is designed to address the unique needs of each child and every family we serve.

Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work Tufts Health Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by Tufts Health Plan and the resources they provide patients directly within their communities would be a blow to our most

vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

A handwritten signature in black ink, appearing to read "Dawn Forbes DiStefano".

Dawn Forbes DiStefano
President & CEO
Square One



April 29, 2021

Dear Governor Baker,

I am writing on behalf of The Guild to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with BMC HealthNet Plan and their MCO system as we work to serve neighborhoods Dorchester, Roxbury and Mattapan of the Greater Boston Area. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

The Guild is a multi-sited social enterprise and development ecosystem — owned and led by people of color. Our work has a proven track record of success through scalable, replicable, public-private partnerships. By healing generations' worth of energetic and emotional scars and embodying a solutions-based spirit toward entrenched disparities imprinted upon the lives of the residents of its community, The Guild is transforming stories of neglect and perceptions of deficiency into a thriving ecosystem of collaborative action and positive impact.

BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work BMC HealthNet Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by BMC HealthNet Plan and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

Sincerely,



Jhana Senxian
President & CEO
The Guild



The Honorable Governor Charlie Baker
Massachusetts State House
Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Vitra Health to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

At Vitra Health, we offer several services for elderly and disabled to ensure individuals maintain their health, wellness and independence – allowing individuals in need or seniors to remain at home with the help of an assigned nurse and case manager. By investing in caregivers, being active within the community, and prioritizing the quality of care above all else, Vitra Health has grown into an innovative healthcare leader that strives to be better each and every day.

Our organization has worked directly with BMC HealthNet Plan and their MCO system here in Massachusetts as we offer services to the elderly and people with disabilities across the Commonwealth. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Like Vitra Health, BMC HealthNet Plan prioritizes personalized outreach and culturally competent care management that we know, not only works for our members, but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. BMC HealthNet Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

As we all work together to continue our work to offer more services, partner in new ways, improve access to Massachusetts' health care system and take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems and companies that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.



Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities and allow them to receive the care they need in their own home. We look forward to continuing our work with MCOs, like BMC HealthNet Plan, on doing just that.

Sincerely,

Max Voshchin
CEO

May 7, 2021



the Business of
Opportunity
Building

35 Mt. Carmel Avenue, Chicopee, MA 01013
413.552.1554 • Fax: 413.532-3237

Stephen C. Huntley,
Executive Director

**Community Action Agency
Serving Chicopee and Holyoke
and Surrounding Communities**

Energy Assistance

Nutrition

Early Education & Care

Youth Services

College Access

Adult Education

Senior Services

Housing

Money Management

Dear Governor Baker,

I am writing on behalf of Valley Opportunity Council (VOC) to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities, and ask that you and your Administration work to preserve this model within the MassHealth system.

Our organization has worked directly with Tufts Health Plan and their MCO system here in Greater Hampden County area as we work to serve low- and moderate-income neighbors, families and friends to achieve greater independence and a higher quality of life. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally-based programs that do the work of operating on the ground in chronically underserved areas.

As a local MCO, Tufts Health Plan prioritizes personalized outreach and culturally competent care management that we know not only works for our residents in need but helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Altering the MCO program would be a devastating blow to our community and the vulnerable residents who rely on it.

Valley Opportunity Council knows how important this work is. In 2020, our annual budget of over \$34 million has been a significant investment in the Holyoke and Chicopee communities by providing services, training, and materials. VOC also represents a significant economic investment in the community as a major employer of over 250 staff members and 155 community partners. VOC reaches 88,000 people of all age groups, backgrounds and circumstances who want to better themselves. More broadly, VOC leads the way for individuals and families to access education and training aimed at developing skills vital to their goals of attaining self-sufficiency.

Tufts Health Plan has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours, in serving our most vulnerable residents and addressing social determinants of health.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

We have seen, firsthand, the important work Tufts Health Plan has done to support our local communities, our residents, and the overall health and well-being of our region - something we have been invested in building for quite some time. Losing the services offered by Tufts Health Plan and the resources they provide patients directly within their communities would be a blow to our most vulnerable residents -- the ones who are already being disproportionately impacted by the pandemic and are always the group at the highest risk of being left behind during any kind of social or health crisis.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Tufts Health Plan, on doing just that.

Sincerely,

Stephen Huntley
Executive Director



Creating a hunger-free community

May 27, 2021

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

I am writing on behalf of Worcester County Food Bank to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

Worcester County Food Bank is one of three Feeding America member food banks in Massachusetts. We are dedicated to engaging, educating, and leading Worcester County, Massachusetts in creating a hunger-free community. We accomplish this through partnerships in our community (including food and fund donors, volunteers, business, and community leaders) and advocating for policies and programs that decrease hunger and increase access to healthy food. During the first 12 months of the pandemic, we, and our network of 115 local pantries and community meal programs distributed 7.7 million lbs. of food to 106,000 of our neighbors in all 60 cities and towns in Worcester County.

Our organization has worked directly with Fallon Health and their MCO system as we work to serve all residents in Worcester County. Fallon Health has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Furthermore, Fallon Health prioritizes personalized outreach and culturally competent care management that helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. The pandemic has shone a glaring light on the inequities that exist in many of our communities, and it has also underscored the

474 Boston Turnpike • Shrewsbury, MA 01545-3948
P: (508) 842-3663 • F: (508) 842-7405
foodbank.org



importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward emerging from this public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. We look forward to continuing our work with MCOs, like Fallon Health, on doing just that.

Sincerely,



Jean G. McMurray
Chief Executive Officer

May 18, 2021

The Honorable Governor Charlie Baker
Massachusetts State House, Room 360
Boston, MA 02133

Dear Governor Baker,

eliminating racism
empowering women
ywca

Central Massachusetts

1 Salem Square
Worcester, MA 01608

P 508.767.2505

F 508.754.0496

15 Grove Street
Westborough, MA 01581

P 508.366.8005

F 508.389.1815

54 Main Street, Suite 001
Leominster, MA 01453

P 978.537.2306

F 978.537.3502

ywcacm.org

I am writing on behalf of YWCA Central Massachusetts to express my support for Massachusetts' Managed Care Organizations (MCO), which play an important role in providing comprehensive care to those most in need right within their communities and ask that this model be preserved within the MassHealth system.

YWCA Central Massachusetts has served as a life-long positive force for women and girls, their families and communities for more than 135 years. The YWCA is committed to eliminating racism, empowering women and promoting peace, justice, freedom and dignity for all. As an organization, we strive to be an all-inclusive women's advocacy and resource center with a pro-active membership serving the diverse needs of women through leadership, service and support. Women come to us for various reasons including in times of crisis, as survivors of domestic violence; career counseling; childcare; and health and wellness. By leveraging the reach, power and passion of our members and supporters, we look for lasting change in our members' lives.

Our organization has worked directly with Fallon Health and their MCO system here in Central Massachusetts as we work to serve women, girls, and their families. The pandemic has shone a glaring light on the inequities that exist in many of our communities and it has also underscored the importance of locally based programs that do the work of operating on the ground in chronically underserved areas.

Fallon Health prioritizes personalized outreach and culturally competent care management that we know not only works for our members but also helps local providers ensure that the varied physical and behavioral health needs of the region are being comprehensively addressed. Fallon Health has partnered with us and other local organizations to administer behavioral and physical care, distribute pandemic supports, connect residents to resources, and much more. They do a tremendous job using on-the-ground knowledge, as well as a deep understanding of organizations like ours. Altering the MCO program would be a devastating blow to our community and other vulnerable residents who rely on it.

Massachusetts' health care system is not perfect, and many aspects need fixing. As we all take steps forward in combating this latest public health emergency, it is imperative that we continue to support local health care systems that not only serve the needs of Massachusetts' most underserved residents through primary care and

behavioral health services but also take steps to adequately address the social determinants of health.

Thank you for the opportunity to share our concerns and comments about the importance of protecting the MCO system in Massachusetts. Now more than ever, we must continue to focus on maintaining systems that give people the opportunity to access quality services across the spectrum of care within their own neighborhoods and communities. We look forward to continuing our work with MCOs, like Fallon Health, on doing just that.

Sincerely,



Linda Cavaoli
Executive Director



May 27, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

I am writing on behalf of the American Federation of Teachers (AFT) Massachusetts, which represents over 23,000 public school teachers, paraprofessionals, librarians, and public higher education faculty and staff across the Commonwealth, to urge you and the Baker Administration to work to invest in and support the state's Managed Care Organizations (MCOs) and their partnerships with Accountable Care Organizations (ACOs) to deliver integrated, coordinated care to the residents and families in need who rely on MassHealth.

Across the state, the MCOs and their ACO partners have worked with regional and local organizations to deliver behavioral and physical health care, distribute pandemic supports, connect residents to resources, and much more. By using on-the-ground knowledge, as well as a deep understanding of the specific needs of different regions and communities, MCOs are not only serving our most vulnerable residents' health needs, but actively addressing social determinants of health.

The COVID-19 pandemic laid bare something many of us already know to be true – there are great inequities that exist in our communities. AFT Massachusetts represents teachers and school support staff in some of our state's most chronically underfunded communities – like Boston and our Gateway Cities, including Lowell, Lynn, Chelsea, Lawrence, and Salem. Due to the structural racism that exists in these underserved communities – which are predominately Black, Latinx, Asian, and Indigenous – our students and their families are not only at a greater risk of being impacted by a crisis, like COVID-19, but have fewer resources to protect them and help them recover.

The pandemic has also underscored the importance of locally-based programs that bring critical support to those most in need at the community level, especially in our hardest hit areas. The state's five, not-for-profit MCOs have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide. This keeps down the rates of unnecessary hospitalizations and ER visits, while reducing the overall costs to the system. Integrated and coordinated health care delivery has provided demonstrable results across our communities and systems. As we take steps to recover from this public health emergency, it is imperative that we continue to build upon the work that the MCOs, their ACO partners and community partners have done to deliver comprehensive care to our most vulnerable residents.

In order to build strong foundations for our students, their families, and communities, the AFT Massachusetts focuses on supporting them both inside and outside of the classroom. We know that in order for a student to be successful at school, they must have the critical supports and services necessary at home and in their neighborhoods. For example, schools are the one place where many of our students can be guaranteed a full meal during their day. When the pandemic hit, our teachers and support staff immediately began working to get food and supplies to these communities, helping our students and families put food on their table during this difficult time.

The MCOs and ACOs have the flexibility to take the same approach – understanding that putting members on a stable path with access to critical services and care helps build a stronger and healthier foundation for our communities. Now more than ever, it is imperative that we direct resources to the systems that take a holistic approach beyond simply delivering medical care as we look to support our most vulnerable families and residents.

As we look to recover from the pandemic and move the Commonwealth forward, we need to make sure our most vulnerable, including our residents and families on MassHealth, are able to access high-quality, comprehensive care they need to survive and thrive – especially if we are serious about making sure no one gets left behind.

Thank you for the opportunity to share our comments about the important role the MCOs and their ACO partners play in delivering critical services to those most in need. We hope these partnerships continue to have the necessary funding and supports to continue their invaluable work.

Sincerely,



Beth Kontos
President, AFT Massachusetts



June 3, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

I am writing on behalf of the Coalition for Social Justice, a grassroots organization founded in 1994 to bring together people affected by and concerned about poverty to advocate for economic opportunity, to urge you and the Baker Administration to maintain state investment in Managed Care Organizations (MCOs), which deliver critical, coordinated care to some of the Commonwealth's most vulnerable residents on MassHealth.

The state's five, not-for-profit MCOs, in partnership with local Accountable Care Organizations (ACOs), work to streamline care for those most in need of services in some of our state's most underfunded regions. MCOs also have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide.

The COVID-19 pandemic laid bare something many of us already know to be true – there are great inequities that exist in our communities. It has also underscored the importance of locally-based programs that bring critical support to those most in need at the community level, especially in chronically underserved areas.

Due to the structural racism that exists in these underserved communities – which are predominately Black, Latinx, Asian, and Indigenous – are not only at a greater risk of being impacted by a crisis, like COVID-19, but have fewer resources to protect them and help them recover.

As we take steps to recover from this public health emergency, it is imperative that we continue to build upon the work that the MCOs, their ACO partners and community partners have done to

deliver comprehensive care to our most vulnerable residents – the residents who are most at risk for being left behind or disproportionately impacted by a crisis like this. By using on-the-ground knowledge, as well as a deep understanding of the specific needs of different regions and communities, MCOs are not only serving our most vulnerable residents' health needs, but actively addressing social determinants of health.

The state's five not-for-profit MCOs, in partnership with local Accountable Care Organizations (ACOs), have worked with regional and local organizations to deliver behavioral and physical health care, distribute pandemic supports, connect residents to resources, and much more. The MCOs and ACOs understand that putting members on a stable path with access to critical services and care – including those not typically thought of as medical care, like emergency housing or food assistance – helps build a stronger and healthier foundation for our communities.

As we look to recover from the pandemic and move the Commonwealth forward, we need to make sure our most vulnerable, including our residents and families on MassHealth, are able to access high-quality, comprehensive care they need to survive and thrive – especially if we are serious about making sure no one gets left behind.

Thank you for the opportunity to share our comments about the important role the MCOs and their ACO partners play in delivering critical services to those most in need. We hope these partnerships continue to have the necessary funding and supports to continue their invaluable work.

Sincerely,

Deb Fastino
Executive Director
Coalition for Social Justice



Greater Boston Labor Council

AFL-CIO

8 Beacon Street, 5th Floor, Boston, MA 02108 • Office: (617) 723-2480 • GBLC.us

Louis A. Mandarin Jr.
President

Darlene Lombos
Executive Secretary-Treasurer

Jessica Tang
Vice President

June 10, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

On behalf of the Greater Boston Labor Council, which represents over 100,000 union members and their families in 24 cities in towns in the region, to urge you and the Baker Administration to maintain and protect the state's Managed Care Organizations (MCOs), which deliver integrated and coordinated care to tens of thousands of residents and families on MassHealth.

The Greater Boston Labor Council's mission is to improve the lives of working families within the 24 communities while working within each of those communities to help fight for social, economic, and racial justice.

This pandemic has shined a light on what many of us already know to be true – there are great inequities that exist in our communities, especially for low-income, working families. The pandemic has also underscored the importance of locally-based programs that bring critical support to those most in need at the community level, especially in chronically underserved areas.

Across Massachusetts, the state's five not-for-profit MCOs, in partnership with the state's Accountable Care Organizations (ACOs), work with regional and local organizations to deliver comprehensive care to those most in need – addressing the physical, behavioral, and emotional health needs of their patients right within the safety of their own communities.

Serving: Arlington • Belmont • Boston • Brookline • Cambridge • Chelsea • Everett • Lexington • Lincoln • Malden • Medford • Melrose
Needham • Newton • Revere • Somerville • Stoneham • Waltham • Watertown • Wellesley • Weston • Winchester • Winthrop • Woburn



Louis A. Mandarinini Jr.
President

Darlene Lombos
Executive Secretary-Treasurer

Jessica Tang
Vice President

MCOs serve some of our state’s most chronically underfunded communities. Due to longstanding underfunding and the structural racism that exists in these cities – which are predominately Black, Latinx, Asian, and Indigenous – these residents and families are not only at a greater risk of being impacted by a crisis, like COVID-19, but they have fewer resources to protect them and help them recover.

On top of delivering coordinated care, MCOs stepped up during this unprecedented time to distribute pandemic supports, connect residents to additional critical resources, and much more. By using on-the-ground knowledge, as well as a deep understanding of the specific needs of different regions and communities, MCOs are not only serving our most vulnerable residents’ health needs, but actively addressing social determinants of health.

MCOs have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide. This keeps down the rates of unnecessary hospitalizations and ER visits, while reducing the overall costs to the system.

Integrated and coordinated health care delivery has provided demonstrable results across our communities and systems. As we take steps to recover from this public health emergency, it is imperative that we continue to build upon the work that the MCOs, their ACO and community partners have done to deliver comprehensive care to our most vulnerable residents.

The pandemic has starkly demonstrated health inequities and the importance of addressing not only physical and behavioral health care needs, but also other emergency services housing and food assistance. Putting individuals on a stable path with critical services and preventative care can help build a foundation for healthier outcomes – for our patients and our communities. The MCOs and ACOs have the flexibility to deliver a full array of these types of services beyond simply delivering medical care.

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Greater Boston Labor Council

AFL-CIO

8 Beacon Street, 5th Floor, Boston, MA 02108 • Office: (617) 723-2480 • GBLC.us

Louis A. Mandarinini Jr.
President

Darlene Lombos
Executive Secretary-Treasurer

Jessica Tang
Vice President

Thank you for the opportunity to share our comments about the importance of the MCOs and their ACO partners in delivering services to MassHealth members. It is important that these partnerships be given appropriate funding and support to continue their work. Now more than ever, we must ensure that our citizens are receiving high quality, comprehensive care that recognizes the need to address social determinants of health in our communities.

Sincerely,

Darlene Lombos
Chief Officer and Executive Secretary-Treasurer
Greater Boston Labor Council



NEW ENGLAND STUDIO MECHANICS

IATSE Local 481

*International Alliance of Theatrical Stage Employees, Moving Picture Technicians,
Artists and Allied Crafts of the United States, Its Territories, and Canada, AFL-CIO, CLC*

*10 Tower Office Park, Suite 218
Woburn, MA 01801*

Phone 781-376-0074

Fax 781-376-0078

June 7, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

I am writing on behalf of International Alliance of Theatrical Stage Employees, Moving Picture Technicians, Artists, and Allied Crafts (IATSE) Local 481 and the members and working families we represent to urge you and the Baker Administration to continue to support the state's Managed Care Organizations (MCOs), which deliver critical, coordinated care to some of the Commonwealth's most vulnerable residents and working families on MassHealth.

Since 1989, IATSE Local 481 has represented the technicians and craftspeople who work on a diverse range of motion picture productions throughout New England, including across Massachusetts. The over 1,100 men and women of our union are the ones working behind the camera on everything from feature films and episodic television shows being shot here to documentaries to music videos and more. As longtime advocates for working families, we know how important it is to ensure continuity – in terms of employment opportunities, services, and access to critical care and benefits – especially during a public health crisis of this magnitude.

The state's five, not-for-profit MCOs, in partnership with local Accountable Care Organizations (ACOs), work to streamline care for those most in need of services in some of our state's most underfunded regions. MCOs also have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide.

The COVID-19 pandemic laid bare something many of us already know to be true – there are great inequities that exist in our communities. It has also underscored the importance of locally-based programs

that bring critical support to those most in need at the community level, especially in chronically underserved areas.

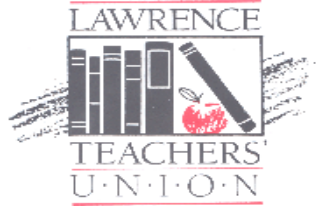
The MCOs have worked with regional and local organizations to deliver behavioral and physical health care, distribute pandemic supports, connect residents to resources, and much more. The MCOs and ACOs understand that putting members on a stable path with access to critical services and care – including those not typically thought of as medical care, like emergency housing or food assistance – helps build a stronger and healthier foundation for our communities. By using on-the-ground knowledge, as well as a deep understanding of the specific needs of different regions and communities, MCOs are not only serving our most vulnerable residents' health needs, but actively addressing social determinants of health.

Thank you for the opportunity to share our comments about the important role the MCOs and their ACO partners play in delivering critical services to those most in need. Now more than ever, we need to be fighting for the programs and services that will not only help working families get past this pandemic, but put them on a path to grow and thrive within their own communities.

Sincerely,

A handwritten signature in cursive script, appearing to read "Chris O'Donnell".

Chris O'Donnell
Business Manager



May 27, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

I am writing on behalf of the Lawrence Teachers Union, Local 1019, AFT Massachusetts, AFL-CIO, which represents all teachers, registered nurses, long-term substitutes, and building-based educators in the city's public schools to urge you to continue to support the state's Managed Care Organizations (MCOs), which deliver integrated, coordinated care to the residents and families in need who rely on MassHealth.

The state's five MCOs, in partnership with local Accountable Care Organizations (ACOs), have worked with regional and local organizations to deliver behavioral and physical health care, distribute pandemic supports, connect residents to resources, and much more. Our students and their families have accessed these services themselves through Allways Health Partners and their MCO, which provides area MassHealth patients care and coverage. By using on-the-ground knowledge and collaborating with local organizations with deep understandings of the specific needs of our region – including Lawrence General Hospital and the Greater Lawrence Family Center – Allways and their MCO are not only serving our most vulnerable, but actively addressing social determinants of health.

The COVID-19 pandemic laid bare something many of us already know to be true – there are great inequities that exist in our communities. As one of the state's most chronically underfunded communities, the city of Lawrence is always at risk when facing a crisis of this magnitude – and this pandemic was not an exception. Due to the structural racism that exists in underserved, predominately Latinx communities like Lawrence, our students and families are not only at a greater risk of being gravely impacted by this crisis – physically, emotionally, and financially – but have fewer resources to protect themselves and recover.

While we are always dedicated to serving our students and their families by providing additional supports outside of the classroom, I am proud to say that we have ramped up our efforts to

provide key resources – food, school supplies, winter clothing, etc. – during the pandemic, when many Lawrence residents have lost jobs and income.

The pandemic has also underscored the importance of locally-based programs that bring critical support to those most in need at the community level, especially in our hardest hit areas. The state's five, not-for-profit MCOs have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide.

As we take steps to recover from this public health emergency, it is imperative that we continue to build upon the work that the MCOs, their ACO partners and community partners have done to deliver comprehensive care to our most vulnerable residents – the residents who are most at risk for being left behind or disproportionately impacted by a crisis like this.

As teachers, we know that in order for a student to be successful at school, they must have the critical supports and services necessary at home and in their neighborhoods. For example, schools are the one place where many of our students can be guaranteed a full meal during their day. When the pandemic hit, our teachers and support staff immediately began working to get food and supplies to these communities, helping our students and families put food on their table during this difficult time.

The MCOs and ACOs have the flexibility to take the same approach – understanding that putting members on a stable path with access to critical services and care helps build a stronger and healthier foundation for our communities. Now more than ever, it is imperative that we direct resources to the systems that take a holistic approach beyond simply delivering medical care as we look to support our most vulnerable families and residents.

As we look to recover from the pandemic and move the Commonwealth forward, we need to make sure our most vulnerable, including our residents and families on MassHealth, are able to access high-quality, comprehensive care they need to survive and thrive – especially if we are serious about making sure no one gets left behind.

Thank you for the opportunity to share our comments about the important role the MCOs and their ACO partners play in delivering critical services to those most in need. We hope these partnerships continue to have the necessary funding and supports to continue their invaluable work.

Sincerely,

Kimberly Barry
President, Lawrence Teachers Union



June 3, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

As the Director of the Massachusetts Communities Action Network, a federation of faith-based community improvement organizations with affiliate groups throughout the state working to bring about change and progress at the local level, I've spent decades advocating for programs and investments to lift up our underserved residents and families within their own communities.

I am writing to you today to urge you and the Baker Administration to maintain and invest in our state's five not-for-profit Managed Care Organizations (MCOs), which deliver critical, coordinated care to some of the state's most vulnerable residents on MassHealth.

The state's five, not-for-profit MCOs, in partnership with local Accountable Care Organizations (ACOs), *work to streamline care for those most in need of services in some of our state's most underfunded regions.* MCOs also have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide.

The COVID-19 pandemic laid bare something many of us already know to be true – there are great inequities that exist in our communities. It has also underscored the importance of locally-based programs that bring critical support to those most in need at the community level, especially in chronically underserved areas.

Due to the structural racism that exists in these underserved communities – which are predominately Black, Latinx, Asian, and Indigenous – are not only at a greater risk of being impacted by a crisis, like COVID-19, but have fewer resources to protect them and help them recover.


As we take steps to recover from this public health emergency, it is imperative that we continue to build upon the work that the MCOs, their ACO partners and community partners have done to deliver comprehensive care to our most vulnerable residents – the residents who are most at risk for being left behind or disproportionately impacted by a crisis like this. By using on-the-ground knowledge, as well as a deep understanding of the specific needs of different regions and communities, MCOs are not only serving our most vulnerable residents' health needs, but actively addressing social determinants of health.

The MCOs have worked with regional and local organizations to deliver behavioral and physical health care, distribute pandemic supports, connect residents to resources, and much more. The MCOs and ACOs understand that putting members on a stable path with access to critical services and care – including those not typically thought of as medical care, like emergency housing or food assistance – helps build a stronger and healthier foundation for our communities.

As we look to recover from the pandemic and move the Commonwealth forward, we need to make sure our most vulnerable, including our residents and families on MassHealth, are able to access high-quality, comprehensive care they need to survive and thrive – especially if we are serious about making sure no one gets left behind.

Thank you for the opportunity to share our comments about the important role the MCOs and their ACO partners play in delivering critical services to those most in need. We hope these partnerships continue to have the necessary funding and supports to continue their invaluable work.

Sincerely,



Lew Finfer
Founder and Special Projects Director
Massachusetts Communities Action Network



May 20, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

I am writing on behalf of the Massachusetts Nurses Association (MNA), which represents over 23,000 registered nurses and health professionals across the Commonwealth, to urge you and the Baker Administration to work to invest in and support the state's Managed Care Organizations (MCOs) and their partnerships with Accountable Care Organizations (ACOs) to deliver integrated, coordinated care to MassHealth members.

The MNA is the largest union and professional association of registered nurses and health professionals in the state, and the third largest in the nation, representing more than 23,000 members working in 85 health care facilities, including 51 acute care hospitals, as well as a growing number of nurses and health professionals working in schools, visiting nurse associations, public health departments, and state agencies.

This pandemic has shined a light on what many of us already know to be true – there are great inequities that exist in our communities, especially for low-income, working families. The pandemic has also underscored the importance of locally-based programs that bring critical support to those most in need at the community level, especially in chronically underserved areas.

At the MNA, we are dedicated to improving and increasing the availability of health care services for all people across the state. Through our work to support our registered nurses and health care professionals and provide them with the skills and resources they need to be the best that they can be, we've spent over a hundred years working to ensure patients across the Commonwealth get the care they need and deserve.

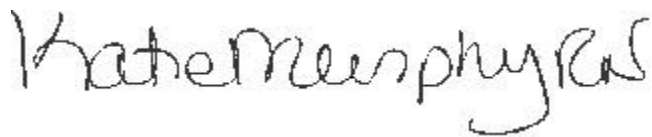
Across the state, the MCOs and their ACO partners have worked with regional and local organizations to deliver behavioral and physical health care, distribute pandemic supports, connect residents to resources, and much more. By using on-the-ground knowledge, as well as a deep understanding of the specific needs of different regions and communities, MCOs are not only serving our most vulnerable residents' health needs, but actively addressing social determinants of health.

The state's five, not-for-profit MCOs have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide. This keeps down the rates of unnecessary hospitalizations and ER visits, while reducing the overall costs to the system – providing our nurses and other medical professionals on the frontline the ability to care for those in need of immediate services without having to also help patients who would have been better served elsewhere in the health care system. Obviously, this increase in access to care and decrease in costs benefits the community as a whole – especially during a pandemic.

Integrated and coordinated health care delivery has provided demonstrable results across our communities and systems. As we take steps to recover from this public health emergency, it is imperative that we continue to build upon the work that the MCOs, their ACO partners and community partners have done to deliver comprehensive care to our most vulnerable residents. The pandemic has starkly demonstrated health inequities and the importance of addressing not only physical and behavioral health care needs, but also other emergency needs like housing and food assistance. Putting individuals on a stable path with critical services and preventative care can help build a foundation for healthier outcomes – for our patients and our communities. The MCOs and ACOs have the flexibility to deliver a full array of these types of services beyond simply delivering medical care.

Thank you for the opportunity to share our comments about the importance of the MCOs and their ACO partners in delivering services to MassHealth members. It is important that these partnerships be given appropriate funding and support to continue their work. Now more than ever, we must ensure that our citizens are receiving high quality, comprehensive care that recognizes the need to address social determinants of health in our communities.

Sincerely,

A handwritten signature in black ink that reads "Katie Murphy RN". The signature is written in a cursive, flowing style.

Katie Murphy, RN
President, Massachusetts Nurses Association



June 2, 2021

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

I am writing on behalf of the National Association of Government Employees (NAGE), which represents 22,000 state workers in 60 agencies throughout state government, to urge you and the Baker Administration to continue your investment and support of the state's Managed Care Organizations (MCOs) that, in partnership with Accountable Care Organizations (ACOs), deliver integrated, coordinated care to hundreds of thousands of residents and families on MassHealth.

Our union was started by people organizing for economic security, dignity, and respect. To this day, the men and women of NAGE remain on the frontlines in the struggle for social and economic justice. For decades, we've worked to not only improve the lives of our workers and their families, but to also help create a more just and humane society for all.

The COVID-19 pandemic showed us all that there is still much work that needs to be done to address critical inequities in our communities across the state. In order to secure a path forward for all families, we need to start at the local level. That's why we need to continue to invest in on-the-ground programs to serve our most vulnerable residents – which is exactly what the state's five MCOs and their ACO partners have been doing. Working specifically in underserved communities, they're collaborating with regional and local organizations to deliver behavioral health and physical health care, distribute pandemic supports, connect residents to critical resources, and much more.

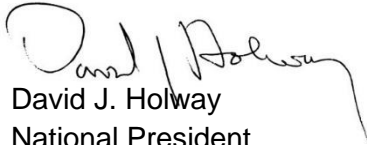
Under the current waiver, more MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide. MCOs have a higher success rate of connecting at-risk, underserved patients with the life-saving supports and services they need within the health care system, including behavioral and mental health services. Integrated and coordinated health care delivery has provided demonstrable results across our communities and systems. As we take steps to recover from this public health emergency, it is imperative that we continue to build upon the work that the MCOs, their ACO partners and community partners have done to deliver comprehensive care to our most vulnerable residents.

As we know, a variety of components play into the success of our families and communities. The MCOs and ACOs have the flexibility to address more than access to care. They're working to directly connect our families with the critical care and local services to put them on a stable path, while building a stronger and healthier foundation for our communities. Now more than ever, it is imperative that we direct resources to these systems that take a holistic approach beyond simply delivering medical care as we look to support our most vulnerable families and residents.

As we look to recover from the pandemic and move the Commonwealth forward, we need to make sure our most vulnerable, including our residents and families on MassHealth, are able to access high-quality, comprehensive care they need to survive and thrive – especially if we are serious about making sure no one gets left behind.

Thank you for the opportunity to share our comments about the important role the MCOs and their ACO partners play in delivering critical services to those most in need. We hope these partnerships continue to have the necessary funding and supports to continue their invaluable work.

Sincerely,



David J. Holway
National President

National Association of Government Employees



Teamsters Local Union No. 25

affiliated with the

International Brotherhood of Teamsters

544 MAIN STREET • BOSTON, MASSACHUSETTS 02129-1113 • (617) 241-8825 • Fax (617) 242-4284
www.teamsterslocal25.com

June 3, 2021

SEAN M. O'BRIEN
President/Principal Officer

THOMAS G. MARI
Secretary-Treasurer

STEVEN J. SOUTH
Vice President/Business Agent

PETER S. BERRY
Recording Secretary

JOHN J. JUSZKIEWICZ, III
Trustee

JOHN F. GILLIS
Trustee

ROSS H. MCDONAGH
Trustee

JOHN A. MURPHY
Business Agent

ROBERT J. AIGUIER, JR.
Business Agent

JASON A. LOPES
Business Agent

JOAN C. COREY
Business Agent

ANDREW P. WALSH
Business Agent

MICHAEL C. HALLEY
Field Representative

JOSEPH F. FOTI
Field Representative

Mr. Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health & Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Dear Assistant Secretary Tsai,

I am writing on behalf of the Teamsters Local 25, which represents over 12,000 workers and their families across the Commonwealth, to urge you and the Baker Administration to work to invest in and support the state's five, not-for-profit Managed Care Organizations (MCOs) and their partnerships with Accountable Care Organizations (ACOs) to deliver integrated, coordinated care to MassHealth members.

This pandemic has made it impossible to ignore what many of us already know to be true – there are great inequities that exist in our communities, especially for low-income, working families. We have also seen this last year that the best way to help our most vulnerable and underserved residents is to bring them critical services directly – within their own communities. Otherwise, those most in need are at an even greater risk for slipping through the cracks.

We know MCOs have a higher success rate of connecting at-risk, underserved patients with the lifesaving supports and services they need within the health care system, including behavioral and mental health services. If we are serious about serving the most in need, the focus should remain on ensuring MassHealth patients have access to MCO plans and the direct connection to a network of coordinated services they provide.

Across the Commonwealth, MCOs have worked with regional and local organizations to deliver behavioral and physical health care, distribute pandemic supports, connect residents to resources, and much more. By using on-the-ground knowledge, as well as a deep understanding of the specific needs of different regions and communities, MCOs are not only serving our most vulnerable residents' health needs, but actively addressing social determinants of health.



The pandemic has starkly demonstrated health inequities and the importance of addressing not only physical and behavioral health care needs, but also other emergency services housing and food assistance. Putting individuals on a stable path with critical services and preventative care can help build a foundation for healthier outcomes – for our patients and our communities. The MCOs have the flexibility to deliver a full array of these types of services beyond simply delivering medical care.

By delivering comprehensive care and supports, our already overburdened medical centers and brothers and sisters working on the frontlines will see fewer unnecessary hospitalizations and ER visits, while reducing the overall costs to the system. Obviously, this increase in access to care and decrease in costs and capacity benefits not just the patient and medical community, but the Commonwealth as a whole.

Maintaining and investing in these services is not only important, it's imperative if we are going to help lift up all of our residents as we try to come out on the other end of this pandemic. We should all be focused on supporting critical services and expanding access to care for those most in need, including those with developmental disabilities and their families. Fighting for working families, especially those grappling with special needs and services has been a hallmark not only of my career, but is a key foundation of our union's mission – one our brothers and sisters work every day to uphold.

As you may know, Teamsters Local 25 has been the premier fundraiser for Autism Speaks since 2007. As a member of their Board of Directors, I am proud of our work to lobby the state on behalf of families affected by autism and the role we played in fighting for insurance reform to require insurers to pay for autism-related expenses.

Now more than ever, we must ensure that our working families and those in need are receiving high-quality, comprehensive care that recognizes the specific needs within each community and gives people the resources and supports to not improve their quality of life but help them thrive in their communities.

Thank you for the opportunity to share our support for the work the state's MCOs and ACOs do to serve our communities, our working families, and our most vulnerable friends and neighbors.

Sincerely,



Sean M. O'Brien
President/Principal Officer

MCO Values Videos – Links to Final Videos

- **Video #2 - Building Strong Community Relationships**
<https://vimeo.com/565702539/985f76c4e3> (Tufts)
- **Video #3A – A Different Way to Care for People** <https://vimeo.com/565710395/cc87072a0a>
(Fallon, BMCHP, Tufts, HNE)
- **Video #3B – Doing More for Members** <https://vimeo.com/565719307/f5f9c506b2> (HNE)
- **Video #4A – Addressing Disparities in Care During COVID-19**
<https://vimeo.com/565724390/224937bbb6> (Tufts, BMCHP)
- **Video #4B – Caring for the Homeless During the COVID-19 Pandemic**
<https://vimeo.com/565728163/f0508960aa> (AllWays)
- **Video #5A – Integrating Behavioral Health and Complex Care**
<https://vimeo.com/565742690/0acd224f3d> (BMCHP, HNE, AllWays)
- **Video #5B – One Patient’s Story** <https://vimeo.com/565746204/a8d85115ee> (BMCHP)
- **Video #5C – Impact on Real Members** <https://vimeo.com/565758961/8aaf8f3f26> (Fallon)
- **Video #6 – Closing the Health Equity Gap – Housing** <https://vimeo.com/565761151/cb04f1755a>
(HNE and BMCHP)
- **Video #7 – Closing the Health Equity Gap – Food Insecurity**
<https://vimeo.com/565766150/35c8d94ff5> (Tufts, HNE, BMCHP, AllWays)
- **Video #8 – Creating a Safe Environment** <https://vimeo.com/565770363/30532dc5f3> (HNE)
- **Video #9 – Equity and Inclusion** <https://vimeo.com/565791606/542c6d037c> (BMCHP, HNE, Tufts)



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milliman.com

August 3, 2021

Sarah G. Chiaramida, Esq.
 Senior Vice President, Health Policy
 Massachusetts Association of Health Plans
 40 Court Street, Suite 550
 Boston, MA 02108

[Sent via email: chiaramida@mahp.com]

Re: Massachusetts 1115 Waiver Review

Dear Sarah:

It was a pleasure speaking with you and the managed care organizations (MCOs) about your concerns regarding Massachusetts' goals for the next 1115 waiver, which may include significant changes in care delivery and financial efficiencies for Model A. This letter outlines the concerns shared by the MCOs and additional clarification requested regarding the information shared to date by MassHealth regarding the differences between Model A and Model B. We understand that this letter will be shared with MassHealth to continue the discussion around potential changes to the program under the next 1115 waiver.

BACKGROUND AND SCOPE

MassHealth currently has a 1115 waiver for a five-year Delivery System Reform Incentive Program (DSRIP). The program started in state fiscal year (SFY) 2018, with the goal to support integration between MCOs and accountable care organizations (ACOs). MassHealth created three separate models to support this goal. Model A (Partnership Plans) and Model B (Primary Care ACOs) are anticipated to continue into the next version of the 1115 waiver. Model C (MCO Administered ACOs) is unlikely to continue after the initial five-years.

On December 15, 2020 MassHealth shared an analysis of the costs during Federal Fiscal Year (FFY) 19 between Models A and B, as summarized in Figure 1 below. The full presentation from the December 15, 2020 strategy meeting is included in this letter as Attachment A, with Figure 1 below shared on Slide 8.

Figure 1 - MassHealth Analysis on Cost of Models A and B

	Average PMPM before accounting for EOHHS cost (FFY19)		
	Medical ¹	Non-medical ²	Total
Model A	~\$488	~\$39	~\$527
Model B	~\$487	~\$11	~\$498
Model A / B	100%	342%	106%

- Controlling for differences in population mix and acuity, average PMPM for Model A ACOs is 6%, or ~\$29 PMPM, higher than Model B
 - Medical spend is similar; difference driven entirely by higher non-medical payments
- **After accounting for fixed and variable costs incurred by EOHHS above and beyond non-medical payments³, Model A remains 4% more costly than Model B**

For the time period studied, MassHealth concluded that:

- Model A and Model B medical costs were roughly the same between the two models
- Model A had significantly higher non-medical costs than Model B

Based on the analysis, MassHealth anticipates setting additional requirements for MCOs in the future, such as care delivery, innovation, and integration standards. MassHealth is also considering setting additional financial efficiencies for Model A to bring the two models into “cost parity” for MassHealth.

MAHP asked Milliman to conduct an analysis of the information provided by MassHealth. To understand the Model A MCOs concerns around the analysis and other information shared in the December 15, 2020 strategy presentation, Milliman conducted interviews with each of the five MCOs in Model A: Always Health Partners, Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Health New England, and Tufts Health Plan.

Based on our review of the information provided and our conversations with the MCOs, at a high level, we do not believe that MassHealth has provided enough information or detail to conduct the analysis requested and determine if the methodology used by MassHealth is reasonable and appropriate for use in making major program decisions. **If MassHealth intends to use this analysis to make major policy decisions based on the outcomes, we suggest that MassHealth provide either additional information around the analysis performed or additional analysis that further supports the conclusion that Model A is more expensive than Model B.** The following information is necessary to better understand the analysis:

- Considerations of additional savings achieved after FFY 2019
- Analysis of the impact of COVID-19
- Additional detail on the normalization between Model A and Model B to allow for a comparison between the two models
- Additional detail regarding what’s included in the Model A and Model B administrative costs
- Considerations around any other differences between Model A and Model B that may affect this comparison

Once this information is provided, we will review and provide additional thoughts or questions regarding the analysis performed.

The remainder of this letter outlines the concerns shared by the MCOs during these meetings and provides more detail regarding the additional information or clarifications needed to fully understand the comparison performed by MassHealth.

ADDITIONAL INFORMATION NEEDED AND MCO CONCERNS

Medical Cost Comparison

1. **Use of FFY 2019 data for the analysis:**
 - a. The current 1115 Waiver program was launched by MassHealth on March 1, 2018 with the focus on providing integrated care for beneficiaries through ACOs. The comparison of service and administrative costs was performed on October 2018 to September 2019 (FFY19) data, which may be premature data upon which to draw conclusive comparisons between Model A and Model B.

- i. Specifically, it takes time to start to realize savings through MCO and ACO initiatives to manage a beneficiary's care. The medical costs shown in Figure 1 for Model A may be higher than the same set of services would cost in future years after plans are able to implement their initiatives for a number of reasons, including but not limited to:
 1. For the first 90 days of the program there were continuity of care contractual requirements, limiting the initial management efforts of the MCOs. Therefore, the managing of care of beneficiaries could not begin in earnest until June 1, 2018.
 2. At the beginning of the program there was significant movement of beneficiaries between MCOs due to initial mis-attribution of members. While a beneficiary may have been in the program since March 2018, if they were not enrolled in their ultimate MCO until later in the year, their care was not able to be managed until that time.
 3. It takes time to build relationships, systems, and protocols between the MCOs and ACOs to start to drive savings. Therefore, the impact of the ACOs partnering with MCOs to drive savings may not be fully realized as early in the program as FFY19. For example, some of the contracts between MCOs and ACOs stepped into shared savings models overtime, first starting with pay-for-reporting and then transitioning into pay-for-performance models.

The MCOs acknowledge that it is difficult to look at recent data due to the COVID-19 pandemic; however, they would encourage MassHealth to not make premature decisions about the future of the 1115 waiver based solely on one year of data from the beginning of the program.

2. Normalization between Model A and Model B:

- a. There are many differences between Model A and Model B that should be normalized for in order to compare the service costs to one another. The MCOs request additional transparency as to how the following items were adjusted for in the Model A vs. Model B comparison shared by MassHealth.
 - i. Geographic Area: The cost of providing services to beneficiaries can vary by geographic area due to differences in provider sophistication (service mix differences), provider contracting (unit cost differences) and provider access (utilization differences), among other things.
 - ii. Population Mix: Due to the unique nature of the ACOs in Model A vs. Model B, there are material differences in the make-up of the beneficiaries in the two Models. For example, there is a pediatric ACO in Model A without a corresponding pediatric ACO in Model B. While risk adjustment helps to normalize for differences in population mix, no risk adjustment mechanism is perfect. In particular, risk adjustment mechanisms typically under predict the relative acuity for members with chronic conditions and over predict the relative acuity for low cost members. How did MassHealth adjust for these population mix differences, and what was the predictive value of the risk scoring within each model?
 - iii. Auto-assignment Differences: In other states, we typically observe that members that do not select a plan and are auto-assigned have lower than average acuity. If there was a difference in the type or proportion of members auto-assigned between Model A vs. Model B, there may be material differences between the comparison given that there is not any historical data to normalize these members using a risk scoring methodology. For

example, if a larger portion of auto-assignment members are being assigned to Model B and their costs are lower than the average cost of the existing population in the program, these members could bring down the overall costs of Model B.

- b. It is our understanding that Models A and B have been administered using differing risk adjustment methodologies. Can MassHealth please provide additional details on how these differences were accounted for, while risk adjusting the service costs in the analysis?

Non-Medical Cost Comparison

The MassHealth comparison reports that Model A non-medical expenses in FFY19 were approximately \$39 per-member-per-month (PMPM) compared to approximately \$11 PMPM in Model B. The MCOs request additional transparency in the calculation of both the Model A and Model B non-medical PMPMs to ensure they are on a comparable basis.

1. Model A

- a. In a review of the calendar year (CY) 2019 NAIC annual statements for the five MCOs, the average administrative PMPM, net of taxes and fees, was \$34.80 PMPM as reported on the 'Underwriting and Investment Exhibit Part 3 – Analysis of Expenses' page of the annual statement. To help understand the difference between the NAIC reported administrative costs and the \$39 PMPM referenced by MassHealth the following information is requested:
 - i. Does the \$39 PMPM in the analysis only include the allowance for MCO administrative functions or does it also include the underwriting gain?
 1. If underwriting gain is included, should it be removed? MCOs are taking the risk for adverse deviation from projected costs in return for an inclusion of an underwriting gain. Conversely, the Model B does not take on the same level of risk. Including the underwriting gain as part of the basis of comparison may not be appropriate given this difference.

2. Model B

- a. Please provide additional detail on the types of expenses included in the Model B comparison. Did MassHealth include considerations for allocation of agency resources to the administration of Model B, including but not limited to the following functions?
 - i. Claim adjudication
 - ii. Program integrity
 - iii. Provider credentialing
 - iv. Customer service
 - v. Enrollment and educational requirements
 - vi. Reporting (financial, quality, etc.)
 - vii. Contract compliance activities
 - viii. Preparation and participation in MassHealth meetings, calls, etc.
- b. Please clarify where in the comparison any shared savings payables or receivables from the Model B ACOs are reported in the comparison, service costs or administrative costs.
- c. Does the \$11 PMPM include Executive Office of Health and Human Services (EOHHS) funded services and services funded by DSRIP, or only those funded by EOHHS?

- d. Did the state consider the additional administrative costs to the state if a significant number of additional members are covered under Model B?

Other Considerations

1. **MCO Value:** The MCOs bring extensive experience providing beneficiary care that may not be apparent in a purely financial comparison between Model A and Model B. Has MassHealth evaluated the value of non-financial items between Model A and Model B, including but not limited to the following examples?
 - a. **Customer Service:** Positive customer service experiences can help to ensure that beneficiaries understand and are engaged in their healthcare decisions. The MCOs spend significant resources ensuring that if a beneficiary has plan resources available to them and if a question or issue arises there is access to customer service representatives that can promptly assist the individuals.
 - b. **Case Management:** MCOs work to coordinate the care and management of each member. This is accomplished through activities such as:
 - i. Identification of medication adherence barriers.
 - ii. Assigning each member to a team trained in a patient-centered approach.
 - iii. Review of pharmacy data layered with ACO site attribution to proactively manage high-risk patients through transitions to ensure continuation of medication therapy.
 - iv. Assisting members who have issues accessing medication.
 - v. Care transition assessment support.
 - vi. Medication adherence management.
 - vii. Managing members who lack housing stability to ensure smooth transitions to and from hospitals, transitional shelters, and homeless shelters.
 - viii. High touch interaction for members with high and rising risks, as well as members who are pregnant, post-partum, have cancer or transplants.
 - c. **Quality Metrics:** The MCOs are continuously engaging with their ACO partners to help facilitate the highest quality care is provided to their beneficiaries. Has MassHealth reviewed recent comparisons of quality metrics between Model A and Model B?
 - d. **Provider Data Feeds:** Having complete and accurate data is a huge contributor to a primary care physician (PCP) at an ACO being able to manage the complete care of a patient. The MCOs have established data feeds with their ACO partners to allow them to access this data on a timely basis.



NEXT STEPS

The MCOs request a call with MassHealth to walk through the concerns outlined in this letter. Once additional details are provided regarding the analysis, we can review and provide additional feedback.

CAVEATS AND LIMITATIONS

We prepared this letter for the specific purpose of providing concerns around the state analysis of Model A and Model B costs. It may not be appropriate, and should not be used, for other purposes.

This letter is intended solely for the internal use and benefit of the Massachusetts Association of Health Plans (MAHP), and it is only to be relied upon by MAHP. Milliman recognizes this letter may be shared with the State; however, Milliman does not intend to benefit, and assumes no duty or liability to, parties other than MAHP who receive this work. We understand that this letter will be shared with Massachusetts capitated plans. This material should only be distributed and reviewed in its entirety.

In preparing this letter, we relied on data and information from MAHP, the Massachusetts health plans, and the State. We did not audit any of the data sources or other information. If the data or other information used is inadequate or incomplete, the results will be likewise inadequate or incomplete.

The results of this letter are technical in nature and is dependent upon specific assumptions and methods provided by the State. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Andrew Gaffner and Jill Bruckert are actuaries at Milliman and members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial communication contained herein. To the best of our knowledge and belief, this communication is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This letter is subject to the terms in our Consulting Services Agreement with the Massachusetts Association of Health Plans effective January 1, 2012.



Sarah, please let us know if you have any questions about anything contained in this letter. Thank you for the opportunity to assist MAHP with your concerns.

Best regards,

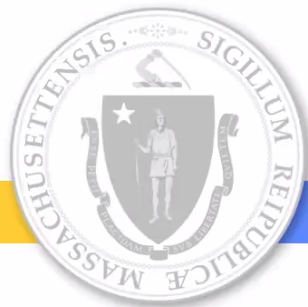
Andrew L. Gaffner, FSA, MAAA
Principal and Consulting Actuary

Jill A. Bruckert, FSA, MAAA
Senior Consulting Actuary

ALG/JAB/bl

Attachment

FOR POLICY DEVELOPMENT PURPOSES ONLY



MassHealth Payment and Care Delivery Reform: Strategic Design Meeting #3

Executive Office of Health & Human Services

Discussion document
December 15, 2020

- Content of this presentation represents a potential framework for payment and care delivery reform presented for group discussion as part of an iterative process for policy development.
- The information presented is initial view intended for working discussion session and does not represent or predict EOHHS final decisions.

Guidance for Participants for Virtual Meetings

- Be aware that members of the public are observing this meeting
- Please mute yourself when not speaking, and please be aware that your background is visible when the camera is on
- If you are joining via zoom online, please activate your camera
- If you are a selected Work Group member joining by phone and have not already done so, please email your phone number to Alysa St. Charles (Alysa.StCharles@umassmed.edu) so that you may be granted appropriate permissions
- Please be mindful of background noise, and please position your camera appropriately so that you are visible
- Please avoid multi-tasking
- Chat is only available for selected Work Group participants.
- When you speak, please be sure to share your name and organization, if applicable
- For IT issues, or for feedback on session logistics, please use the chat feature to message us or contact Alysa St. Charles (Alysa.StCharles@umassmed.edu)

Today's Facilitators

- Aditya Mahalingam-Dhingra – Chief, Office of Payment and Care Delivery Innovation
- Ipek Demirsoy – Chief Accountable Care, Analytics and Systems Officer
- Christie Hager – Interim Director, Behavioral Health
- Kaha Hizanishvili – Chief, Provider and Pharmacy Programs

Agenda

Last Time	Focus of Today
<ul style="list-style-type: none"><li data-bbox="272 415 643 451">▪ Evolving ACO Models<li data-bbox="272 474 643 506">▪ Care Coordination	<ul style="list-style-type: none"><li data-bbox="841 415 1149 451">▪ ACO Recap<li data-bbox="841 474 1149 506">▪ Behavioral Health<li data-bbox="841 529 1149 569">▪ Pharmacy

Goals for the next 1115 waiver

MassHealth has identified five preliminary goals for the next waiver:

1. **Continue the path of restructuring and re-affirm accountable, value-based care** – holding a high bar for how ACOs improve care and trend management, and refining the model
2. Make reforms and investments in **Primary Care, Behavioral Health and Pediatric Care** that expand access and move the delivery system away from siloed, fee-for-service health care
3. **Advance health equity**, with a focus on initiatives **addressing health-related social needs** and specific disparities, including **maternal health** and health care for **justice-involved** individuals
4. **Sustainably support the Commonwealth's safety net** – including level, predictable funding for safety net providers, with a continued linkage to accountable care
5. Simplify the **MassHealth delivery system for members and providers** by standardizing **behavioral health** networks and **pharmacy** formularies, and by simplifying and streamlining **care coordination**

Evolving ACO models: what we heard

- Model A (Partnership Plans) and Model B (Primary Care ACOs) **each have relative strengths and weaknesses**. For example:
 - Model A's tend to be **smaller and more regionally-focused** than Model B's, which can support **provider engagement and CP integration**
 - Some Model A's have had **challenges implementing programs in partnership** between the MCO and ACO Partner. In many cases, the partnerships have not implemented value-based payment or innovative contracting structures beyond what MassHealth is doing in Model B
 - **Data sharing challenges** exist in both models. Model B's data reporting from the state has had limitations, particularly earlier in the program. Some Model A partnerships share more/ more timely data than Model B's receive, while others share less
- Medical spend and quality performance are **comparable** between the two models, but the **all-in administrative cost of Model A is substantially higher** than the all-in administrative cost of Model B
 - Additional data detail - next two slides
- Consider sunsetting Model C, which has struggled with scale and operational challenges at the end of the current contract

Further detail on cost of Models A and B

	Average PMPM before accounting for EOHHS cost (FFY19)		
	Medical ¹	Non-medical ²	Total
Model A	~\$488	~\$39	~\$527
Model B	~\$487	~\$11	~\$498
Model A / B	100%	342%	106%

- Controlling for differences in population mix and acuity, average PMPM for Model A ACOs is 6%, or ~\$29 PMPM, higher than Model B
 - Medical spend is similar; difference driven entirely by higher non-medical payments
- After accounting for fixed and variable costs incurred by EOHHS above and beyond non-medical payments³, Model A remains 4% more costly than Model B**

¹ Based on analysis of MMIS claims, MCE encounters, and concurrent member-level risk scores (1.004 normalized score for both Models A and B based on SDH 3.1 model) for Federal Fiscal Year 2019; Model B do not consider some offsets from MH purchased Rx

² Includes non-medical component of the rate (excluding payor surcharge), care management costs covered by DSRIP, and non-medical component of PCACO MBHP rate; all FFY19 estimates

³ Key drivers of difference include MassHealth operational costs, vendor costs, and \$10 enhanced fee paid to PCACO participating primary care providers



Potential path forward: renewing both models, with a high bar for Model A reflecting its higher cost to the state and high potential

1. **Set a high bar for care delivery, innovation and integration for Model As, including:**
 - Significant **non-FFS contracting** with providers, incl. mandatory participation in primary care sub-cap
 - High level of **payer/provider integration** (e.g., delegated care management)
 - Clear demonstration of **health plan levers** otherwise not achievable by MassHealth (e.g., advanced network management, sophisticated UM / clinical management)
 - Demonstrated high **performance in quality and member experience** metrics
 - Demonstrated **sophisticated data & analytics capabilities** to support provider performance improvement

2. **Set a high bar for financial efficiency for Model As, moving towards parity with Model B in terms of overall cost to MassHealth**
 - Demonstrated **TCOC performance or success implementing performance projects**
 - **Built in savings / clinical efficiency** in the payment model
 - **Adjust A vs. B admin** to bring them closer

Recall: the Commonwealth's Behavioral Health Roadmap

- The Executive Office of Health and Human Services is in the process of finalizing its **Behavioral Health Roadmap for Massachusetts**, based on extensive stakeholder feedback and interagency policy development
 - The Roadmap is broad, and addresses issues including and beyond MassHealth
- The Roadmap will aim to create a system of behavioral health that:
 - Ensures **equitable and open access to outpatient and urgent behavioral health care**
 - Makes it significantly **easier for individuals and families to navigate the system, find a provider, and get the treatment they need**
 - Promotes **early identification/intervention** and **evidence-based treatment**, and
 - Advances **integration** between mental health and addiction treatment *and* between behavioral health care and physical health care
- Many components of the Behavioral Health Roadmap specific to MassHealth will go into effect during the current waiver period (2021-22), while others will be incorporated into the new 1115 waiver proposal
- **The 1115 waiver stakeholder engagement process includes opportunities for input on how the new demonstration can build on and realize the goals of the Roadmap relative to MassHealth**

Behavioral Health Management- goals for next waiver

- In the course of developing the Roadmap, EOHHS identified **key challenges driven by complexities in the existing behavioral health care system**
 - Behavioral health providers report that it is **administratively complex and burdensome** to credential, enroll, and navigate policy differences between plans
 - Members report **difficulty finding a BH provider** that accepts their MassHealth coverage
 - Members **may have to switch their BH provider(s)** if they **switch plans**
- **As a result, several of our goals for next waiver focus on simplifying the current system and making it easier for members and providers to navigate:**
 - **Simplify provider credentialing, enrollment and participation**
 - **Simplify the experience for members** to more easily access behavioral health treatment by creating a **robust, single behavioral health provider network** for ACO/MCO/PCC members
 - **Simplify management** of the BH benefit to allow for streamlined implementation of coverage expansions and delivery system innovations
 - **Ensure a cohesive approach to implementation of the Behavioral Health Roadmap** to fully realize its goals
 - *Additional goals related to behavioral health coverage, integration, and care coordination will be discussed in future workgroup meetings / stakeholder engagement opportunities*

Behavioral Health Management- context from the current waiver

The MassHealth behavioral health (BH) benefit is currently **managed by multiple entities**, creating a **complex behavioral health delivery system** :

Plan	Entity that Manages BH
PCC	BH vendor (MBHP) contracted to MassHealth
ACO B	BH vendor (MBHP) contracted to MassHealth
ACO A	Directly by the ACO or by a BH vendor subcontracted to the ACO
MCO	Directly by the MCO or by a BH vendor subcontracted to the MCO

- **Overlap** between the MassHealth BH vendor's network and the ACOs'/MCOs' BH networks is considerable, but there is significant variation in contracted independent practitioners
- **Administrative complexity in the BH landscape poses particular challenges** due to the underlying challenges in navigating the BH system cited by both consumers and providers
- **ACOs are accountable for BH coverage, cost and quality**
 - *Cost*: BH spend is included in TCOC, for which ACOs are held at upside/downside risk*
 - *Quality*: Several BH metrics are included in the ACO quality measure slate, the scores of which determine the share of shared savings or losses the ACO retains

- Based on available metrics, there is **no one model over another:**
 - In RY18, **comparable BH PM** across ACO As, ACO Bs, MCOs, and the PCC plan
 - In RY18, **similar quality experience** across ACO Bs, MCOs, and the PCC plan

*CBHI, ABA, and SUD services are excluded from...

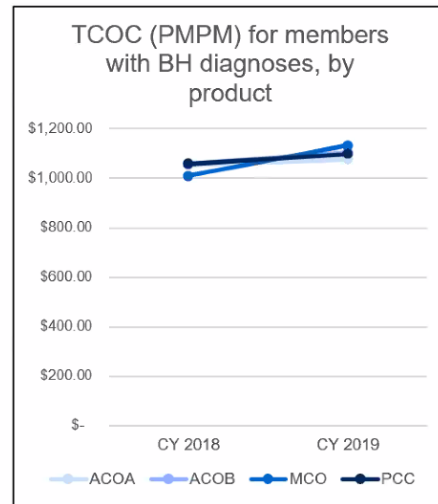
KK From Kaitlyn Kenney Walsh to Everyone

In addition to sheer number of providers, I think we need to be conscious of how we diversify the...

ACO/MCO/PCC Plan BH Quality Comparison

- **Cost and performance across ACO A, ACO B, MCO, and PCC plan types are comparable** in terms of total cost of care for members with BH diagnoses and certain quality metrics
- **At the (sub)contractor level:** MBHP's quality scores for these three measures for the PCC Plan and Model B population were comparable to that of the Model As/MCOs and their subcontractors
 - MBHP's scores were slightly higher for FUM and FUH, while slightly lower for IET
- **At the ACO/individual plan level:** There is **significant amount of performance variation at the ACO/individual plan level**, indicating an opportunity for improvement and alignment of member experience

Measure Code	MY 2018 Measures	MBHP Avg.	MCO Avg.	Min Rate	Max Rate
FUM	Follow up after ED Visit for Mental Illness (7 days)	76%	73%	69%	83%
FUH	Follow up after Hospitalization for Mental Illness (7 days)	51%	47%	43%	56%
IET	Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment				
	Initiation Total	44%	50%	28%	61%
	Engagement Total	18%	23%	9%	24%



Discussion: Improving BH Management

Contracting Structure

- What challenges does the current variation in networks, payment design, and credentialing create for members and providers? Are there any benefits of this variation?
- From your experience, which of the current MassHealth plan models (ACO A vs ACO B vs MCO vs PCC) do you believe best supports quality delivery of the BH benefit, or do they equally support quality delivery of BH?
- What opportunities exist for MassHealth to simplify and standardize behavioral health management and managed care delivery?
- MassHealth is considering creating a robust, single network of BH providers across MCO/ACO/PCC plans to increase overall access and consistency. Do you agree? What is the best way to achieve this?

Integration

- What are best practices/ "wish list items" for integrated management of BH that you would like to see from MassHealth plans?
- Do you believe that plans that deliver BH directly rather than via subcontract have better potential for enhanced cost/ quality performance or medical-BH integration as a result?

Quality & Financial Accountability

- For what kinds of quality metrics should ACOs, BH vendors, or both be accountable?

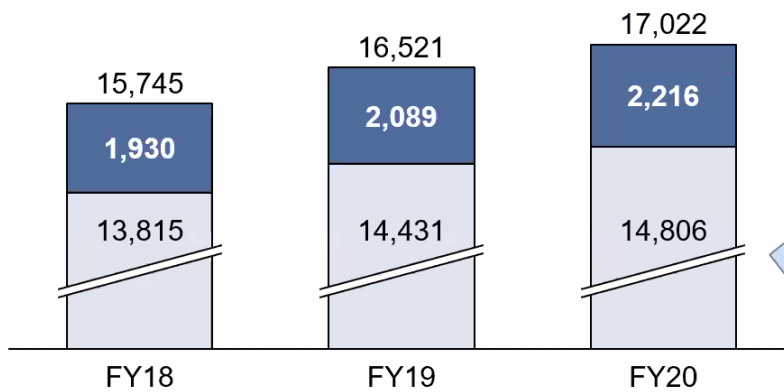
Agenda

Last Time	Focus of Today
<ul style="list-style-type: none"> ▪ Evolving ACO Models ▪ Care Coordination 	<ul style="list-style-type: none"> ▪ ACO Recap ▪ Behavioral Health ▪ Pharmacy

Pharmacy spend is growing faster than total healthcare spending

MassHealth Spend on Pharmacy* vs other programs
\$ Millions

■ Pharmacy Spend
■ Non-Pharmacy Spend



YoY growth

Rx	8.2%	6.1%
Non-Rx	4.4%	2.6%

Rapid growth and increasing complexity of Rx market dynamics requires focused attention and close management of pharmacy by all payors

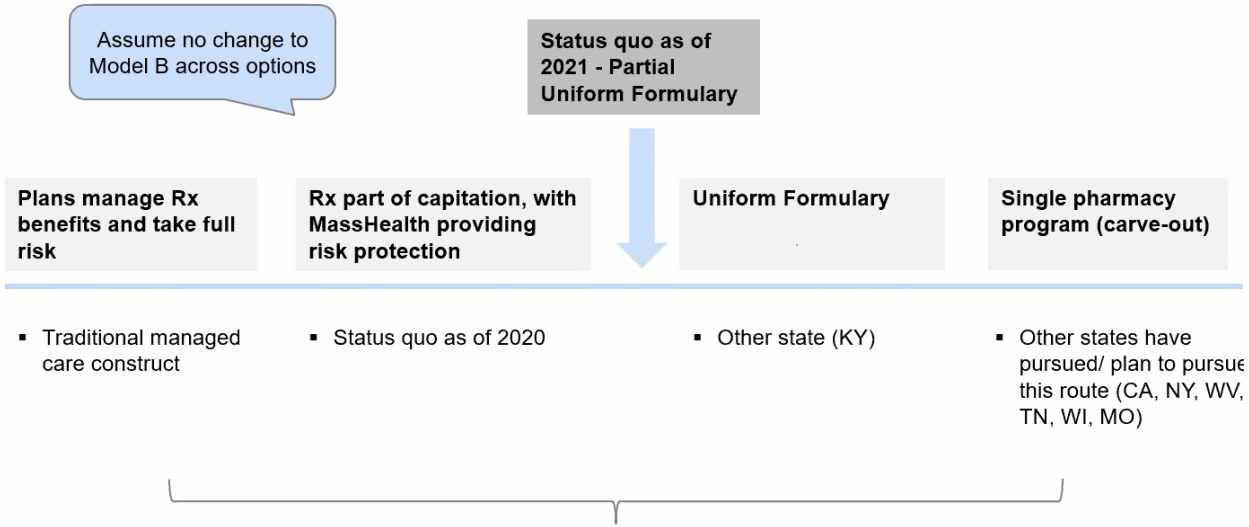
MassHealth Pharmacy structure today

- **Currently MassHealth Pharmacy is split between in-house pharmacy program (FFS/PCC/ACO-Bs) and 5 separate pharmacy programs under Managed Care plans**
- MassHealth's in-house Pharmacy program **defines the formulary**, creates drug PA criteria and processes claims for FFS/PCC/ACO-Bs; it also **negotiates** supplemental rebates with manufacturers and **collects** federal and supplemental **rebates on entire pharmacy spend** (i.e. including drugs paid for via cap payments to managed care plans), does not use PBM
- Managed care plans operate **5 separate pharmacy benefit programs**. All plans **contract with PBMs**, frequently with different terms, for the majority of administrative activities related to pharmacy benefit management, including P&T + PA criteria development, manufacturer and pharmacy contracting, rebate strategy and management, claims processing, prior authorizations and data reports;
- MassHealth operates a **Partial Uniform Formulary**: for select drug categories, plans are required to adopt MassHealth's drug preferences within a therapeutic category, which enables rebate maximization.

Goals for Future Pharmacy State

Goals	What works well currently?	What is not working well?
Simple to follow formulary for providers & members		
Clinical Integration (e.g. Medical/Rx reports at ACO level; attention to medication adherence in chronic/complex care management)		
Manage Rx Trend , which is currently 2-3x non-Rx trend and driven significantly by high-cost drugs		
Maximize Rebates		
Ability to nimbly respond to changing market dynamics (e.g. new drugs, new rebate agreements, shortages and emergencies)		

Options for consideration for Model A ACOs/ MCOs



- Traditional managed care construct
- Status quo as of 2020
- Other state (KY)
- Other states have pursued/ plan to pursue this route (CA, NY, WV, TN, WI, MO)

- Considerations across options:**
- Member and provider experience
 - Clinical integration
 - PBM "spread"
 - Rebate leverage
 - Overall efficiency
 - Risk bearing (for price and/or utilization)



September 20, 2021

Acting Assistant Secretary Amanda Cassel Kraft
EOHHS Office of Medicaid
One Ashburton Place - 11th Floor
Boston, MA 02108
Attention: 1115 Waiver Demonstration Comments
Sent via email to 1115-Comments@mass.gov

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of the 78,000 healthcare workers of 1199SEIU's Massachusetts Division, we write to respectfully share our top priorities and specific recommendations for MassHealth reform and to comment on the state's Request to Extend the MassHealth Section 1115 Demonstration.

We are fundamentally in strong support of MassHealth's thoughtful 1115 waiver renewal proposal and the efforts to continue to incentivize comprehensive delivery system reform and restructuring. We continue to share the Administration's commitment to Accountable Care Organizations (ACOs) and to the shared savings/shared risk payment structures that ensure essential cost savings for the Commonwealth, improve integrated care for all consumers, and support quality care incentives for Massachusetts' health care providers.

In proposing additional reforms that strengthen integration, adjust financing, and streamline administration, the state's extension request will advance state and national health care reform efforts, incentivize additional reforms, and contribute to health care cost containment. As outlined below, we appreciate this opportunity to offer additional comments.

Safety Net Care Pool

Throughout the current demonstration period and with this request to extend, MassHealth has fully committed to redesign of the Safety Net Care Pool (SNCP) and the restructuring of payments to safety net providers under the SNCP. Consistent with this commitment, the amendments proposed help to further align the restructured payments to ensure predictable funding for safety net providers.

We support the proposal to expand Safety Net Provider funding to nine additional hospitals in order to reflect up-to-date information on hospitals' public payer mix and to increase support for providers that became newly eligible for SNCP funding during the current demonstration period. We also are pleased to see efforts to enact reforms to the 340B drug discount program by tiering payment for 340B drugs to best support safety-net hospitals and community health centers participating in an ACO and that serve a high percentage of MassHealth members while incorporating a strong model of clinical-pharmacy integration.

As a general matter, we understand and appreciate that the Administration remains in active dialogue with the provider community, including many hospitals and health systems that employ 1199SEIU members, and to further develop and refine reforms of these critical funding streams. We also recognize that overall funding levels remain subject to these discussion and negotiation of a final 1115 waiver extension. Accordingly, we offer no formal position on these details even as we ask that

MassHealth continue to work closely with these providers and other stakeholders to establish robust supports for community and safety-net hospitals. Particularly as these providers begin to emerge from the incredibly difficult pandemic, it remains extremely important that the new 1115 waiver carefully and creatively utilizes all available resources to better support hospitals and health systems across the Commonwealth.

Sustainably supporting the Commonwealth's safety net and all MassHealth providers is 1199SEIU's top priority for the next 1115 waiver demonstration. In addition, we offer the following comments on other aspects of the proposal that are important to our health care worker membership:

Health Equity

1199SEIU is fully committed to addressing systemic issues of oppression even as we remain steadfastly dedicated to both delivering healthcare to all people and to eliminating social determinants of health based on what one looks like, how much money one earns, and where one lives. To further health equity, we are consistent advocates for access to quality, affordable healthcare across the entire healthcare spectrum and at every stage of life. And we've consistently called for greater investment in essential community and safety-net providers, for increased state oversight of programs relied upon by vulnerable seniors and people with disabilities, and for healthcare jobs that recognize the value of our diverse and lower-income workforce.

Therefore, we strongly support and commend MassHealth for recognizing that the 1115 Waiver extension offers critical opportunities to reduce health disparities that persist when stratifying key measures by race, ethnicity, language, disability, sexual orientation, and gender identity. More specifically, we offer our strong support for the new ACO incentive program, continuing the Flexible Services Program, for newly proposed housing supports, and for offering expanded services to justice-involved populations. We agree that new provider rate funding should be targeted primarily toward safety net hospitals, significantly expand upon data collection, and establish substantial equity-focused performance incentives. We also strongly support the admirable proposal to create a five-year, \$500 million health equity incentive program for ACO-participating hospitals. With this comment, we ask that you continue to dialog with affected hospitals/health systems on the details of this initiative and that MassHealth continue to carefully consider whether there is an opportunity to increase funding for this critical initiative.

Consumer Reforms & Investment in Primary Care, Behavioral Health & Pediatric Care

The 1199SEIU health care workforce, many of whom rely on MassHealth for health insurance coverage, greatly appreciate that MassHealth remains committed to making significant investments to expand services and achieve improvements in primary care and behavioral health services in the next demonstration period. Proposals to improve pediatric, oral, behavioral, and primary care health integration and to transition primary care payment in the ACO program to a new sub-capitation payment model will support enhanced care delivery expectations as we move further away from the out-date fee for service model. 1199SEIU also strongly supports the "Roadmap for Behavioral Health Reform" and especially the new 1115 waiver initiatives to support behavioral health workforce retention, recruitment, and related diversity initiatives. More generally, we're pleased to see MassHealth recognize the importance of the full spectrum of both direct and indirect caregivers with proposals to better support community, family, and other health care workers. As described above, we ask MassHealth to ensure that the primary care sub-capitation rate provide adequate resources for primary care practices to sustain valuable non-clinician team members.

Maintaining Near-Universal Coverage

As a matter of health equity, and in support of the 1199SEIU membership and other working families across the Commonwealth, it is of fundamental importance to maintain Massachusetts very low uninsured rate. Affordability issues persist, including both rapidly growing premiums for private insurance as well unsustainably high out-of-pocket costs. But our state's generous MassHealth eligibility standards and substantial cost-sharing subsidies for low-income individuals enrolled in Health Connector plans remain key tools.

We greatly appreciate MassHealth requesting authority to continue current eligibility and coverage policies. Additionally, the 1115 Waiver extension proposes essential and targeted updates that expand and update eligibility requirements and processes for disabled adults, children, pregnant members, those who are post-release from County Correctional Facilities or DOC Facilities, or for individuals experiencing homelessness. Especially important are the extension of retroactive coverage reforms, extending continuous eligibility for the several targeted populations, and changes to the CommonHealth eligibility standards to better support adults living with disabilities.

Thank you for the opportunity to engage in this on-going dialogue. As a union of health care workers, 1199SEIU is fully committed to ensuring quality, accessible health care for all. We intend to remain strong advocates for ensuring the continued success of the Medicaid/MassHealth program through careful reform and fair Medicaid rate payments to providers.

Please consider our comments as you finalize the Commonwealth's 1115 waiver proposal for submission to the Centers for Medicare and Medicaid Services (CMS). We look forward to working with the Commonwealth, the Center for Medicare & Medicaid Services, and all stakeholders to ensure the success of the state's new 1115 waiver program.

Sincerely,



Tim Foley
Executive Vice President



FayeRuth Fisher
Massachusetts Political Director



September 20, 2021

Amanda Cassel Kraft, Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to 1115-Comments@mass.gov

Re: Comments on MassHealth 1115 Demonstration Extension Request

Dear Acting Assistant Secretary Cassel Kraft,

Our four legal advocacy organizations strongly support the agency's goals of maintaining near-universal coverage, and advancing health equity with a focus on initiatives addressing health-related social needs and specific disparities affecting maternal health and justice-involved individuals. In particular, we applaud MassHealth's proposed expansions of eligibility and services, and of the Flexible Services Program (FSP), which include significant investments in addressing the nutritional and housing needs of whole households. We are also appreciative of the many opportunities for stakeholder engagement in the development of the proposal, and look forward to continuing to work with the agency as the proposal advances.

Nevertheless, we urge the agency to consider the following recommendations for changes to certain features of the proposal related to establishing and maintaining eligibility. We believe these changes will be essential to the success of the waiver's goals for strengthening the delivery system, improving access to primary care, behavioral health and pediatric care, and supporting the safety net. The comments and recommendations below are based on our experiences working with MassHealth applicants and members with low incomes and are informed by flexibilities adopted during the COVID-19 public health emergency.

Retain Three Months Retroactive Coverage

The original 1997 MassHealth Section 1115 demonstration and each renewal since then has included a waiver of the three calendar months of retroactive eligibility that federal law requires states to make available to applicants. 42 USC §1396(a)(34). We were heartened to see that the current proposal would restore three months retroactive coverage for pregnant women and children, but disappointed the agency did not propose to restore coverage for all MassHealth

members. We urge MassHealth not to deprive any of its members of 3 months retroactive eligibility. The time for waiving this important feature of the Act has passed.

Retroactive coverage was added to the Medicaid Act in 1972 to protect people who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented them from applying.¹

Full retroactive eligibility strongly fosters the purposes of the Medicaid Act, the Affordable Care Act and Massachusetts health reform by reducing the number of months that a household is uninsured. It reduces the burden of medical debt suffered by the poor, and we know 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. It also addresses the problems that arise when people who recently had coverage do not realize that their coverage has lapsed.

Medical debt is a significant problem for low income families in Massachusetts. The 2019 Massachusetts Health Insurance Survey (MHIS) shows significant rates of medical debt as well as the disproportionate burden of medical debt on just those adults MassHealth's proposal will leave out --people of color, families with minor children, and people with disabilities and/or poor health.

The MHIS shows that in 2019 16.2% of adults in Massachusetts reported problems paying family medical bills over the last year, and 16.6% had medical debt or medical bills that were being paid off over time. Among adults with income of 138% FPL or less, 18% reported problems paying medical bills and 12% had medical debt or were paying off bills over time.² These rates were higher for people who were Black or Hispanic (20% and 19.6% respectively).

A recent census report based on 2017 SIPP data shows higher rates of medical debt among families with children under 18 (24.7%) compared to families without children (16.5%), and higher rates of medical debt among people with fair or poor health (31%) compared to others (14%). While this is national data, there is no reason to think the disparity does not exist in MA too. It also includes this telling statistic: over a third in each group (34% of the insured and 39% of the uninsured) say they were unable to pay for basic necessities like food, heat, or housing as a result of medical bills.³

¹ H.Rep. No. 231, 92d Cong. 2d Sess., reprinted in 1972 U.S.Code Cong. & Ad.News 4989, 5008, 5099. See also, *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States* MaryBeth Musumeci and Robin Rudowitz Published: Nov 10, 2017 KFF <https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/>

² *Findings from the 2019 Massachusetts Health Insurance Survey*, CHIA, <https://www.chiamass.gov/assets/docs/r/survey/mhis-2019/2019-MHIS-Report.pdf>

³ *Who had medical debt in the U.S.?* US Census Report, April 7, 2021, <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>

During the COVID-19 public health emergency, MassHealth reinstated three months retroactive coverage for those under age 65. For those who know of this policy, it has been an important protection. These are three examples of individuals who applied during the COVID PHE and were able to obtain retroactive coverage in three typical scenarios where applications are not filed within 10 days of the date of service: the patient does not realize their private insurance has lapsed or the limitations of their coverage; a MassHealth member has unwittingly been churned off coverage⁴; and individuals are preoccupied with a medical emergency and/or received misinformation about eligibility.

Outdated information that patient was covered by private insurance. Patient was admitted to the hospital for substance use treatment. Patient and hospital staff believed they still had private coverage through their parent because it ran as active coverage. Patient later learned (well after the 10-day retro period had passed) that the policy had been terminated at the time of their admission, and the insurance company had been slow in updating their enrollment records. This resulted in the patient receiving a bill for \$4,000 for the cost of their admission. Patient was MassHealth eligible, and the hospital's CAC helped them enroll and obtain retroactive coverage to cover their bills thanks to the flexibility allowed during the COVID pandemic.

MassHealth churn: Member unaware of gap in coverage.

Client had a 23-day MassHealth coverage gap and incurred \$2,575 in debt to a hospital for emergency services without realizing that she was uninsured. By the time she realized she was uninsured and re-enrolled in MassHealth, the 10-day retroactive period did not cover the dates of service. After MassHealth implemented the 90-day retroactive coverage policy for the duration of the Public Health Emergency, HLA helped this client obtain 90-day retroactive coverage, which fully covered the debt.

Emergency conditions and erroneous eligibility information from MassHealth

Individual recently relocated to Massachusetts to join family members. Several weeks later, he swam in a local pond and drowned. He was taken by ambulance to a local hospital, revived and transferred by helicopter to a larger hospital where he died. He had no insurance. The family was insured through MassHealth but had not yet added the new household member at the time of his death. They were erroneously advised by MassHealth that an application could not be made posthumously. After receiving bills for over \$20,000 for emergency transportation alone, and well after 10 days from the tragic accident, the HCFA Helpline assisted them in establishing eligibility and obtaining retroactive assistance.

In addition to the compelling policy reasons for reinstating three month retroactive eligibility for all MassHealth residents, there are serious legal objections to extending the waiver for another five years. When the 1115 waiver was first approved in 1995, the rationale for the elimination of retroactive eligibility may have been the promise that expedited and streamlined eligibility procedures, including a higher income limit and gross income test and elimination of the asset

⁴ See, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic*, ASPE Issue Brief, April 12, 2021, <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf> (Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance).

test would erase the need for retroactive eligibility. However, as the 2019 MHIS and the examples above show, medical debt remains a persistent problem. Further, the Affordable Care Act now requires coverage for adults under 65 with a higher income limit and without regard to assets as well as an online application capable of real-time determinations, but it also retained the requirement of three months retroactive eligibility. The ACA also introduced a much more complex methodology for determining income and household size than the rules that were in effect under the earlier iterations of the demonstration. The MAGI methodology now requires a cadre of certified counselors to help people complete the 30 page application form or the online application. Ten days, in many cases, is simply not long enough to gather the information needed to understand and accurately complete the application.

After 23 years, the burden is on EOHHS to show that reducing coverage from three months to 10 days will “assist in promoting the objectives” of the Medicaid Act as required by Section 1115. The objectives of the Act are “to furnish medical assistance” on behalf of those “whose income and resources are insufficient to meet the costs of necessary medical services.” 42 USC 1396-1. A waiver must have a valid research value and cannot be instituted only to save money.⁵

Whatever justification there may have been for waiving three months of retroactive coverage in the late 90’s, there is no justification for seeking renewal of this feature of the demonstration in 2022. Retroactive coverage serves a valuable purpose and should be available to Medicaid members under age 65 in Massachusetts as it is in almost all other states.

Lengthen the 30 Day Appeal Period

During the COVID-19 emergency, Massachusetts used Section 1135 waiver authority to temporarily extend its appeal period to 120 days. We are disappointed that MassHealth’s Section 1115 extension request does not include a proposal to make this extended appeal period permanent. MassHealth allows its applicants and members only 30 days to request a fair hearing after receiving an appealable notice. 130 CMR 610.015(B). MassHealth could extend its appeal period to 90 days without a waiver, just by amending its state plan (42 CFR 431.221(d)). While a 90 day appeal period would be a significant improvement, we recommend that Massachusetts make the 120 day appeal period permanent by including it in its Section 1115 extension request.

As of 2018, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that at least 25 other states had longer appeal periods than Massachusetts. A 30 day appeal period is too short to account for the complications of everyday life, particularly for people living with low incomes. It also fails to account for the changing realities of mail service. The pandemic has caused on-going mail delays, and MassHealth no longer postmarks its mail to members, making it impossible for members to prove a mail delay that might otherwise extend their deadline to file an appeal.

As Medicaid advocates in Massachusetts, we frequently encounter clients who are blocked from having their meritorious appeals heard because of MassHealth’s short appeal period. The following are a couple examples:

⁵ See, *Newton Nations v. Betlach*, 660 F. 3d. 370 (2011). *Gresham v. Azar*, 950 F. 3d. 93, 102-103 (2020) (Overturning Secretary’s approval of work requirements and reduction in retroactive coverage to 30 days for failure to account for “critical issue of loss of coverage”) cert. granted 141 S. Ct. 890 (Dec. 2020).

A MassHealth member with intellectual disabilities had his request for PCA hours denied. This member's 81 year old father and legal guardian requested a fair hearing 41 days after the date of the denial notice, because he mistakenly thought that he needed to obtain and submit medical documentation with the appeal. The Board of Hearings dismissed the appeal for being untimely, and then denied the father's request to vacate the dismissal. GBLS then got involved, filed a 30A complaint, and settled the matter. The member's PCA hours were ultimately approved. If GBLS had not intervened, this member would not have received the PCA hours he needed and for which he was eligible, simply because his legal guardian submitted his appeal 11 days (6 days, accounting for mail) late.

A MassHealth member's coverage was wrongly terminated based on incorrect information about her residency. The member was hospitalized at the time, and didn't return home until 10 days after the termination notice was mailed. She then submitted her request for fair hearing 28 days after returning from the hospital, and 38 days after the notice of decision was mailed. The Board of Hearings dismissed the member's appeal for being untimely. The member requested the dismissal be vacated. GBLS then got involved and got the dismissal vacated by showing that the member had appealed within 30 days of receiving the notice (after she returned from the hospital). The member prevailed at the hearing and her coverage was reinstated retroactive to the date of termination. All this could have been avoided with a longer appeal period.

A longer appeal period would allow more appeals to be decided on the merits, ensuring that those who are eligible for MassHealth benefits and services are able to receive them.

Lengthen the 10 Day Period to Request Aid Pending Appeal

In addition to requesting an extension of the appeal period, we recommend that MassHealth request an extension of the period for requesting aid pending appeal. Both federal and Massachusetts regulations allow members just 10 days after receiving an appealable notice to request aid pending appeal. 42 CFR 431.230(a), 431.231(c)(2), and 130 CMR 610.036(A). However, during the COVID-19 pandemic, seven states have received CMS' approval under section 1135 waiver authority to extend the timeframe from 10 days to the same amount of time the state allows to request a fair hearing. This 10 day limitation is in the regulations, not the statute, and extending the time period would not impinge on basic due process rights. On the contrary, it would enhance such rights. In these circumstances, it is appropriate to request authority under section 1115 to allow a longer period.

Our experience as Medicaid advocates has demonstrated that ten days after receiving an appealable notice is not a reasonable amount of time to request aid pending appeal. Mail delays, lack of regular access to fax machines, the post office, or phones, and the complications of everyday life when living in poverty or with complex medical needs all make this 10 day timeline difficult for many to meet. MassHealth's services are critical to the health and wellbeing of its members. If a member misses the 10 day opportunity to request aid pending appeal, then they could miss months of essential services, such as PCA hours or prescriptions, before the Board of Hearings reinstates their coverage.

We recommend that MassHealth request an extension of the 10 day time limit to request aid pending appeal. We propose an extension to a minimum of 20 days, or another amount proportional to the time to request a fair hearing: 30 days if the timeline to request a fair hearing is extended to 90 days, or 40 days if the timeline to request a fair hearing is extended to 120 days.

Extend 12 Month Continuous Eligibility to All Children and Adults

We applaud MassHealth for including continuous eligibility for incarcerated individuals, postpartum individuals, and unhoused individuals in its Section 1115 Demonstration Extension Request. However, we continue to strongly urge MassHealth to seek 1115 Waiver approval of 12-month continuous Medicaid and CHIP eligibility broadly for both adults and children. Continuous eligibility would facilitate ACO plan stability, prevent unnecessary acute and emergency care costs, and promote better health outcomes for MassHealth members.

Prior to the pandemic, many states already provided twelve months of continuous coverage for certain Medicaid recipients, particularly children, as a means to prevent churn, improve health outcomes, and facilitate continuity of care. Since March 2020, MassHealth members have benefited from the Families First Coronavirus Response Act's ("FFCRA") continuous coverage condition for enhanced FMAP to Massachusetts. FFCRA § 6008(a)-(b). We urge you to extend the benefits of continuous coverage for at least 12 months at a time after the public health emergency ends.⁶

States have the option to provide continuous Medicaid and CHIP coverage to children without a waiver. Thirty-four states offer 12-month continuous coverage to children through Medicaid and/or CHIP.⁷ Massachusetts now has the opportunity to provide continuous coverage to adults through a Section 1115 waiver, as New York and Montana have done.^{8 9}

Providing continuous coverage would help stabilize membership in ACO plans, which is crucial to ensure the success of the accountable care model. Volatility in ACO plan enrollment remains a primary concern for the MassHealth administration because it undermines the financial viability of MassHealth's accountable care system. Unfortunately, income volatility is common in the MassHealth program. In 2017, 34% of those terminating their Health Connector coverage were individuals transitioning to MassHealth, and 31% of new Health Connector enrollees were transitioning from MassHealth.¹⁰ Coverage volatility also creates greater administrative burden,

⁶ See, ASPE Issue Brief, Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic, April 12, 2021, <https://aspe.hhs.gov/system/files/pdf/265366/medicaid-churning-ib.pdf>

⁷ Continuous Eligibility for Medicaid and CHIP Coverage, Centers for Medicare & Medicaid Services. <https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html>

⁸ GIS 15 MA/022: Continuous Coverage for MAGI Individuals, New York State Department of Health, Dec. 2015. https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma022.htm

⁹ Section 1115 Waiver for Additional Services and Populations (WASP). Montana State Department of Public Health and Human Services. <https://dphhs.mt.gov/montanahealthcareprograms/medicaid/medicaid1115waiver>

¹⁰ D. Nelson and J. Rushakoff. Massachusetts' remaining uninsured, Harvard Kennedy School, (2019), at 26. <https://www.hks.harvard.edu/sites/default/files/degree%20programs/MPP/files/PAE%20Final%20-%20Nelson%20Rushakoff%20NO%20LOGO%20NO%20NAME.pdf>

as MassHealth must disenroll and re-enroll members as their income fluctuates from month to month.

Medicaid recipients with chronic health conditions who undergo changes in coverage experience higher emergency department utilization, increased acute care costs, increased uncompensated care costs, and overall worse health outcomes.^{11 12} As Medicaid advocates, we have worked with many clients with fluctuating income who lose coverage for administrative reasons due to difficulty understanding and keeping track of the documents and deadlines required to maintain coverage, leading to medical debt and poor health outcomes. Not only are these care outcomes bad for individual patients, but preventable medical problems also increase costs across the MassHealth system while making it harder to ensure plan accountability for patients cycling in-and-out of coverage.

MassHealth members with lower incomes tend to experience greater rates of income volatility,¹³ which creates more opportunity for churn. And in general, people of color disproportionately experience income volatility.¹⁴ Moreover, larger trends in the labor market have shifted more workers into the so-called “gig” economy with irregular earning patterns. Contract work and income fluctuation among workers has increased in recent years: one in five jobs is now held by a contract worker, and 49% of contract workers report fluctuating incomes.¹⁵ Workers with fluctuating incomes disproportionately rely on government-sponsored health insurance as their primary insurance: 54% of individuals with income that changes from month to month or seasonally are not offered employer-sponsored health insurance.¹⁶ As the COVID-19 pandemic has caused widespread income loss, the number of individuals covered by MassHealth as primary insurance has grown by 10%.¹⁷ Although unemployment numbers improved as the economy reopened in the summer of 2020, such progress has since stagnated, and many job losses have become permanent.¹⁸

Given the high churn in ACO plan enrollment, increase in job and income instability, and the well-documented health and fiscal outcomes of continuous coverage, MassHealth should provide twelve-month continuous Medicaid and CHIP coverage to adult and child populations beyond the COVID-19 public health emergency.

¹¹ X. Ji et al. Discontinuity of Medicaid Coverage: Impact on Cost and Utilization among Adult Medicaid Beneficiaries with Major Depression, 55(8) Med. Care 735 (2017).

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6684341/>

¹² J.C. Rusley et al. Discontinuity of Medicaid Coverage Among Young Adults with HIV, 33(3) AIDS Patient Care and STDs 89 (2019). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6442235/>

¹³ How Income Volatility Interacts with Americans Families’ Financial Security, Pew Charitable Trusts (2017). <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security>

¹⁴ Larrimore, J., Durante, A., Park, C., & Tranfaglia, A. (2017). Report on the Economic Well-Being of U.S. Households in 2016. Washington, D.C.: The Federal Reserve Board of Governors. Retrieved from <https://www.federalreserve.gov/publications/files/2016-report-economic-well-being-us-households-201705.pdf>

¹⁵ NPR/Marist Poll (2017). http://maristpoll.marist.edu/wp-content/misc/usapolls/us171204_KoC/NPR/NPR_Marist%20Poll_National%20Nature%20of%20the%20Sample%20and%20Tables_January%202018.pdf#page=3

¹⁶ Id.

¹⁷ Id.

¹⁸ Employment recovery in the wake of the COVID-19 pandemic, U.S. Bureau of Labor Statistics (2020). <https://www.bls.gov/opub/mlr/2020/article/employment-recovery.htm>

Enlist Additional Stakeholders to Advise the Agency on the Expansion of Coverage for Justice-Involved Individuals

We applaud the proposal to expand Medicaid supports for individuals during incarceration as well as after their return to the community. As the proposal convincingly documents, the vast majority of incarcerated people are MassHealth eligible before and after incarceration, and enhancing the quality and scope of health services during incarceration will improve health outcomes and overall system costs. We are proud that MassHealth is invested in this important form of racial health equity.

Inmate health systems, due to their nature as healthcare housed within a carceral setting, present unique challenges and unique opportunities for MassHealth. As we discussed in our recent meeting on this topic,¹⁹ healthcare may be facilitated by correctional officers,²⁰ who will require both training and oversight in order to meet MassHealth standards. Issues of consent have many unique applications in a carceral setting as well.²¹ This proposed program is an excellent opportunity for MassHealth to improve health outcomes over time, but has many unique needs that must be met to achieve this goal.

For these reasons, we strongly urge MassHealth to form an advisory committee of stakeholders to address any ongoing issues unique to this setting. We further urge MassHealth to include representatives from formerly incarcerated populations and community advocacy groups on this committee, as well as healthcare providers. Though MassHealth's work with criminal justice officials regarding this proposal is essential to its implementation, they cannot reflect the perspective of MassHealth members, and we urge you to bring in a wider group of stakeholders. The direct experience of impacted members will be an invaluable tool as the agency creates this new and important infrastructure.

Similarly, ongoing MassHealth support for correctional facilities in the form of training, feedback, and quality assurance will be vital for this new program's success. Because correctional staff are so involved in the health process in carceral settings, they can impact health delivery in many different ways, and those ways may shift over time. It is important that MassHealth remain involved in implementation and especially in measuring quality of service throughout the waiver period.

Finally, we also applaud the proposal for one year of post-incarceration coverage for incarcerated populations. As you know, newly released populations are estimated to have a risk of death 120 times higher than the general population during the first two weeks of release.²² Thus, continuity

¹⁹ MassHealth met with community advocates on 9/14/21 regarding Criminal Justice Involved provisions of 1115 waiver.

²⁰ See, e.g., Inmate Healthcare, documenting instances where correctional officers participate in healthcare delivery (such as specialized cell units and staff role in requesting emergency assistance). *Obtained at* <https://www.mass.gov/service-details/inmate-healthcare>.

²¹ See, e.g., Informed Consent and the Refusal of Medical Treatment in the Correctional Setting, *obtained at* <https://journals.sagepub.com/doi/abs/10.1111/j.1748-720X.1999.tb01458.x>; Beyond Estelle: Medical Rights for Incarcerated Patients, *obtained at* <https://www.prisonlegalnews.org/news/2019/nov/4/beyond-estelle-medical-rights-incarcerated-patients/>.

²² See An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015), *obtained at* <https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-august-2017/download>.

of access to care is critical for maintaining health and wellness of this population not just while incarcerated, but also immediately upon release. It is also important to permit individuals to retain access to care and maintain treatment modalities over time, which is instrumental to maintaining sobriety.²³ The proposed changes will bridge gaps created by breaks in coverage, permitting individuals to retain connection to their healthcare providers in communities and set up new appointments quickly upon re-entry. They will similarly permit those community providers to learn more about medical history during a period of incarceration.

We Strongly Support Expansion of CommonHealth Eligibility

We support and are delighted to see the proposed extension of MassHealth CommonHealth eligibility to non-working adults ages 21-64 and to certain adults age 65 and older who are no longer working. The coverage available to persons with disabilities through MassHealth Standard and MassHealth CommonHealth is often critical to maintaining independent community living. The creation of CommonHealth in 1988 was a big step forward and a big relief to many. However, the rules for accessing CommonHealth for those who are income-eligible for Standard are confusing and time-consuming to manage. These rules leave out those who cannot meet the work requirement and those who cannot meet or manage the documentation requirement for meeting the deductible, many of whom are in vulnerable and underserved populations. And those who have relied on CommonHealth for coverage of services for independent living face an eligibility cliff at 65 when eligibility requires income lower than 100% of the federal poverty level and an asset limit of \$2000. We all know and work with people who have relied on CommonHealth for many years for health coverage of items and services - coverage not otherwise available- that has allowed them to live and work in the community and who live in dread of the eligibility cliff at age 65. MassHealth's proposal to simplify CommonHealth for adults by making it operate in the same way as CommonHealth for disabled children will increase access to health care for people with disabilities across the age spectrum, allowing them to live in the least restrictive setting. We heartily agree that it is time to remove the barriers to CommonHealth's important coverage and are eager to work with you and the disability community on the details.

Strengthen Equity Incentives

We are pleased to see MassHealth's commitment to health equity through its proposed health equity incentive payments for ACOs and hospitals. We agree with MassHealth that the measure of health equity performance must include accurate collection and stratification of demographic data. This is essential to identifying health disparities, which must then be targeted with effective interventions. However, these measures should not be optional, but required of all health plans. We agree with the comments submitted by the Alliance for Community Health Integration (ACHI), recommending three changes to improve this program:: (1) couple the incentive payments with downside risks for failure to meet health equity performance measures at some point, (2) improve the transparency of stratified data on health related social needs, (3) expand the incentive program to include community health centers and other primary care settings. We

²³ See, e.g., Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition), obtained at <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>.

agree with ACHI that these changes would strengthen the incentive program's efficacy in advancing health equity in the Commonwealth.

Thank you for your commitment to strengthening the MassHealth program and its ability to better serve its members, we urge you to consider our recommendations in furtherance of these shared goals. We look forward to continuing to work with you on our many shared goals.

Yours truly,

Massachusetts Law Reform Institute

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www.moar-recovery.org

September 19, 2021

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear EOHHS Office of Medicaid,

As Executive Director of **MOAR**, Massachusetts **O**rganization for **A**ddiction **R**ecovery, I very much appreciate the opportunity to give comment to extend the MassHealth Section 1115 Demonstration (“Request”) to the Centers for Medicare and Medicaid Services. We understand that The MassHealth 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise eligible for coverage through Medicaid or the Children’s Health Insurance Program (CHIP), offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve the quality of care and health outcomes, increase efficiency, and reduce costs.

MOAR gives voice to our members, who are people in recovery, families, and friends educating the public about the value of living in recovery, and supportive of the multiple pathways to engage, build, and sustain recovery. However, navigating the system towards getting support poses challenges often not knowing where to go and how to get there. In a most recent survey, health care insurance coverage from learning how to access and use remains a pronounced issue. With that, MassHealth has the least challenges but can always be improved to “improve access.”

We look at future of having the Behavioral Health Roadmap incorporated in this request, to help “improve access.” We are working with other peer centered organizations to look at ways of educating our members about it. We are grateful to EOHHS for support with this. We in need of addiction recovery services need to be able to navigate the system with the ability to get the help when needed supported by a team who communicates with one another. This includes health care coverage that supports the best options for mental health and physical health.....with a map that leads to housing, food, education, and job support. We so appreciate the steps taken in the current waiver to build a recovery-oriented system of care.

MOAR really appreciates that MassHealth will submit an 1115 demonstration extension to continue progress in improving health outcomes and closing health disparities. Our addiction centered workforce lacks the census, stability, professional development and incentive to fulfill the services for the community in need. We have some wonderful services, which lack the personnel to fulfill the opportunities. There are too many of our community settling on the streets of our cities. With the advent of COVID, there was a 5 % increase in overdoses in the past year specifically addressing more of the communities of color. Racial, cultural, and gender discrimination must be addressed.

Thank you for the 5 Proposed Goals

1) Continue the path of restructuring and re-affirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model:

- This seems to incorporate building a seamless continuum of care with an infrastructure inclusive of the business, customer relations, and financial sustainability woven with a transparent focus.

2) Reform and invest in primary care, behavioral health and pediatric care that expands access and moves the delivery system away from siloed, fee-for-service health care:

We value this move to

- Align the waiver proposal to support the Commonwealth's [Roadmap for Behavioral Health Reform](#), which will result in investments of >\$200 million per year to expand behavioral health access and integration; **Integration is key.**
- Improve behavioral health workforce capacity and diversity via loan repayment for clinicians making a multi-year commitment to serve MassHealth members; and training for peers and community health workers; **(Please know we are in the very early exploration process of aligning ourselves with peer workers from recovery coaches, peer specialists, family specialists and community health workers – to honor differences and enhance collaboration. Opportunities for education, continued education, and loan repayment to build capacity is very much needed and valued to become employable, have a living wage, and be able to afford education. The above holds for the whole behavioral health workforce. We must increase the incentive to be employed in this field. If all were to be instituted, the Commonwealth might have more capacity to build healthier communities. This suggestion needs to be backed by study)**
- Expand coverage for diversionary behavioral health services to MassHealth fee-for-service members; **This sounds excellent to build in capacity for outpatient services – but it must still be that of a seamless continuum that offers comprehensive support with effective outreach and continued care. We realize that part of the building of diversionary behavioral health services is to bring in the capacity to make referrals to well qualified caregivers vs – leaving hospitals without a warm hand to the next level of care or boarding in the emergency room or short-term hospitalizations that repeat themselves.**
- Strengthen expectations for ACOs to invest in pediatric preventive care and coordinate care for children with complex needs. **We believe that prevention is key !**

3) Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals:

We at MOAR find the following to be a must. We are going through our organizational move to assess and structure the necessary change to eliminate racial and gender identification disparities.

- Launch a \$500 million initiative over five years for ACO-participating hospitals that measure and reduce health care disparities; from education to eliminate race, culture, and gender discrimination.
 - **To ascertain MassHealth support when leaving prison vs being discharged to the streets with no healthcare coverage. Having healthcare coverage can eliminate stress. More assistance is needed beyond healthcare but having healthcare would be an added plus to supporting life in the community versus possible recidivism.**
- Addressing racial and ethnic disparities in maternal health is important to help mothers integrate the support needed to raise their children from infancy with helpful services.
- Coverage to support the path to enlisting and maintaining LTSS for can help to

build in the components for necessary daily living...and improved quality of life.

- MassHealth building in innovative ways to support healthcare coverage that include honoring risk factors -----may just promote emotional well being that could eliminate certain crises when it feels like the system is working against you. It just may give the expression of “How can I help you” real meaning

4) Sustainably support the Commonwealth’s safety net, including level, predictable funding for safety net providers, with a continued linkage to accountable care:

This area provides the capacity of safety net providers to be able to give “Equitable care” while eliminating inequities experienced by those in need of services.

5) Maintain near-universal coverage, including updates to eligibility policies to support coverage and equity:

This covers poverty level, health care for all, CommonHealth application simplification, postpartum support for all, and never-ending eligibility for those experiencing homelessness and prison post release. This is true healthcare for all. For those suffering from addiction and building a life in recovery helps to replace barriers with an open door to services. Health care needs to be a right - and thank you for mapping a pathway towards it.

MOAR would very much like to participate in any effort moving forward on the support of this application, and its outcome. We can arrange meetings, information delivery, surveys, and other ways to support these efforts from our membership.

Please know I can be reached by cell at 617 279 3395, and by email – maryanne@moar-recovery.org . Thank you for the opportunity to give comment.

My Very Best,

Maryanne Frangules

Maryanne Frangules, **MOAR** Executive Director
105 Chauncy Street, Sixth Floor, Boston, MA 02111

People who are incarcerated need good health care coverage.

Once they are released they need comprehensive, affordable health care coverage. Enabling such health care coverage under MassHealth as is proposed by the Massachusetts Medicaid Waiver would enable this and we hope it will be done.

This will help the health of the individual and lessen overall health care costs and help in lessening recidivism.

Lewis Finfer

Massachusetts Communities Action Network (MCAN)

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399 Revolution Drive | Somerville, MA 02145

By Electronic Mail

September 13, 2021

Massachusetts Office of Medicaid
Attention: 1115 Demonstration Comments
1 Ashburton Place
11th floor
Boston, MA 02108

RE: MassHealth Proposed FY22-FY27 Section 1115 Demonstration Project Extension Request

Dear Acting Assistant Secretary Cassel-Kraft:

Mass General Brigham, Incorporated (Mass General Brigham), comprised of the following providers, is pleased to comment on the above-referenced section 1115 demonstration project extension request.

PECOS Group Practice PAC ID

Brigham and Women’s Physicians Organization, Inc.	3870405988
Massachusetts General Physicians Organization, Inc.	2466365820
Newton Wellesley Ambulatory Services	0244133494
North Shore Physicians Group	3577467224
Mass General Brigham Community Physicians	1759273436
Nantucket Physicians Organization, Inc.	6608065438

Institution Provider Number

Brigham and Women’s Hospital	22-0110
Brigham and Women’s Faulkner Hospital	22-0119
Cooley-Dickinson Hospital	22-0015
Massachusetts General Hospital	22-0071
Massachusetts Eye and Ear Infirmary	22-0075
Martha’s Vineyard Hospital	22-1300
McLean Hospital	22-4007
Nantucket Cottage Hospital	22-0177

Newton-Wellesley Hospital	22-0101
Salem Hospital	22-0035
Spaulding Rehabilitation Hospital – Boston	22-3034
Spaulding Rehabilitation Hospital – Cambridge	22-2000
Spaulding Rehabilitation Hospital – Cape Cod	22-3032
Wentworth Douglass Hospital	30-0018

Mass General Brigham commends MassHealth for its commitment to maximizing the quality and value of health care services provided its members and welcomes the opportunity to provide the following comments on the waiver renewal.

Mass General Brigham in the current (FY18-FY22) 1115 Waiver

Mass General Brigham is the largest health care provider in the Commonwealth, primarily serving the metro-Boston, Northampton and outer-cape island geographic service areas. We are deeply committed to providing excellent medical and behavioral healthcare to MassHealth members ranging from primary and preventive care in our community-based settings to the most complex and acute treatments in our Academic Medical Centers. Mass General Brigham participates as a Primary Care Accountable Care Organization (ACO), also referred to as a “Model B”, under the current 1115 waiver. Our ACO champions the care of 145K members across 173 primary care practices.

Under the current waiver, the MGB ACO has leveraged the delivery system reform incentive program (DSRIP) funds to invest in infrastructure and programming to move our MassHealth population toward accountable care. Tangibly, we have established critical screening and interventional programming for substance use disorder, implemented Intensive Care Management Programs (ICMP/ICMP +) which have demonstrated efficacy in cost and patient outcomes, leveraged Community Partners to better manage the care of our more complex MassHealth ACO members and utilized flexible service dollars to support the extensive health-related social needs of the members in our care. Together, these investments have enabled Mass General Brigham to deliver enhanced, better coordinated care to Mass Health members.

We commend MassHealth for their continued communication, establishment of processes, and collective problem solving with participating ACO providers throughout this inaugural ACO period. The involvement of providers at all levels has allowed for the success of the current waiver and sets the foundation for further, more targeted success in this proposed FY23-FY27 waiver.

Comments on the MassHealth Proposed FY23-27 Section 1115 Demonstration Waiver

I. Accountable Care Organizations

Mass General Brigham supports the MassHealth proposal for maintaining and building off of the Accountable Care Organization (ACO) program. Additionally, we are aligned with the focus within the ACO of structure of expanding investment on Primary Care, Behavioral Health and Pediatrics. These core services, long undervalued within the fee-for-service paradigm, are foundational for the health and wellness for our ACO members.

a. Primary Care Sub-capitation

MassHealth's proposal to pay for primary care services under a sub-capitation enables us, and other providers in the system, to move away from the constraints of FFS and care for our members in a more flexible and innovative manner that is responsive to the individual needs of each member. We agree that behavioral health (BH) is a critical component of primary and preventative care and are pleased that BH will be included in the sub-capitation. It is, however, difficult for provider organizations to plan for the transition to a sub-capitated primary care model without a detailed understanding of what is included in the sub-capitation. We look forward to hearing the details of the services included as soon as CMS conceptually approves the 1115 Waiver proposal.

b. Children, Youth, and Families

Mass General Brigham agrees with MassHealth's position that initiatives for children, youth and their families must systemically recognize their unique needs and appropriately tailor their health services. To that end, MassHealth is proposing a targeted case management approach to coordinate care for the most complex, highest risk children. This service will be embedded in certain pediatric health centers with capacity to provide a broad range of specialized services. We understand that children and youth with mental and behavioral health conditions will not be in this targeted case management system, but instead will receive main services within an enhanced pediatric primary care practice, with more complex conditions going to either the Child Behavioral Health Initiative (CBHI; for most complex) and some combination of mental health specialists in the ACOs or the new Community Behavioral Health Centers. We would like more detail around the interplay of these care management approaches with the community partners. All of these initiatives require a highly trained workforce which is of limited supply. For providers to create an environment that maximizes its support of and impact on children, youth and families, we ask that MassHealth engage providers on detailing the credentialing and expectations for the care team for our most complex pediatric patients.

As proposed, pediatric practices will be sub-capitated in a similar manner to their adult counterparts. We are hopeful that this sub-capitation reflects MassHealth's stated recognition of the uniqueness of pediatric service and reflects the differentiated services required in providing care throughout the childhood development spectrum. We ask to be involved in the modeling of services and competencies expected of a sub-capitated pediatric practice to ensure the model supports high-quality, efficient care of our young

people and their families, including mental and behavioral health integration in primary care.

We support MassHealth's proposal to provide retroactive coverage for 3 months prior to application for Medicaid eligible pregnant women and youth up to age 19. This retroactive coverage acknowledges an exposure in the current system wherein pregnant and young people may avoid care due to an uninsured status. This upstream care is critical for the health and prevention of illness in these populations; retroactive coverage will cover any gaps in coverage and associated gaps in care.

c. Care Coordination

Mass General Brigham has seen increasing levels of success in our care coordination efforts as we have developed and made more robust our ACO programs. Care coordination has been supported via DSRIP funds. We understand and support the MassHealth proposal to include care coordination funding that supports ~80% of the current DSRIP funded programs. We are also eager to learn about new care coordination services MassHealth would like us to add this waiver period. However, we suggest that MassHealth allow a reasonable transition period for providers to minimize disruption in care for our patients. To the extent that existing care coordination structures will need to be realigned, sufficient notice and lead time will be critical to minimize adverse impacts, as well as maximize benefits, for our patients.

Our primary care physicians provide comprehensive care and effectively manage the health needs and concerns of the patients on their panel. As such, we agree that the vast majority of ACO members can and should be care managed by their PCP. We do request that the cost of such PCP-driven care management be substantively incorporated into the proposed sub-capitation mentioned in section a above. We welcome the opportunity to work more directly with BH and Long-Term Support Service (LTSS) Community Partners (CP) for our patients that require more intensive supports. The MassHealth proposal to designate a single care coordination home per patient will be greatly helpful to our patients that require multiple supports and have experienced confusion around whom to go to for help with their care.

d. Flexible Services

Mass General Brigham supports the MassHealth proposal to extend the nascent flexible services initiative into this next waiver period. In particular, we support the expansion of Flexible Services funding to cover childcare for the duration that parents/guardians are engaged in nutrition and/or tenancy supports.

II. Workforce Initiatives

Mass General Brigham strongly supports MassHealth's request for authority to bolster behavioral health workforce retention and diversity initiatives, expand diversionary behavioral health services to members in MassHealth's fee-for-service program, and

continue Massachusetts' current substance use disorder waiver and pending serious mental illness waiver to maintain these critical services in the Commonwealth. COVID served to exacerbate this already strained workforce and investing in fiscal supports for recruitment and retention of both clinical and direct care BH staff will be key for successful operationalization of the integrated BH/PCP model envisioned for every MassHealth ACO patient in this waiver proposal.

III. Diversionary Behavioral Health and Substance Use Disorder Services

Mass General Brigham supports the MassHealth request to expand coverage of behavioral health diversionary services to include the fee for service population. Our ACO and managed care enrolled patients have benefited tremendously from access to these cost effective, targeted community interventions which have allowed for successful transitions from inpatient setting and diversion to community settings. Expanding these valuable resources to the MassHealth fee for service population will have positive impacts for those patients and the entire system.

IV. Health Equity Incentives

a. Data collection

Mass General Brigham commends MassHealth for its proposal to promote better data collection and use of sociodemographic and social determinants of health data. These efforts align well with similar CMS initiatives to enhance health equity data collection for the Medicare population through RFIs released in conjunction with 2022 Medicare rulemaking. We strongly support MassHealth's proposal to improve self-reported granular race and ethnicity data through positively incentivizing providers to improve data collection, such as with a pay-for-reporting payments in during the first year of the Waiver period.

We caution MassHealth against inferring the racial and ethnic identity of Medicaid beneficiaries using the imputation methods suggested as a potential solution in the short term. We believe if MassHealth moves to use imputation now, hospitals may not do the work necessary to improve collection of self-reported data from patients, which is the gold standard of race/ethnicity data. Further, a benefit of stratifying quality measures by sociodemographic data that it facilitates root cause analysis of disparities; such analyses work better with complete data sets, like those utilizing self-reported data or proxy data such as dual eligibility status.

b. Social Risk Factors

Mass General Brigham is deeply committed to reducing health care disparities and is actively undertaking a multi-pronged approach toward greater health equity in our system via our "[United Against Racism](#)" initiative. As indicated in this Waiver proposal, we look forward to active participation with MassHealth in the development of the equity

incentive measures and their implementation and execution expectations over the Waiver's 5-year period.

V. Maintaining Near-Universal Coverage; Expansion Populations

Mass General Brigham is proud to provide care in the Commonwealth where near universal coverage is a stated goal and all stakeholders work toward providing high quality care to all our residents. We strongly support MassHealth's proposal to cover individuals while incarcerated and 12 months post release; extending CommonHealth to non-working adults aged 21-64, and the retention of CommonHealth benefits to for disabled adults age 65+. These coverage expansions acknowledge the very real challenges that these groups of individuals face and unburdens them from concerns about health care coverage so that they can more robustly engage with their communities and seek employment, if viable. Mass General Brigham also acknowledges the health equity benefits of enhancing healthcare coverage for individuals involved in the criminal legal system.

VI. Hospital Assessment

Mass General Brigham has been an active participant in the workgroup convened by the Massachusetts Hospital Association (MHA) on the development of the hospital assessment which leverages funds from hospitals to support critical waiver initiatives. We support iterative efforts of this workgroup and plan to support their forthcoming recommendations.

Mass General Brigham appreciates the true partnership that MassHealth has initiated with the provider community in the development of this FY23-27 Section 1115 Demonstration Waiver. Should there be any questions regarding this comment letter please contact Kelly Driscoll, kdriscoll12@partners.org.

Sincerely,



Niyum Gandhi
Chief Financial Officer & Treasurer



Lindsay Jubelt
Chief Population Health Officer



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



Tom Sequist, MD
Chief Patient Experience and Equity Officer

September 20, 2021

Ms. Amanda Cassel Kraft, Acting Assistant Secretary
MassHealth
Commonwealth of Massachusetts
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: Comments on 1115 MassHealth Demonstration (“Waiver”) Extension Request

[Submitted via email to: 1115-Comments@mass.gov]

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of the Massachusetts League of Community Health Centers (the League), we are pleased to offer these comments regarding the Waiver Extension Request.

About the League and Massachusetts Community Health Centers (CHCs)

The League is Massachusetts’ Primary Care Association, representing and serving the state’s 52 community health center organizations, serving patients at more than 300 access sites across the Commonwealth. 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. The health center model consists of: an integrated health home which is open to all, regardless of ability to pay, consumer-board governance, locally tailored and responsive services that are culturally-competent. The model is supported in significant part through a bundled payment built on the Medicaid FQHC prospective payment system (PPS), which ensures adequate investment in health centers’ comprehensive services. Multiple studies over the decades have demonstrated the quality outcomes and cost savings this model can produce, including a multi-state study of Federally-Qualified Health Center (FQHC) Medicaid patients that demonstrated a 24% reduction in total cost of care¹.

Over the last decade, including through the current 1115 Wavier, we have worked to further advance that integrated model which includes medical, behavioral health, dental, vision, pharmacy and substance use disorder care; as well as enabling (non-clinical) and other support services, which often focus on social determinants of health.

Health centers serve as the largest safety net provider network for primary care in the Commonwealth, 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: 14% uninsured, 44% Medicaid, 12% Medicare. Fifty-percent of the average Massachusetts health

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](#)

center's revenue comes from MassHealth. Reimbursement for these services varies depending on coverage type.

With your support, community health centers have been on the frontline of the COVID-19 pandemic, quickly transitioning to telehealth for continuity of care and to promote access, standing up COVID-19 operations, serving both patients and the broader community, with an explicit focus on equitable access to COVID-19 testing, tracing, treatment, and vaccines.

We appreciate the opportunity to provide comments on the proposed waiver renewal and, as close working partners, we look forward to continuing to work together on the areas below—both before and after the waiver's submission.

Restated Health Center Priorities in 1115 Waiver Renewal

Health centers are in 10 different MassHealth ACOs. FQHCs, which have additional requirements and protections, are in 8 different ACOs. Necessarily, this means that there are going to be different approaches for each, but across health centers there are core priorities and initiatives health centers would like to see addressed in the 1115 waiver renewal.

Overall, as shared with MassHealth this Spring, health center priorities are:

1. **Prior to the beginning of the next waiver period**, establishment of an adequate and compliant health center **payment**, including implementing the state's first FQHC Prospective Payment System (PPS), as a fundamental necessity in order for health centers to join MassHealth in achieving multiple 1115 waiver renewal objectives, including a possible primary care sub-capitation model;
2. **Alignment** of future payment models with FQHC payment requirements;
3. Continuation of essential health center **workforce investments** that support supply, capacity, recruitment, and retention to further an integrated, team-based model of care;
4. Enhanced focus on **health equity**, access to care, and health-related social needs.

Summary of Comments on Key Issues

In this letter we provide additional details and context about our key issues and where they align or may diverge from MassHealth's proposed request; to summarize:

- The waiver request contains some very positive and impactful proposals, including eligibility and coverage expansions for members experiencing homelessness, pregnant and post-partum members, and justice involved members, for which we commend and thank the Baker Administration, and most especially the team at MassHealth.
- The request also signals an acknowledgement of the need to ensure that future payment approaches, such as primary care capitation, are aligned with federal statutory FQHC requirements. While this area needs further flushing out, we are encouraged by MassHealth's direction on this issue.
- We are very enthusiastic about MassHealth's significant proposed investments in community-based behavioral health workforce with some recommendations for clarifications. We are, however, disappointed about the lack of primary care and workforce development investment in the waiver.
- We are concerned about the approach to the Health Equity investments, most notably the unexpected exclusion of health centers from the draft request.

- We see great promise in MassHealth’s 340B proposal, as a pathway to remedy the elimination of health center’s ability to generate 340B savings at the ACO launch (a policy which was not applied to other 340B entities), and to provide some renewed reliable revenue which can be reinvested into expanded access to care.

Key Issue: Payment/Primary Care Capitation

We are extremely pleased that this Spring we were able to reach agreement with the Baker Administration on an FQHC payment methodology that would establish a blended PPS rate for medical and behavioral health, as well as a separate dental PPS for all FQHCs in the state. While we are still working in earnest with MassHealth to complete the implementation of this new system, this progress was foundational for community health centers in the Commonwealth in order to build on a compliant and adequately funded system, as we contemplate a move towards capitation.

Directionally, we support a model that moves away from fee-for-service and empowers providers and care teams, but we have significant operational and implementation questions. We look forward to learning more specifics about the design of the program, details on the exact capitated rate development approach, calculations of quality incentives, approach to risk, and model contract language, etc. We believe that a primary care capitation model can work in harmony with the requirements of FQHC, as has been the case in other states, and we look forward to working with you in the coming months to work towards that goal in Massachusetts. Until such time as we are able to work through these important considerations, we cannot offer unqualified support.

We offer the additional specific comments/requests relative to Primary Care Capitation:

1. **FQHC Methodology/BIPA:** Regarding FQHCs, the waiver request indicates: *“ensuring that they are paid at or above their PPS rates as required under the federal Benefits Improvement and Protection Act of 2000 (BIPA)”* (emphasis added). **The current language in the proposal suggests intent to comply with BIPA, but we request the following edit to further clarify this critical issue: “while still ensuring that they are paid at or above their PPS rates in accordance with an approved FQHC payment methodology as required under the federal Benefits Improvement and Protection Act of 2000 (BIPA).”** (proposed addition in blue).
2. **Reconciliation** The waiver request indicates: *“To meaningfully move the focus of primary care practices away from fee-for-service incentives, and towards value in primary care, the proposed primary care sub-capitation model would not include a back-end reconciliation against utilization, except to the extent required to calculate and ensure appropriate PPS payment for FQHCs.”*

We are heartened that this demonstrates MassHealth’s intent to adhere to BIPA’s FQHC requirements. However, we believe **we will need to work closely together in order to devise a compliant methodology that achieves this for all participating FQHCs across eight different ACOs, and in likely different tiers within the broader primary care sub-capitation model. This methodology will need to account for the interaction between varied services in the different primary care sub-capitation tiers and FQHC services.**

We appreciate MassHealth's clear acknowledgement that in the case of FQHCs there must be a mechanism to ensure that FQHCs are getting paid no less than PPS for FQHC services.

3. **Risk** The waiver request indicates: *"primary care providers would be required to experience a meaningful portion of their annual Medicaid patient service revenue opportunity as tied to value-based performance measures."*

This is also an area where we need more information on how this will interact with FQHC floor for FQHC services, as we are not sure we have alignment with MassHealth on this issue.

4. **Children, Youth, and Families:** We seek clarification with regards to clinical expectations for providers serving children in the primary care sub-capitation model, and again seek to ensure alignment with the current or future health center FQHC payment model is an important consideration.

Key Issue: Health Equity Incentives

Health equity is and has always been a priority area for health centers, and we are deeply grateful to see MassHealth elevate equity as a core priority in this waiver. We are pleased to see proposals for vulnerable patient populations, like post-partum coverage regardless of immigration status, and eligibility changes for homeless and justice-involved members.

We were, however, surprised and disappointed to see that health centers were not explicitly outlined as a part of the "Health Equity Incentives", as they had been during the workgroup process. This program now appears to be limited to hospitals and ACOs. We are still unclear about how health centers and other community-based, safety net providers can be assured of accessing equitable (or any?) levels of investments in this critical area. This is concerning, as we know that focusing on primary care and addressing members' health related social needs, which health centers have always led on, are essential and impactful ways to reduce health disparities. If health centers are expected to rely on any equity dollars to flow through ACOs that is a major concern and an inadequate way to invest in equity.

The track record of success by health centers in reducing health inequities comes from their community-led (consumer-majority board), hyper-local, tailored approach to designing a model of care that meets their patients' needs in a culturally proficient way. Above almost any other area, health equity interventions are those best designed by the health centers who know their patients and communities best, and a top-down, one-size-fits-all approach runs counter to what we know works based on our over 50-year track-record. MassHealth is acknowledging the benefits of investing in and empowering providers directly to do this work through their direct investment in hospitals, and we are supportive of hospitals receiving equity dollars.

We offer the following recommendations relative to the Health Equity incentives:

1. **Direct Equitable Investment in Health Centers:** We urge MassHealth to invest directly in interested health centers for targeted efforts to close health inequities. Direct investments in health centers for equity efforts should ideally be *equitable*, but at a minimum should be *equal* to that of other providers. **We would urge MassHealth to reconsider their current design and**

direct any dollars anticipated to flow to health centers through this program (an amount which is unclear to us and may need to be increased to be equitable), and to develop a health equity investment pool to fund health centers who opt into the fund, directly.

- 2. Alternative Approach:** If MassHealth does not adopt this approach, at a minimum we ask you to continue to work with the League and health centers to design a program that empowers health centers, primary care providers, and other safety net providers to design equity programs for the patient populations they know best. Health centers are experts in designing programs with a health equity focus. **We request that MassHealth require ACOs to meaningfully and proportionately invest these dollars directly in health centers and provide health centers with the authority to design their own programs.**

The League would also like to reiterate the equity importance of language access and investment in medical interpreters. Health center patients are uniquely diverse, exemplified by the fact that more than 36% of Massachusetts health center patients are best served in a language other than English, and at the 75th percentile of FQHCs this number approaches 50%. Robust medical interpretation services are essential when it comes to moving the needle on health equity and outcomes. Health centers have expressed the need for more medical interpreters, and for these staff members to be considered as an integral part of the care team, which is particularly beneficial for families and children. We believe that the implementation of FQHC PPS and the corresponding future change in scope methodology will provide the means to ensure these vital services are fully incorporated into any future payment model, but they bear mentioning here.

Key Issue: Workforce

Without an adequate, diverse workforce there is no real access or equity. In the current waiver, a suite of innovative, effective, and massively impactful programs has provided the essential boosts to access that health centers had hoped for and laid the foundation for a more diverse, community-oriented workforce of the future.

These programs were essential in supporting the health center workforce across important, necessary domains for continued care delivery innovations, which are: (1) Supply and Capacity, (2) Recruitment and Retention, (3) Shaping the Workforce of the Future, (4) Distribution of Providers, and (5) Support of and Preparation for ACO Model of Care. Health centers have been able to “grow their own” through workforce development programs, and significantly support staff needs across the continuum. DSRIP has enabled health centers to recruit and retain both diverse and culturally proficient providers.

For this reason, we were disappointed that four programs that directly benefit health centers were eliminated from the current waiver proposal:

1. CHC/CMHC Loan Repayment program for primary care and behavioral health
2. Special Projects Program
3. Nurse Practitioner Residency Program
4. Family Medicine (MD) Residency program

In addition, two additional programs that health centers benefitted from, if they were CPs (CP Recruitment Fund) or CMHCs (the Recruitment and Retention Fund), were also not included in the waiver.

Many of these programs have been vitally important to health centers' ability to staff their organizations in recent years. Additionally, several of these programs were recommended in the recent Legislative Health Equity Taskforce Force report, as a way to achieve health equity and economically empower communities. Loan repayment has helped drive desperately needed clinicians to work at health centers, and served as an effective retention tool; including NP and MD residencies which have helped to grow a new generation of community-trained providers.

Health centers are not prepared to absorb the loss of these programs and the loss of the community-based workforce training infrastructure that has been built during the waiver period. We strongly believe this would be a regrettable policy decision.

The Commonwealth's independent evaluator recommends that several of the workforce investments be continued because these initiatives have strengthened the provider workforce across the board—a recommendation that the proposed renewal does not adopt. In addition, unfortunately the draft mid-point evaluation is deeply flawed and incomplete on the workforce provisions. There was inadequate engagement with key stakeholders on the effectiveness of the programs and clear unfamiliarity with the structure, so we request a more comprehensive approach going forward and also ask that MassHealth determine a way to rectify the report's inadequate representation of these successful programs. This report is already being referenced by Legislators and funders, so the inaccuracies and omissions are of consequence. We will comment more on our concerns regarding the evaluation's treatment of the workforce programs in the appendix to these comments.

We offer the following recommendations on the workforce proposals:

1. **New Behavioral Health Programs:** We are very supportive of the two new behavioral health programs for licensed or almost licensed behavioral health clinicians and psychiatrists practicing in community-based settings. There is a continued need for behavioral health providers, as health centers continue to acutely experience a workforce shortage. **Under program 1, for licensed or almost licensed clinicians, we ask that this group of eligible providers be expansive,** including but not limited to social workers (LCSW and LICSW), psychologists, LMHC, LADC, and those staff who are working towards licensure or passing their exam. **Under program 2 for psychiatrists, we request that MassHealth clarify the proposed requirement that 40% of the psychiatrist's "panel" be: (1) at organizational level at least for FQHCs; and (2) include uninsured patients in the 40%.**
2. Over the last four years, the community health center **Student Loan Repayment Program** has enabled community health centers to retain clinicians across all provider types. There is so much demand for this program with approximately 33% of eligible candidates turned away. **We request that MassHealth continue to this program with a minimum of \$7.3 million for primary care clinicians at community health centers.**
3. Our **Family Medicine Program** has helped to address physician shortages with an emphasis on primary care, while also allowing Teaching Health Center programs to recruit and add diverse and mission-oriented physicians who will have the experience to serve their entire residency in a

community health center setting. **We request that MassHealth continue to invest in this program.**

4. Over the last four years, the health center **Family Nurse Practitioner Program** has had 38 Nurse Practitioners slots at over 9 health centers. Each of these provider slots represents a significant, **immediate impact on the health center that trained them, but also an investment in the career of an individual** who will have decades of service informed by and likely to be grounded in community-based care, including serving MassHealth members. These residents are able to attain the equivalent of years of practice experience through their intensive post-graduate residency and health centers and their communities benefit from better provider productivity, reduced turnover, and more access to care. **We request that MassHealth continue to this program with a \$5 million investment.**
5. Our new **Psychiatric Mental Health Nurse Practitioner Fellowship pilot program** allows health centers to increase their much-needed psychiatric capacity. The program includes intensive training and student loan support, and increases behavioral health services for children, adolescents, adults, and families across the state. **We urge MassHealth to invest \$10.7M into the 4-year continuation of this program**
6. One of the most frequently cited workforce needs from community health centers is the need for broader **Care Team Investments. We request that MassHealth invest in training initiatives for this group.** As entities born out of the War on Poverty and Modern Civil Rights Movement, health centers have a long track record of empowering communities by hiring community residents, developing career ladder programs, and serving as catalysts for economic development. They have specialized training and “up-skilling” to provide both sustained and advanced career opportunities for nurses, community health workers, medical assistants, recovery coaches and behavioral health providers at various levels, as well as other positions that are vital to supporting new models. However, the competition for this workforce is at an all-time high right when the need for these essential team members will be even more significant in a primary care sub-capitation model. As larger systems move to adopt our team-based approach to care, the demand for these valuable staff is greater than ever as their scarcity is increasing, and a new mechanism to grow the pool is needed. **We urge MassHealth to invest a minimum of \$13 million in this effort.**
7. Over the last four years, the **Primary Care and Behavioral Health Special Projects Programs** have worked to improve community-based primary care, while working to support the goals of the ACO program. This retention tool has allowed providers an opportunity to explore professional development, while also identifying a need within their health centers to improve the primary care and behavioral health integrated workforce in the community. **We request that MassHealth continue its support for this program with a \$2.3 million investment.**

Key Issue: 340B

The League sees the proposed change to 340B as one of the greatest opportunities in the draft waiver. Health centers have long sought a remedy to the loss of a critical revenue mechanism with the end of 340B savings with the launch of ACOs in 2018; notably, which did not impact other 340B providers. 340B supplemental payments were appreciated as essential mitigation to the loss of revenue. However, these

payments were: (1) discounted by each individual health center's rate increase in that same year (2) flat block grant-style payments and (3) designed to decrease and eventually end, while 340B savings had been growing for some health centers by double-digit percentage increases prior to ACO launch. We do note and appreciate MassHealth's efforts over the last several years to freeze those planned decreases.

The change that appears to be contemplated in the draft proposal may offer a promising pathway for remedying this loss and restoring some health center revenue which can be reinvested into expanded access to care, as the 340B authorizing statute intended. We applaud MassHealth for its creativity and commitment to remedying this issue.

We offer the following recommendation on 340B:

While lacking detail, **we request: (1) any opportunity to restore 340B savings and restore adequate and equitable reimbursement across safety net providers and ACOs, and are inclined to support this proposal; and (2) that all FQHCs automatically attain Tier I status.**

Other issues:

Health-Related Social Needs (HRSN), Access, and Eligibility

We support the following proposals from MassHealth, which align with our priority areas of expanded access and equity:

1. **Flexible Services Program** We are especially excited to hear about the inclusion of childcare to facilitate access to flexible services, and the continuation of this program aligns with our outlined priorities. We know that health centers have valued these partnerships and programs, and are looking forward to continuing to be able to provide these HRSN resources to some of their most vulnerable patients.
2. **Community Support Program (CSP)** changes
3. **MassHealth coverage for otherwise-eligible members during incarceration** We look forward to continuing to work with MassHealth, other state agencies, and the provider/CBO community to support members' continuity of care and re-entry into the community, with a particular focus on behavioral health and substance use disorder (SUD) needs for this population.
4. **CommonHealth eligibility expansion**
5. **24-months continuous eligibility to individuals with a confirmed status of homelessness** Health centers are eager to learn more about how this will be implemented and how MassHealth will define "confirmed status of homelessness". We look forward to continued work with MassHealth to best serve this population.
6. **12-months continuous eligibility to individuals upon release from incarceration** We look forward to partnering with the state and others on providing critical care and a medical home for individuals during the precarious post-release (re-entry) period.
7. **Retroactive eligibility** We are supportive of this proposal, but as a matter of health equity and financial security, would encourage MassHealth to reconsider waiving retroactive eligibility for the rest of the MassHealth population. Reinstating 90-day retroactive eligibility is likely to most benefit members with limited English proficiency, members experiencing homelessness, and other vulnerable patient populations.

Focus on Children, Youth, and Families

We support an increased focus on children, youth, and families. The League and health centers look forward to working with MassHealth on planning for and implementing child and family-focused initiatives. **Per federal Uniform Data System (UDS) reporting, Massachusetts FQHCs cared for more than 151,000 patients under the age of 18 in 2020.**

Behavioral Health and Care Coordination

We support MassHealth's proposals to evolve care coordination into baseline, enhanced, and specialized levels of support. As MassHealth is aware, health centers provide a range of behavioral health and care coordination services to patients, including those that could fall into the enhanced and specialized categories (e.g., homeless patients) of care coordination. Care coordination services are most effective if provided by someone that the patient/family trusts. Health centers have built this trust with patients, and should be eligible to provide care coordination services to ACO members assigned to enhanced and specialized categories of care coordination. In addition, we look forward to more discussion about how primary care and behavioral health integration will work under the proposal, as well as how the new proposed payment approach will support this work across different tiers.

Overall, FQHC PPS, including the implementation of the future Change in Scope methodology, should provide a mechanism to allow for reimbursement of an expanded role for health centers in this realm.

Health centers and the League look forward to working with MassHealth to ensure that the services they already provide to their patients can be maintained and expanded where appropriate, and adequately financed. We look forward to working with MassHealth in collaboration with ACOs, MCOs, and Community Partner (CP) Programs.

Thank you for the opportunity to provide feedback on the 1115 Waiver Demonstration request. The League and our health center members look forward to our continued collaboration to deliver primary care, behavioral healthcare, specialty services, and health-related social support to MassHealth members across the state.

Please contact Liz Sanchez, Director of Health Policy and Access at lsanchez@massleague.org with questions, or to discuss any topics in further detail.

Sincerely,



Michael A. Curry, Esq.

President & Chief Executive Officer

Appendix

Background on the DSRIP Statewide Investments programs:

Through a contract competitively awarded by the Massachusetts Executive Office of Health and Human Services (EOHHS) in 2018, the League has worked with MassHealth to develop and implement seven community health workforce initiatives as part of MassHealth's \$1.8 billion Delivery System Reform Incentive Payment (DSRIP) Program. The statewide investments to support workforce initiatives are allocated over five years (2017-2022) to expand loan repayment, residency training, and clinical learning and leadership opportunities for community-based primary care and behavioral health clinicians. A program of technical assistance to strengthen health center readiness for accountable care is also included. The League is working closely with the Association for Behavioral Healthcare (ABH) to administer the behavioral health components of these programs.

These investments to grow statewide capacity across the community-based primary care and behavioral health workforce are intended to support MassHealth's broader restructuring efforts to increase quality and lower the total cost of care for members.

Mass League Feedback to the 1115 Demonstration Interim Evaluation Report²:

- **We were disappointed that no one on the League's Workforce & Training team or any community health center administrators or participants in any of the workforce programs were interviewed.**
- There are several inaccuracies, misleading information, and/ or fundamental misunderstandings of the programs presented in the report, including the following:
 - Only one minor mention of possible beneficiaries of the programs was mentioned on page 770:
 - "Only about half of the ACO primary care providers, who are required to bear financial risk under their ACO's contract with MassHealth, reported receiving financial incentives when surveyed in 2020."
 - The report combines CP information with Student Loan Repayment Program information, which is inaccurate (the CP Program is a separate program).
 - When describing the Student Loan Repayment Program, the section opens stating, "[m]any organizations reported taking advantage of the Student Loan Repayment Program (SWI 1), which provided community-based providers the ability to pay back student loans, as a recruitment and retention strategy. Another such retention strategy is the learning days program, for which attendance was mandatory for Loan Repayment Program participants. This program, offered quarterly, allowed participants to take time away from clinical duties to focus on topics and skills to encourage and enhance community-based care."
 - The report moves on to describing the awards made in this program, including the Behavioral Health Workforce Development Program; however, it concludes stating, "The last arm of the program, the CP Recruitment Incentive Program, had 88 total awards, 77 for Care Coordinators and 11 for RN/LPNs."

² DRAFT Independent Evaluation Interim Report Massachusetts Medicaid 1115 Demonstration Extension 2017-2022 Released for Public Comment, August 2021; <https://www.mass.gov/doc/1115-demonstration-interim-evaluation-report/download>

- This is inaccurate, as the CP Recruitment Incentive Program is separate from the Student Loan Repayment Program, and it gives the impression that the retention strategies such as the Learning Days are included the CP Recruitment Incentive Program, which is not accurate.
- The report phrases the Learning Days in a way that gives the impression it is a separate program, instead of a component of the Student Loan Repayment Program on page 81: “another such retention strategy is the learning days program, for which attendance was mandatory for Loan Repayment Program participants.”
- On page 83, there is only one paragraph regarding the two distinct residency programs. This paragraph has inaccurate information about the total amount in awards made, and **there is no mention of the role of the community health center HC, the goal, the demand, or the impact:**
 - The NP Residency Program allows health centers to stand up and continue residency programs past the funding received. It has created a new pipeline of providers to be retained at the health center after their residency year. The report gives the impression that the state provides money for already-existing programs, which is inaccurate for the majority of the health centers in the state. The report states, “The Family Medicine and Nurse Practitioner Residency Training program is one part and aims to place more family medicine PCPs and NPs within community health centers.” **This is an underwhelming description** that makes no mention of the goals and importance of the training that occurs in the residency programs; it does not simply just place more providers in CHCs.
 - There is no discussion of the whole new programs that were designed and stood up under this investment and no attempt to measure their impact which we know from health centers has been substantial.
- Also, on page 83, the paragraph regarding the CMHC BH Recruitment Fund has inaccurate data about the money that awardees receive in both loan repayment and special project awards, and states that this program was created for recruitment, when it was **created for recruitment and retention.**
- The report is heavily focused on the CPs and the CP Recruitment Incentive Program, while important to the overall delivery system, are not programs with the greatest level of impact, and also has distributed the least amount of money:
 - Care Coordinators received up to \$7,500 in exchange for 18 months of obligated service in their CP, and the RNs recruited for this program receive up to \$30,000 in exchange for four years of obligated service.
 - In comparison, in the Student Loan Repayment Program, PCPs, Psychologists and Psychiatrists receive up to \$50,000; NPs, PAs, APRNs, and BH providers (LICSW, LMHYC, LCW, LMFT and LADC1) receive up to \$30,000.
- **The report makes a significant recommendation to continue and expand these programs,** which has not been fully reflected in the current waiver renewal discussions. Additionally, the report focuses on MassHealth continuing loan repayment, but does not include any mention of continuing special projects and residency programs:
 - Page 277: “Recommendation: MassHealth should continue investments in SWI programs like student loan repayment, special projects funding, competency-based training programs for front line staff, and training opportunities for CHWs, CHW supervisors, and recovery coaches to support the expansion of the community-based workforce and recruitment and retention of staff by ACOs and CPs. MassHealth should

also consider targeting programs and policies that facilitate building the supply of providers in workforce areas facing the greatest need.”

- Page 768: “MassHealth agrees with the IE’s observations, and its recommendation both to continue investing in workforce and to specifically target those investments to areas that need them most. Within the current demonstration, MassHealth intends to continue its SWI workforce investments for the remainder of the DSRIP program. Additionally, as part of its next Section 1115 extension, MassHealth intends to continue and further target its student loan repayment programs.”



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

MASSACHUSETTS MEDICAL SOCIETY COMMENTS SECTION 1115 DEMONSTRATION EXTENSION REQUEST

SEPTEMBER 20, 2021

The Massachusetts Medical Society, on behalf of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings, appreciates the opportunity to provide comment to the Executive Office of Health and Human Services on the Section 1115 Demonstration Extension Request. The Medical Society is committed to advocating on behalf of patients for a better health care system, and on behalf of physicians, to help them to provide the best care possible. We see the MassHealth program, and its 1115 Waiver, as critical means toward accomplishing those ends, and as such, we applaud the transparent and inclusive process undertaken over the past many months to ensure ample stakeholder engagement.

The Medical Society has long been a proponent of utilizing the Medicaid program in Massachusetts as a tool for innovation and for improving coverage and delivery of services and social supports for our most vulnerable populations. While we wholeheartedly support the nationwide, federal approach to providing such coverage, we appreciate the flexibility afforded to the states that allows for thoughtful innovation in health care. This advancement is necessary to ensure the sustainability of the system while also equitably expanding eligibility and covered services.

Overall, the Medical Society strongly supports the goals of this waiver application that seek to continue progress in improving health outcomes and reducing health disparities. We would like to present comments on the implementation of some of these objectives. We are pleased to detail these areas of interest through the comments below.

Accountable Care Organizations

The Medical Society is supportive of the continuation of the Accountable Care Organization (ACO) program and the proposed changes aimed at improving the program based on lessons learned. We applaud the focus on improving health equity and reducing disparities, which is apparent through all program design changes. We appreciate that expanding incentive payments to Model B ACOs based on combined performance on quality and health equity indicators will not only

improve quality accountability but also improve equitable health outcomes. While we appreciate the considerations and practical experience that informed MassHealth's decision to discontinue the Model C ACO, we urge to you continue to consider alternative structure offerings that can provide a meaningful entryway to risk-based contracting for physician practices with smaller membership numbers. Such an offering could include, for example, no downside risk and upside-only risk based on performance on quality and equity measures. This will help encourage more providers to participate in the MassHealth ACO program and accelerate adoption of value-based care.

We value the state's commitment to investing in primary care and behavioral health care and particularly its commitment to addressing the unique needs of children, youth, and families. Looking beyond the primary MassHealth member to the family unit as a whole is a holistic approach that will make progress toward improving the population health of our most vulnerable communities.

Care Coordination

MMS also supports efforts to streamline and improve care coordination, including the creation of a new Targeted Case Management benefit to support the highest risk, most medically complex children. We are encouraged by the signs of success of the Community Partners program and believe that having ACOs contract directly with Behavioral Health Community Partners (BH-CPs) and Long-Term Services & Supports Community Partners (LTSS-CPs) will promote improved integration and access to these critical services. Moreover, while there is an abundance of care coordination resources for patients, we often hear from our physician members about the confusion generated from multiple points of contact, which ultimately undermines care coordination efforts. Efforts to streamline and create a three-tiered framework for care coordination with standardized approaches will help address these concerns. We also support improving network adequacy by increasing the minimum number of contracted BH-CPs and LTSS-CPs to deliver MassHealth-defined supports. The Medical Society would like to understand additional detail behind the actuarial calculations that will be used to develop administrative payments to ACOs to directly pay BH-CPs and LTSS-CPs, as opposed to those CPs receiving direct payment from the state. Moreover, we would appreciate additional clarity relative to the responsibilities of the ACO versus the BH-CPs/LTSS-CPs to identify members and determine what level of care coordination is warranted. Lastly, we would like to better understand how specialized care coordination for high- and rising-risk members meeting specific medical necessity criteria will interplay with the standard care coordination programming.

Primary Care Payment Reform

The Medical Society applauds MassHealth for its attention to primary care throughout this waiver proposal. MMS has long supported greater investment in and improvements to primary care. We supported primary care reforms and investments in the last waiver—including support of care coordination and IT infrastructure for population health programs—that likely helped lead to the reported increases in primary care utilization within the MassHealth ACOs over the past several years. We see the role of primary care within medicine as increasingly critical, especially for patients with complex medical and social needs. MMS has long envisioned the potential of primary care through initiatives such as behavioral health integration, greater care coordination, and greater abilities to tend to the social needs of patients. In order for the visions of primary care to be realized, however, reimbursement rates and payments systems must be aligned with these ideals.

MMS supports the adoption of alternative health care delivery systems such as ACOs and the global payment structures that accompany them. MMS supports movement toward the capitated payment structures that ACOs promote, while also appreciating the need to retain other payment models such as fee-for-service to allow for different physician practice types to select the payment model that best serves their practice and patients. We feel this is well reflected in the growing MassHealth ACO program alongside the continued existence of the PCC plan. We continue to underscore, as we did in waiver comments five years ago, the value of physician participation in the governance of ACOs and in public policy discussions about the future structuring of these organizations.

MMS appreciates that a system that pays ACOs on global, capitated bases, but that permits the ACOs to pay for underlying primary care on a fee-for-service basis, will be unlikely to bear the fruits of the intention and potential of ACOs to promote the highest value care. We thus support MassHealth conceptually as it endeavors to establish a sub-capitation payment system for primary care. The flexibility and predictability of such prospective payments, if structured properly, could be a meaningful step in allowing primary care to implement many of its preferred reforms. Proper risk adjustment, inclusive of social risk factors, will continue to be critical to assuring success of any program. We appreciate the elimination of an administratively burdensome required back-end reconciliation against utilization, which has often been present in commercial sub-capitation pilot programs.

There are many features of this proposal that appear promising. MMS supports MassHealth in proposing a tiered payment system that proportionally increases the sub-capitation rate based

upon the practice's capabilities on key areas such as behavioral health integration, care coordination, unique needs of children, youth, and families, and expanded access. We believe that higher payments based upon this tiering construct will incentivize and reward investments in more expansive services. We wish to underscore, however, the reality that many of these capabilities require capital, upfront investment by practices. We therefore encourage continued funding and technical assistance to practices who wish to increase these capabilities with a desire to better serve their patients and to increase the tiering and resulting payment.

Beyond many of these conceptual discussions is the reality that the merits of a sub-capitated payment proposal are largely grounded in the actual level of funding. The Medical Society urges the release of additional detail to better assess the adequacy of the proposed payments. Primary care has not benefited from many of the supplemental funding sources available to hospitals who serve similar populations. We continue to call for increases in reimbursement to create sustainable models of integrated, high-quality physician practice that serve MassHealth members. We further urge accompanying resources to allow for transformation for physician practices toward higher tiers of care through expansion of services and capabilities for patient care.

Behavioral Health Reform

The Medical Society has prioritized advocacy in furtherance of an improved behavioral health system. We have worked extensively with stakeholders in this space to improve payment, workforce, and ultimately, access to high quality behavioral health for all patients in the Commonwealth. We believe the *Massachusetts Roadmap for Behavioral Health* is an important step in the right direction. We support accompanying financial investments in behavioral health infrastructure, and we support the better care coordination proposed for patients with complex behavioral health care needs.

On the issue of workforce, MMS supports continuation of loan forgiveness for primary care and behavioral health professionals, including psychiatrists, who pledge to work in settings with high-MassHealth membership settings.

Children, Youth, and Families

The MMS strongly supports the specific attention given in the waiver to improvements of the care of children, youth, and families. Improvements in pediatric behavioral health care (as embedded in the *Roadmap*), in family-centered care coordination of pediatric patients, and in health equity

work to improve maternal and child health, are all enthusiastically welcomed by MMS and consistent with similar advocacy to drive analogous improvements in the commercial market.

Incentivized Data Collection

The Medical Society highly commends the commitment to advancing health equity through a focus on initiatives that address health-related social needs and specific disparities. Importantly, this proposal includes a critical first step toward improving health inequities: incentivizing the collection of accurate social risk factor data on an aligned measure set to better understand why and how health disparities originate. The insights gleaned from the collection of such data will help to guide development of effective interventions and performance measure approaches that seek to identify and eliminate inequitable health disparities. The proposed incentive payments will allow physicians serving disproportionately socially-at-risk populations to focus on health equity performance. The Medical Society looks forward to staying engaged with the Commonwealth to develop parameters for success of this program, including those surrounding the standardization of data collection, the process for identifying and monitoring health and health care inequities, and the implementation of evidence-based interventions to reduce inequities.

Flexible Services Program

The MMS also supports the continuation of the Flexible Services Program (FSP), which offers nutrition or housing supports for members experiencing health-related social needs. We know the value of interventions such as the Food is Medicine plan and the importance of housing security to people's overall health and well-being. We are committed to working with the state to maximize access to services for vulnerable populations and addressing social determinants of health, which have a substantial impact on people's health, well-being, and quality of life.

The Medical Society promotes a comprehensive approach to health care that recognizes the importance of health-related social needs such as stability in nutrition and housing. Furthermore, it is critical to acknowledge how these needs have a disproportionate negative impact on people of color. In Massachusetts, Black and Latinx people experience homelessness and food insecurity at rates far exceeding those for white individuals. The goods and support services provided by the FSP have positive impacts on members' health and costs of care. Expanding nutrition support services to a member's household would help to maximize the benefits of these supports. The welfare of the family being critical to each member's health, allowing FSP services to be used for childcare allows vital support for families with children, permitting members to devote more time

and effort to nutritional education and skill development. With regard to housing support services, expanding the definition of “chronically homeless individuals” will give more people access to these tremendously helpful services, which work simultaneously to improve health and lower health care costs. Expanded opportunity for housing stability is particularly crucial for children’s educational and emotional well-being.

Postpartum Coverage Expansion

The Medical Society additionally stands in strong support of extending the postpartum period of eligibility for services from 60 days to a full 12 months after birth. The Medical Society is committed to combating the rise in maternal morbidity and mortality and the racial disparities therein. Inadequate postpartum care may contribute to persistent racial and ethnic disparities in maternal and infant health outcomes, and expanded MassHealth coverage in the postpartum period will help to improve these longstanding inequities. A significant clinical paradigm shift in postpartum care has emerged emphasizing that postpartum care is an ongoing process that typically requires multiple visits and follow-up care that may last a year or even longer. Increasing access to postpartum care is particularly important for those who experience pregnancy complications or have chronic conditions, such as cardiovascular disease, hypertension, or diabetes, which disproportionately affect people of color. Moreover, access to behavioral health services for women experiencing postpartum depression – that may not be detected within the first two months postpartum – is essential to the success of mother-infant bonding and the health of the child. Medicaid-enrolled pregnant individuals are more likely than women with private coverage to have certain chronic conditions, preterm births, or low birthweight babies, putting them at higher risk for poor maternal outcomes. The Medical Society sees this expansion in coverage as fundamental to the success of maternal health care services provided through MassHealth and believes it necessary to advance maternal and infant health in our Commonwealth.

Coverage for Justice Involved Individuals

We are further heartened to see the request to expand MassHealth benefits to justice-involved individuals, providing much-needed, continuous health coverage for individuals who experience unique health challenges posed by entering, living in, and transitioning from carceral settings. It is important to note that this expansion would protect not only incarcerated adults from losing their MassHealth benefits, but also incarcerated youth, who face an even greater health risk resulting from incarceration. Overall, incarcerated individuals face drastic health disparities when compared to the general public in relation to health issues such as hypertension, asthma,

substance use disorder, oral health, and mental health conditions. Compared to people who have not been held in carceral settings, incarcerated individuals have a 12.7 times greater chance of death within the two-week period after their release, and they are over 120 times more likely to die of a drug overdose within that same timeframe. This expansion of MassHealth coverage would help to reduce some of the health disparities felt by Black and Hispanic individuals, who are represented in the Massachusetts justice-involved population at rates of 7.5 and 4.3 times that of white individuals, respectively. The Medical Society applauds the recognition that these vulnerable populations need MassHealth coverage during a most vulnerable and critical period.

Safety Net Sustainability and Near-Universal Coverage

The Medical Society additionally applauds the proposals aimed at sustaining safety net providers while at the same time advancing population health and health equity. Some of our Commonwealth's most important resources for treating the most vulnerable populations rely on funding to support their operational needs. Increasing the number of safety net hospitals eligible for this federal funding will create greater opportunity for physicians and other health care providers to treat a wider range of patients with minimal negative financial impact, improving patient care and access, which ultimately betters the health of our Commonwealth. Additionally, toward that end, the Medical Society supports the efforts to maintain near-universal coverage. Streamlining the user experience and providing greater supports for those at risk of disruptions in coverage while preserving affordability, coverage, and access to care through subsidies for lower-income enrollees will make it easier for Massachusetts residents to identify and receive the care they need in a continuous and more reliable fashion.

Thank you for your consideration of these comments, and congratulations on an impressive and comprehensive waiver request. The Massachusetts Medical Society looks forward to remaining engaged with you to help provide the important physician perspective as you refine this demonstration request.

MASSACHUSETTS TRIAL COURT
MASSACHUSETTS PROBATION SERVICE

ONE ASHBURTON PLACE
BOSTON, MA 02108-1612



EDWARD J. DOLAN
COMMISSIONER

TEL: (617) 727-5300
FAX: (617) 727-5333

September 20, 2021

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments,
One Ashburton Place,
11th Floor, Boston, MA 02108.

To Whom It May Concern:

We are writing to provide support for the 1115 MassHealth Demonstration Extension Request. This request will provide Massachusetts with an opportunity to meet the healthcare needs of justice-involved individuals, reduce health disparities amongst BIPOC communities and neighborhoods impacted by incarceration, and ultimately reduce negative health outcomes for justice-involved populations.

MassHealth has completed extensive stakeholder engagement with justice partners over the past year in order to strategically develop an operational plan for this initiative, taking into account the needs and concerns of all agencies involved: DOC, MSA, CCFs, and DYS are all key thought partners and have provide crucial time, resources, and partnership throughout this process and plan to continue to do so through implementation.

The Demonstration Extension Request will address the needs of individuals who are incarcerated in the following aspects:

- MassHealth proposes to provide **uninterrupted** Medicaid coverage to MassHealth-eligible individuals during their incarceration. This would:
 - Further streamline eligibility processes and more effectively integrate this population into the MassHealth program.
 - Decrease disruption of benefits and prevent individuals from “falling through the cracks” after release.
- Going above and beyond the applicable Community Standard of Care for correctional facilities, this expenditure authority is anticipated to contribute to ongoing continuous healthcare improvement efforts for incarcerated and newly released MassHealth members by:

- Increasing continuity of care.
- Improving transitions to and from correctional facilities.
- Enhancing access to healthcare services.

MassHealth and its correctional partners are completing ongoing work to determine how this initiative will be operationalized, with the ultimate goal of ensuring that individuals will have continuous and timely access to coordinated care, consistent with, and in some cases exceeding, community standards

The request to cover individuals in correctional settings is a necessary step the Commonwealth must take in order to achieve social justice and health equity for incarcerated individuals, their families and communities at large. The expansion of MassHealth coverage for justice-involved populations would radically increase opportunities for appropriate healthcare services and address existing gaps in the current continuum of care

Respectfully Submitted,

A handwritten signature in black ink that reads "Edward J. Dolan". The signature is written in a cursive style with a large, stylized initial "E".

Edward J. Dolan
Commissioner



Massachusetts Sheriffs' Association

132 Portland Street, 2nd Floor
Boston, Massachusetts 02114
www.mass.gov/msa



President
Steven W. Tompkins
Suffolk County

Vice President
Nicholas Cocchi
Hampden County

Executive Director
Carrie Hill, Esq.

Sheriffs
James M. Cummings
Barnstable County

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Patrick W. McDermott
Norfolk County

Joseph D. McDonald, Jr.
Plymouth County

Steven W. Tompkins
Suffolk County

Lewis G. Evangelidis
Worcester County

September 20, 2021

(Sent VIA EMAIL ONLY)

Amanda Cassel-Kraft
Assistant Secretary for MassHealth
Medicaid Director
1115-Comments@mass.gov

Dear Assistant Secretary Cassel-Kraft,

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 Massachusetts Demonstration: Seeking Authority to Provide MassHealth to Individuals Experiencing Incarceration*.

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 cooccurring 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.

In addition to addressing crisis, the Sheriffs also excel at collaboration and convening. In an exciting partnership, 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 unprecedented, innovative and sustainable proposal: to expand Medicaid eligibility to all individuals in the Commonwealth experiencing incarceration. Without distinction in status, whether juvenile, pretrial or convicted, we collectively embrace the proposal to support the provision of Medicaid for all eligible incarcerated individuals.

This is a heavy lift and we are prepared to meet the needs and requirements of our federal and state partners. For the past year we have been meeting and working in collaboration on the MIEP 1115 Demonstration proposal. 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. We stand ready. We stand united.

Thank you for your commitment to improving health disparities and inequities for all incarcerated individuals in the Commonwealth. We are in full support of the MassHealth 1115 Demonstration. Please do not hesitate to either contact myself or Carrie Hill at carrie.hill@massmail.state.ma.

Respectfully,

A handwritten signature in blue ink that reads "Steven W. Tompkins".

Steven W. Tompkins, President
Massachusetts Sheriffs' Association

Cc: Secretary Marylou Sudders
Acting Secretary Terrence Reidy
Undersecretary Andrew Peck
Commissioner Carol Mici
Sheriff Nicholas Cocchi
Executive Director Carrie Hill



September 20, 2021

Amanda Cassel Kraft, Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services, Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Assistant Secretary Cassel Kraft:

Thank you for the opportunity to convey our support for the Section 1115 MassHealth Demonstration Waiver Extension Proposal. The Massachusetts Behavioral Health Partnership (MBHP) is honored to manage behavioral healthcare for more than 600,000 MassHealth members statewide and proud to ensure access to high-quality, accessible, culturally sensitive healthcare. As you know, we currently serve members of the MassHealth Primary Care Clinician (PCC) Plan and MassHealth Accountable Care Organization (ACO) programs. We also serve special populations including children in state custody and adults experiencing homelessness.

During the more than 25 years of our partnership with the Executive Office of Health and Human Services (EOHHS), we have launched new programs and initiatives with positive and demonstrable effects on the lives of thousands of children, teens, and adults with mental illness and substance use disorders (SUD). In the mid-1990s, we designed the integrated care management program (ICMP) to offer an enhanced care management program to Primary Care Clinician (PCC) Plan members with complex needs. In the 2000s, alongside partner managed care plans and state agencies, we implemented the Children's Behavioral Health Initiative (CBHI) to provide MassHealth children with serious emotional disturbance (SED) with integrated behavioral health services and a comprehensive, community-based system of care. In collaboration with the Massachusetts Housing and Shelter Alliance, we have implemented a Community Support Program to provide outreach and supportive services to a range of members with psychiatric or substance use disorder diagnoses, including individuals in shelters or experiencing chronic homelessness. Since the advent of the last MassHealth 1115 Waiver, we have worked closely with MassHealth's ACOs and Community Partners (CPs) to provide integrated medical and behavioral health services to ACO members.

Even with this proud history, we are keenly aware of how much more we can and must accomplish together to improve care and realize the promise of integrated physical and behavioral health. The COVID-19 pandemic underscored profound racial and ethnic inequities across the healthcare system, exacerbating longstanding disparities in access to healthcare, including behavioral healthcare services. Black and Latinx communities have historically experienced substantially lower access to mental health and substance use disorder treatment services. We look forward to partnering with ACOs and providers to document, measure, and address the systemic barriers to an equitable healthcare and behavioral health system.

Another challenge that still lies ahead of us is the integration of care for persons with co-occurring substance use disorders and mental illness. The structural barriers that separate these services are deeply embedded, with each system relying on its own data systems and regulations, and they can make it difficult for individuals with co-occurring disorders to receive treatment for both, let alone benefit from coordinated care. MBHP is strongly committed to addressing these issues and to partnering with EOHHS to craft and implement systems of truly integrated and coordinated care.

MBHP strongly supports each of the five goals articulated in the Waiver Extension Proposal, and we applaud EOHHS for its vision and steadfast commitment. We comment below on the three specific goals that relate most directly to our partnership with EOHHS and our common mission to: 1) restructure and reaffirm accountable, value-based care; 2) reform primary care, behavioral health, and pediatric care; and 3) advance health equity, with a focus on initiatives addressing health-related social needs.

Goal 1: Continue the path of restructuring and re-affirm accountable, value-based care – increasing expectations for how ACOs improve care and trend management, and refining the model.

MassHealth has accomplished a great deal through the launch of the MassHealth ACO program and its 17 accountable care organizations. DSRIP’s statewide investments have been successful in strengthening the community workforce and supporting community-based organizations, providers, and payer entities to engage in substantive delivery system transformation. MassHealth members have experienced health improvements, as reported by program evaluators, because of improved communications with and among their providers.

While we are at the early stages of transformation, MassHealth ACOs have adopted many strategies to reduce total cost of care and bend the cost trend. MBHP is proud of its contributions in building and strengthening organizational relationships across the care continuum to promote continuity of care and behavioral and physical healthcare integration.

Looking forward to new authorities enabled by the Waiver Extension Proposal, MBHP continues to fully support the MassHealth ACO program and the Long-Term Services and Supports and Behavioral Health Community Partners (LTSS CPs and BH CPs). We will continue to work closely with the ACOs and the BH CPs to ensure that members with high needs continue to receive needed supports and to provide needed support to ensure that CPs become an enduring part of the MassHealth behavioral health delivery ecosystem.

MBHP is also committed to continuing to support the data infrastructure needed to provide continuous and fully integrated care for these populations. Considerable progress has been made over the past four years to develop data sets, analytic capabilities, and reports. However, more work is still needed. We commit to work closely with MassHealth, the ACOs, and CPs to standardize and streamline data collection processes, indicators, measures, and reporting to improve accuracy; reduce duplication of efforts; integrate care teams more fully; and reduce disparities in health and healthcare.

Finally, MBHP will work with EOHHS to streamline the administration of behavioral health benefits and ensure parity. We stand ready to leverage our experience as an EOHHS partner to help define and disseminate best practices in utilization management, access standards, workforce expansion, and network development.

Goal 2: Reform and invest in primary care, behavioral health and pediatric care that expands access and moves the delivery system away from siloed, fee-for-service health care.

MBHP enthusiastically supports delivery system reform to enhance behavioral healthcare and primary care for children and adults and to move toward the goal of providing whole person, person-centered, integrated healthcare to all MassHealth members. Statewide investments in targeted student loan forgiveness programs have achieved some successes in expanding the workforce in primary care and behavioral health. Significant gaps remain to be addressed, however.

We commend EOHHS for prioritizing the needs of individuals with mental illness and SUD in its ambitious *Roadmap for Behavioral Health Reform* by investing in a system with “no wrong door” and in Community Behavioral Health Centers (CBHCs). In addition, we are delighted that EOHHS intends to expand diversionary behavioral health service coverage to respond to the intensive needs of many MassHealth members. Continued expansion of the behavioral health workforce and the availability and staffing of diversionary services will continue to be critical to the success of ACOs. MBHP commits to lead and participate in collective efforts to institute these improvements. We will design and conduct learning collaboratives and other educational efforts with ACOs to foster continued workforce development. We are able to provide expertise around establishing diversionary services and designing staffing requirements in support of new services. Finally, we are prepared to offer direct technical assistance to ACOs to develop and promote behavioral health integration with medical care, to ensure continuity, and to enhance the use and effectiveness of diversionary services.



Finally, we understand that EOHHS intends to implement primary care sub-capitation payments through the ACOs. We strongly support your approach to set up tiered payments tied to the degree of behavioral health supports integrated in a practice and anticipate that this strategy will drive access, early identification, early treatment, and destigmatization. As a longtime partner to the PCC Plan, MBHP commits to support this transformation, including by providing technical assistance to practices as they work toward higher levels of integration and improved care coordination.

Goal 3: Advance health equity, with a focus on initiatives addressing health-related social needs and specific disparities, including maternal health and health care for justice-involved individuals

MBHP strongly supports the prioritization of health equity under the Waiver Extension Proposal. We will commit our full resources to reduce health inequities and disparities. We urge a broad definition of equity, to encompass considerations of race, ethnicity, language, disability, sexual orientation, gender identity, immigrant status, and justice involvement. Health inequities among individuals with mental illness and substance use disorders have been clearly established. These populations are at much higher risk of poor outcomes including higher mortality rates, which are compounded by their greater health-related social needs. We see tremendous opportunities to improve health equity by addressing health inequities stemming from systemic racism, stigma, and other forms of discrimination in the healthcare system.

One of the specific ways we can address inequities is by routinely identifying those people who are adversely impacted by social determinants of health (SDOH) and connecting them with necessary supports such as food, nutrition, housing, and transportation. MBHP is committed to continuing to address these needs both directly, and through our engagement with and support of the ACOs and CPs.

As EOHHS clearly recognizes, it is essential that we implement improved methods to collect data on race, ethnicity, language, sexual orientation, and gender identity to identify persons at risk of poor outcomes and in need of tailored supports and interventions. We anticipate that incentives for both providers and ACOs will, among other priorities, emphasize data collection and measurement. We commit to work alongside all stakeholders to test and implement methods to provide meaningful and actionable information. We note that new methods of collecting race and ethnicity data have recently been tested in other states and have achieved notable early success.

Of course, identifying and measuring disparities is only a precursor to designing interventions to improve health equity. MBHP has a long history of working with EOHHS to develop innovative programs, like behavioral health diversionary services and the Community Support Program for People Experiencing Chronic Homelessness. We commit to work with you to continually identify new innovations in care that will permit us to assertively address disparities and improve equity.

Thank you for the opportunity to comment on what we consider a thoughtful, ambitious, and comprehensive effort to build on MassHealth's successes through the Waiver Extension Proposal. We are proud to be an EOHHS partner, and we look forward to continuing to work collaboratively with you to improve the lives of MassHealth members.

A handwritten signature in black ink that reads "Sharon Hanson".

Sharon Hanson
Vice President of Client Partnership
CEO, Massachusetts Behavioral Health Partnership

CC: Susan Coakley, Market President, East

I am writing today in support of the Commonwealth of Massachusetts application to update the 1115 waiver. My views are based on being a person with a disability and the importance of the CommonHealth program. I currently work as the executive director of the MetroWest Center for Independent Living in Framingham and want to tell my story. The changes being proposed for the CommonHealth program are a major step forward in ensuring that individuals with disabilities who have used the program will be able to continue to live in the community into their retirement years.

Here is my story;

I have been a disability advocate for over 40 years, beginning in 1975 when I became involved with disability rights as a student at Southeastern Massachusetts University, in North Dartmouth, MA. From those early experiences fighting for access and disabled student rights, it became clear my path forward in life was to become an disability advocate.

During college, I became involved in the greater disability rights movement and independent living. My first job was working as a peer counselor for the independent living program at the Mass. Hospital School in Canton. When I graduated from college in 1981, I faced the very difficult decision of giving up SSI benefits and MassHealth to enter the world of full-time employment. With the help of MRC, which at that time had a CommonHealth like program for working individuals with disabilities, I was able to go to work full-time, give up SSI and get onto the MRC program to continue to receive MassHealth services.

As a person with a disability, I needed and used PCA services. I also needed coverage for MDE services and disability-related medical services not covered by traditional private health care plans. The MRC program enabled me to work full-time by paying a premium for MassHealth coverage with no asset limitations or restrictions. This program was the predecessor of CommonHealth.

During the 1980s, with the introduction of CommonHealth, the MRC program was phased out and I became a CommonHealth user. Under CommonHealth I was able to work and continue to receive the medical services I needed to live independently. In addition, this program enabled me to rise in my career as a disability advocate and actively work in the larger disability rights movement. I have worked on many national issues including the ADA and Olmstead. During the 1980s and 1990s I worked and provided leadership to national organizations such as the National Council on Independent Living and the National Association

for Independent Living. This would not have been possible without the assistance of CommonHealth.

Many do not understand the cost of services needed for a disabled person to live independently, work full-time and function in our society. Costs including PCA services, DME and other medical services that are not provided by private health insurance, which means a disabled person needs Medicaid services to live in the community. In many states, Medicaid services are available only to individuals on SSI or SSDI, with limited assets. Going to work raises your income forcing you to need the support services of CommonHealth, otherwise the out-of-pocket cost for medical services would not be sustainable. Massachusetts has been different and a leader in providing services to disabled working individuals with access to the buy-in program known as CommonHealth. What this means is that disabled persons who need Medicaid services and want to work, have that option and the opportunity to have a career and the American dream.

Now, after over thirty years of a very successful program with CommonHealth, we face a major problem and injustice. People like myself are looking forward to retirement, but CommonHealth has no option for retirement. When CommonHealth was crafted we never thought of retirement, but the time has come to make a change and include a new option for retirement and also the ability to offer CommonHealth to other individuals with disabilities who fall into the trap of turning 65 years or older, but still need the coverage of the Medicaid services that CommonHealth provides.

In my case, I am 66 years old and would like to retire at some point in the future. However, under the current rules of CommonHealth I must continue to work 10 hours per week or face losing all MassHealth benefits. If that happens, in order to get regular MassHealth I must spend out all the assets and savings I have managed to acquire over a lifetime of work. The sad fact is my disability is still the same and my needs are still the same. So we need to fix this injustice and create a new level of CommonHealth coverage for the 65 and older, who have a work history and when they retire, the CommonHealth premium should be based on the individual's retirement income, such a pension or Social Security. There should not be asset or income limits, so the individual can benefit from their work history and effort.

This is a small change, but a major step in maintaining the promise of CommonHealth, which is to provide a path out of poverty for individuals with disabilities, and provide them with the medical services they need to live a normal life in our society. I for one, have been happy to pay the premium required for

these services, and would continue to do so in retirement. CommonHealth is first a medical benefit for disabled persons, but also a social justice program to enable disabled persons to live in freedom in the community without living in poverty.

I know this sounds like a personal ask, but as an advocate, I hear from many who are on CommonHealth and are facing the same issue. We cannot retire if we want to stay living in the community, we all face this problem and we need to update CommonHealth. With the upcoming process for filing of the 1115 waiver, we have the opportunity to fix this problem and make the CommonHealth program better for all.

Changes proposed to create a retired form of CommonHealth

Program open to individuals 65 years and older

Individuals have worked for more than 10 years using CommonHealth

Premiums based on retirement income, no asset limits on savings or income

These changes will go a long way in supporting individuals with disabilities who have lived and worked for many years in the community using CommonHealth.

Paul Spooner

MetroWest Center for Independent Living



September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary and Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Assistant Secretary Cassel Kraft:

The Massachusetts Health & Hospital Association (MHA) offers these comments in response to the Executive Office of Health and Human Services' (EOHHS) request for feedback on its proposed extension of the MassHealth Medicaid Section 1115 Demonstration (1115 waiver). We appreciate the many forums and opportunities to engage with EOHHS on development of policies that are being considered for inclusion in the commonwealth's 1115 waiver renewal proposal and we look forward to continuing this dialogue.

MHA is supportive of the goals EOHHS has outlined in its proposal, including continued support for Accountable Care Organizations (ACOs) and investments in primary care, behavioral health, health-related housing and nutrition services, and safety net providers. We also are strongly aligned with EOHHS in seeking to reduce health disparities in the MassHealth program through greater investments and accountability. Robust federal and state support for these initiatives will be essential over the next five-year waiver term.

Many of the 1115 waiver investments EOHHS proposed assume funding from a continued increased assessment on acute care hospitals. MHA is grateful for the strong collaboration and open communication with EOHHS on this issue. Through the robust process that is now underway with hospitals, policy experts, EOHHS, and the legislature, we are confident that a mutually approved plan can be developed that aligns with the goals of MassHealth and recognizes the financial needs and contributions of hospitals.

As EOHHS continues to solidify the specifics on the 1115 waiver renewal proposal, MHA respectfully requests your consideration of the following comments based on feedback from our member hospitals and health systems.

Health Equity

Hospitals are committed to reducing health disparities and we support the state prioritizing this goal in the 1115 waiver. The COVID-19 crisis has shined a bright light on the pervasive health inequities that exist both here in the commonwealth and across the country. It is clear much needs to be done to improve access and health outcomes for people of color, immigrants, and others in chronically

underrepresented communities. It is also clear that more can be done within the provider community and through state programs to close these disparities. Equitable access to healthcare is at the heart of our mission, and our providers are continually evaluating how their practices and policies reach people of color and other underrepresented communities. They are also taking a renewed focus on how to improve diversity, equity, and inclusion within their own organizations.

MHA greatly appreciates the EOHHS proposal to introduce investments funding through the 1115 waiver to support acute care hospitals' efforts to reduce health disparities. We agree with EOHHS that this funding be separate and distinct from traditional safety net funding in the 1115 Waiver Safety Net Care Pool, which is closely tied to the long-standing federal Medicaid Disproportionate Share Hospital (DSH) funding. As you know, federal law requires state Medicaid programs to issue added financial support to hospitals that serve large numbers of Medicaid and uninsured patients. While Massachusetts currently has a waiver from this provision, this support is technically realized through Safety Net Provider Payments and the Health Safety Net program, both of which are financed in the 1115 Waiver Safety Net Care Pool.

Medicaid DSH funding and financing of safety net hospital care provided to Medicaid and uninsured patients has been assumed in the Massachusetts 1115 waiver since 1997. While tremendous gains have been made in expanding access, reducing the number of uninsured, and providing high-quality care to all Massachusetts residents regardless of color and income, much more needs to be done to address existing health inequities. Additional funding beyond historical and core DSH funding that currently supports safety net providers is needed to make material improvements to further expand and reach communities of color and the disabled. For this reason, MHA strongly supports the commonwealth pursuing new 1115 waiver authority for health equity investments across Massachusetts acute hospitals that is separate and distinct from traditional safety net support.

Under the current EOHHS proposal, 50% of the proposed \$100 million annual investment to support this work is to be funded by acute hospitals themselves through an increase in their provider assessment tax. MHA and its member hospitals are currently aiming to collaborate on a substantial funding proposal to support all acute hospitals in their collective efforts to generate positive change in healthcare outcomes for people of color, immigrants, and others in chronically underrepresented communities. These considerations involve a significant investment by hospitals themselves through a potential change in their provider assessment. Hospitals will also be held accountable for their own performance in these efforts through pay-for-performance. We look forward to working with EOHHS to coalesce on a bold and aggressive plan to introduce new funding with the support of the federal government to make meaningful improvements in reducing health disparities.

Safety Net Provider Payments

The 1115 waiver includes numerous investments that support safety net hospitals, including Safety Net Provider Payments that were introduced in FY2018. We appreciate that EOHHS will update the data that defines safety net hospitals, which will expand the number of hospitals that will qualify. With that update, EOHHS proposes an additional \$20 million in gross funding (state/federal) to support this expansion. We recognize that EOHHS is exploring other hospital payment vehicles, including new health equity investments (supported by the hospital assessment), but additional state general fund support will be needed for safety net hospitals over the next five years. Safety Net Provider Payments have declined for Group 1 hospitals over the past five years and EOHHS is

assuming a continuation of the lowest level funding amount into the next waiver term. Additional funding is assumed for Group 2 hospitals but at a level that yields less funding compared to Group 1 and which also must now support the addition of nine hospitals.

As pillars of their communities, these providers have a distinct role in ensuring equitable care for underrepresented populations. These hospitals collectively serve the greatest number of MassHealth patients and the state has a vested interest in hospitals continuing to enhance efforts that reduce unnecessary utilization, improve care management of those most in need, and produce high-quality outcomes for MassHealth members. As part of our evaluation of a continued increased acute hospital assessment, MHA and hospitals are considering substantial funding to safety net providers in a manner that meets MHA's guiding principles which take into consideration the overall hospital assessment and related spending implications. While hospitals explore this opportunity, we also request that the state reconsider how it is purposing state General Fund dollars to support safety net providers. Ultimately, we strongly believe the commonwealth will need to be ambitious in seeking support of increased 1115 waiver funding for safety net providers.

Clinical Quality Incentive Payments

The EOHHS proposed increased acute hospital assessment plan currently assumes \$150 million in clinical quality incentive payments funded in part by the hospital assessment. Depending how a clinical quality incentive program is designed and how this funding is assumed with the specifics of the Medicaid program, MHA is open to a hospital assessment and spending program that incorporates clinical quality incentives.

Current hospital clinical quality incentive funding through the MassHealth pay-for-performance program is extremely low and we believe additional investments in this area are long-overdue. MassHealth pay-for-performance was introduced in the 2006 state health reform law as an important vehicle to close the MassHealth hospital underpayment gap and to provide an incentive for quality improvement. At its peak, this funding had been \$100 million per year but over the years it has been reduced and now stands at \$25 million, of which only about half (\$12.5 million) is paid to hospitals. On a more than \$3 billion MassHealth hospital program, this funding is unfortunately inconsequential to incentivize clinical quality outcomes. We note that in FY2017, MassHealth separately introduced incentive payments totaling \$265 million to measure and incentivize care delivered to disabled patients. As part of the upcoming 1115 waiver, this specific vehicle is planned to be phased out and disability access measures are anticipated to be incorporated into the overall clinical quality incentive program.

To truly incentivize improvement in clinical quality across more than 60 acute care hospitals and multiple MassHealth managed care offerings, significant funding must be considered as part of the next 1115 waiver. Currently, only the \$265 million disability access incentive payment is identified in the 1115 waiver. In the upcoming 1115 proposal to CMS, MHA believes EOHHS should clearly identify the clinical quality incentive funding in the waiver given the magnitude of dollars now being considered by EOHHS and hospitals.

We also believe given the unique design of the MassHealth program, new 1115 waiver authority should be pursued so that measurement and financing of these incentives can be done in the most appropriate and meaningful way. As you know, MassHealth created its ACO program in FY2018, which introduced 17 new entities that are now accountable for managing care of more than 1

million MassHealth lives. In addition, the long-standing Primary Care Clinician (PCC) program and two Medicaid Managed Care Organizations (MCOs) cover more than 200,000 lives. In total, the MassHealth managed care population is now categorized into 20 groups depending on their ACO, MCO, and PCC affiliation. With the state's upcoming ACO procurement, we envision new entities joining which could increase these offerings.

The current level of choice in the MassHealth program is staggering and welcome. It should only be viewed positively that so many Massachusetts healthcare providers have committed to this new, innovative ACO program that has brought on new options and benefits for Medicaid enrollees. All ACO participations are Massachusetts organizations dedicated to their communities. Many are geographically focused and have a superior understanding of their local environment and the needs of patients living in their community. One ACO is entirely dedicated to serving children, while others are safety net community focused. The innovative MassHealth ACO managed care model stands in stark contrast to some other state Medicaid programs that use out-of-state Medicaid insurance companies charged with managing care across a state.

Hospital care provided to the more than 1.2 million MassHealth members in the 17 ACOs, two MCOs, and PCC plan is currently not evaluated and incentivized broadly from a clinical quality perspective applicable to hospitals directly. We also do not believe it is appropriate or accurate to measure and incentivize hospital clinical quality at this granular level. In many cases, hospital patients associated with a single ACO would likely be statistically insignificant yielding different results for care provided by a single hospital depending on how the patients are grouped by managed care offering. Given the relative newness of the ACO program and upcoming procurement, we would also expect movement of lives among the varying ACOs, MCOs, and PCC program.

We believe strongly that hospital clinical quality incentive program should measure patient outcomes and experience in the aggregate across the entire MassHealth program as opposed to the finely sliced approach across more than 20 MassHealth contracting entities. We believe such an approach will better measure these outcomes and will provide more actionable and meaningful information to hospitals as they evaluate themselves to make improvements in care delivery. For these many reasons, we respectfully ask that EOHHS consider putting forward a request for a new 1115 waiver authority specifying this revised hospital clinical quality incentive program in recognition of the unique and innovative MassHealth ACO managed care program. Similar to existing Medicaid incentive programs, we believe these clinical quality incentive payments should not be counted against any Medicaid hospital specific cost limits.

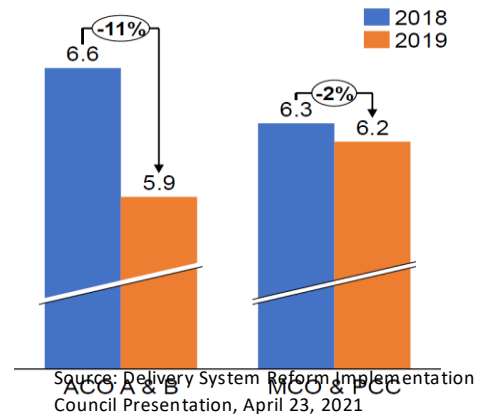
If properly designed, a MassHealth hospital clinical quality incentive program can help to further promote quality improvement initiatives for MassHealth patients. We believe it is in the interest of hospitals and MassHealth to agree to quality measurements and processes that evaluate hospitals in a fair manner, are realistically able to be incorporated into hospital operations, and do not overly burden hospitals with reporting requirements. We look forward to further discussing these details as part of our ongoing discussions related to the 1115 waiver and an increased acute hospital assessment.

ACO Population Health & Care Coordination Funding

MHA is proud of the significant efforts that our member hospitals, health systems, physician organizations, and other partners have made in working with EOHHS to implement the MassHealth ACO program these past four years. The effort is unparalleled and has resulted in the most significant transformation of the MassHealth program since the original 1115 waiver in 1997. More than 1 million MassHealth members, representing 80% of the managed care eligible population, are now enrolled in these newly formed ACOs, achieving one of the most ambitious goals of the state’s 2012 payment and delivery reform law (Chapter 224). Since the first year of the program, 17 ACOs have been held financially accountable for the total cost of care of their patients as well as for patient quality outcomes and experience. ACOs have taken on numerous new responsibilities related to care management and population health, employed new staff essential to all aspects of the program, invested in IT systems focused on patient care management and identifying risk factors, created new programs to better serve MassHealth patients, and enhanced provider relationships and information sharing across the care continuum.

Despite the immense challenges of this undertaking, including during the COVID-19 pandemic, ACOs are making demonstrable progress in achieving the state’s goals to bend the utilization curve while maintaining high-quality care. According to the EOHHS presentation to the state’s Delivery System Reform Implementation Council (DSRIC)¹, ACOs have been successful in shifting utilization away from more acute settings. The presentation notes that “unnecessary hospital admissions decreased among members enrolled in an ACO compared with non-ACO members. At the same time, primary care utilization increased among members enrolled in an ACO.” PCP visits were also 12% higher for ACO members compared to non-ACO members. According to EOHHS, 70% of the ACO programs that were evaluated demonstrated improvement in half, or more than half, of the measures used to evaluate them.

Potentially Avoidable Admissions per 1000 members



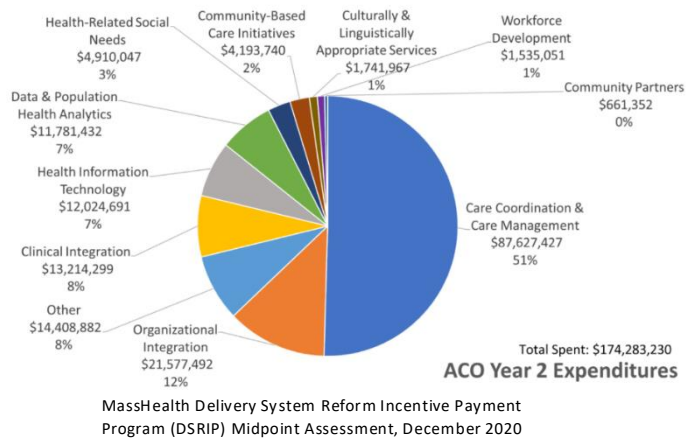
¹ Delivery System Reform Implementation Council, Meeting #27 Presentation, April 23, 2021.

With the support of Delivery System Reform Incentive Payments (DSRIP), ACOs have invested heavily in infrastructure, programs, and workforce to make these trends a reality and improve patient outcomes. ACOs have implemented a wide variety of initiatives focused on understanding and supporting their patients, including screenings, analysis, and greater engagement of those requiring more intensive and diverse care for their complex conditions. According to the independent review of the DSRIP program, ACOs spent more than \$174 million in Year 2 of the ACO initiative on programs, staff, technology, and services to support these goals. More than half of this spending was in care coordination and management.

While ACOs have made tremendous progress in a short time and through challenging circumstances, they are still at the beginning of this journey and will need ongoing support to improve and innovate. The state’s independent auditor found no ACOs were perfect in meeting state evaluation criteria, 12 are on track with limited recommendations, and five demonstrated an opportunity to improve.² Auditors found that ACOs

were staffed appropriately but there are challenges with certain positions, including nurse care managers and community health workers. With workforce shortages abounding in healthcare, funding will be needed to sustain and retain care coordination staff over the five-year period. As the state increases its focus on those with the greatest needs, additional staff will likely be necessary to support these efforts, including workers to permit more one-on-one time between care management staff and patients. ACOs will also continue to need funding for technologies related to population health and care management, including to improve the information exchange between ACO healthcare providers as well as with others in the community.

Continued state and federal support for these efforts is essential if this program and model of care is to succeed for the more than 1 million lives MassHealth ACOs serve. Reductions in the growth of MassHealth spending can be tied directly to these care management and population health services, making both the state General Fund and the federal government beneficiaries of the downstream cost savings. We greatly appreciate that EOHHS will pursue continued federal support for these efforts in the upcoming 1115 waiver renewal by incorporating these services into the core program. MHA respectfully requests EOHHS be aggressive and bold in its request for this funding and assume substantive state General Fund contributions as well for these services. We also ask that EOHHS take into consideration the cost growth for these services over the five-year waiver renewal period given most of this funding supports staffing, which will require cost-of-living updates and adjustments to remain competitive in a tight labor market.



² “MassHealth Delivery System Reform Incentive Payment Program (DSRIP) Midpoint Assessment – Statewide Report,” Public Consulting Group, December 2020.

Retail & Specialty Pharmacy Reimbursement & Policy Changes

EOHHS proposes to establish a uniform formulary and is seeking waiver authority to equalize retail pharmacy reimbursement across managed care offerings. For both fee-for-service and managed care, EOHHS proposes that “340B providers would be classified in two tiers, with the first tier receiving higher payment rates for 340B drugs (likely between 340B AAC and NADAC/WAC, plus dispensing fee).” Tier 2 providers would be paid at 340B AAC (plus dispensing fee) for 340B drugs. Tier 1 would include specifically designated safety net providers that meet certain criteria, such as “serving a patient population that has a high percentage of MassHealth members, ACO participation, and strong clinical-pharmacy integration.”

Many MHA member 340B hospitals have expressed significant concern with the proposed change in reimbursement for retail and specialty pharmacy prescription drugs. We understand that EOHHS will seek to make these reimbursement changes in a budget neutral manner in the aggregate across providers. However, there will be negative consequences for many. Additional mitigation will likely be needed. We have questions and concerns with how EOHHS will designate hospitals to be eligible for the higher reimbursement rates for retail and specialty pharmacy. The federal government already has established rules to determine eligibility for the 340B program based on criteria that includes disproportionate share hospitals, pediatric hospitals, cancer hospitals, critical access hospitals, sole community hospitals, and rural referral centers. We recommend that EOHHS be as expansive as possible to ensure existing providers can maintain these benefits. We also respectfully request EOHHS perform a comprehensive financial impact of its proposal and share the results with stakeholders.

Community Partners Program

MHA and its members recognize the fundamental need to better coordinate care for patients with behavioral health and long-term care needs across both the behavioral health and medical continuums of care, as well as across other community-based social supports. MHA is appreciative of MassHealth’s recognition of these coordination needs through the development of the Community Partner (CP) program.

The CP program has been a challenging aspect of the MassHealth ACO initiative and MHA welcomes substantive reforms to it. MHA members have cited that many of these entities can provide value to ACO patients with significant behavioral health and long-term care needs. However, the experience varies widely depending on the ability to engage the CP and the effectiveness of the CP. Contacting and communicating with CPs have been cited as challenges and the administrative processes of working with CPs can be overly burdensome. We appreciate that many of the changes MassHealth is proposing to the CP program seek to address these issues.

MHA members feel strongly that ACOs should be the lead entity for care coordination as ACOs are responsible for the whole health of the patient, including medical, behavioral, and other care needs. MHA members are concerned that if a CP is the lead care coordinator for the healthcare needs of all services, including medical care, this could result in negative outcomes for patients since the CP lacks expertise to lead medical care coordination. It has been the experience of health systems that care plans developed by CPs often reflect a siloed view of their area of focus and suffer from other clinical shortcomings.

Most CPs are also not tied into a health system’s electronic health records, which hinders their ability to fully understand and manage a patient’s care. The CP concept also stands somewhat

contrary to MassHealth's goal of integrating behavioral health into primary care practices, which are often leading care coordination. CPs by design are separate entities. Another concern raised to MHA is that Long-Term Services & Supports (LTSS) CPs do not have the experience with leading care coordination for all medical and behavioral health needs for these patients.

If MassHealth mandates CPs as the lead entity, ACOs will unfortunately still need to provide parallel care management services to these patients – *an unfunded, duplicated cost*. With ACOs ultimately accountable for the total cost of care of these patients and their quality outcomes, we do not believe it is appropriate to outsource this responsibility to an outside party. MHA supports the continuation of the reformed CP program; however, we respectfully request that ACOs be designated the lead entity for all patient care management.

EOHHS has also proposed that CPs will be contracted directly by ACOs/MCOs rather than with MassHealth; however, EOHHS will determine payment rates and other contracting terms. It is unclear how the added administrative costs of managing CPs and this new contract will be factored into ACO non-medical rates. It will be very important that EOHHS make clear its funding assumptions for these new costs to ACOs in rate development.

In the new waiver, MHA also strongly encourages MassHealth to consider changes to improve communication across care providers. MHA members repeatedly speak of challenges in identifying if a patient is enrolled in the CP program and, if so, who the appropriate contact is and how to contact them. MHA encourages that the CP program in the new waiver allow for easier identification of CP partners and create pathways for providers to speak to each other. Providers can also speak to the challenges in enrolling a patient in the CP program, including the time and approvals needed to develop an intake and treatment plan for a patient to become enrolled.

Behavioral Health Workforce

MassHealth requests authority to renew and expand diversionary behavioral health and substance use disorder services, as well as authority to implement a student loan repayment program specific to behavioral health clinicians. MassHealth proposes two programs: (1) a student loan repayment program to provide up to \$50,000 for licensed behavioral health clinicians or Masters-prepared social workers intending to obtain licensure within one year of the award and who agree to a four-year commitment to working in community-based settings that serve a significant number of MassHealth members; and (2) up to \$300,000 per clinician for psychiatrists or nurse practitioners with prescribing privileges that make a four-year commitment to maintaining a panel that is at least 40% MassHealth members.

As existing workforce programs funded through the waiver have been and are expected to be funded in part by the hospital assessment, MHA respectfully requests that the types of workforce supports detailed above be available to employees of hospitals and health systems. MHA also recommends that the 1115 waiver supports funding for wraparound loan forgiveness to clinicians ineligible for federal Health Resources and Services Administration (HRSA) loan repayment programs that relate to HRSA-designated Health Professional Shortage Areas. As the inpatient behavioral health system in Massachusetts serves the entire commonwealth, regardless of the physical location of an individual inpatient facility, more assistance is needed over and above that targeted by HRSA.

Behavioral health workforce challenges have been longstanding both in Massachusetts and nationally, and MHA members continue to voice significant concern in both attracting and retaining the full spectrum of needed behavioral health professionals, from mental health workers, sitters, and certified nursing assistants to social workers, psychiatric nurses, psychologists, and psychiatrists. These workforce shortages have a direct effect on the ability of providers to fully operationalize their services and consequently limit capacity in the behavioral health system. A survey conducted by MHA and the Massachusetts Association of Behavioral Health Systems in early 2021 of 45 inpatient psychiatric units and facilities found that more than 200 already-licensed inpatient psychiatric beds could be made operational if the facility's staffing needs could be met. As behavioral health workforce challenges have escalated since the beginning of this year, the number of inpatient beds that currently could be brought online just by addressing staffing needs is likely much greater. While MHA and the entire commonwealth looks forward to the needed coming expansion of both inpatient and community-based behavioral health services through the Roadmap for Behavioral Health Reform, facilities are concerned that the need for behavioral health professionals to staff these new programs and services will exacerbate existing workforce challenges.

MHA commends MassHealth for its work in the previous waiver to enhance the behavioral health workforce, particularly through the loan repayment and workforce development programs. In the new waiver, MHA respectfully requests that the proposed programs for both licensed behavioral health clinicians or Masters-prepared social workers and for psychiatrists or nurse practitioners be extended to behavioral health professionals who are employed by hospitals or health systems to ensure that the full continuum of care is staffed to guarantee full access to licensed services. Such interventions are – and will remain – critical in addressing emergent and crises conditions, including the current influx of psychiatric patient boarding within hospital emergency departments (EDs). Additionally, given the workforce challenges across the full spectrum of behavioral health caregivers, MHA recommends that loan forgiveness, grant, scholarship, and other pipeline development programs provide support to those pursuing tertiary degrees as well as for workforce that do not require advanced degrees. Supports such as grants and scholarships for educational advancement and other incentive programs for positions that do not require advanced degrees would serve to both attract and retain these professionals and provide advancement opportunities for those working in entry-level behavioral health positions. Such programs would also provide the opportunity to create a more ethnically, racially, and linguistically diverse workforce that would also serve to bolster health outcomes among immigrant populations and communities of color.

Retroactive Eligibility

The EOHHS waiver proposal calls for using the three-month retro-eligibility federal standard for pregnant women and children. The current waiver only provides 10 days retroactive coverage for new applicants, although during the COVID-19 emergency applicants could request the full three months. MHA commends EOHHS for reinstating the full retro-coverage for pregnant women and children.

Consistent with our recent comments pertaining to the proposed amendment to the existing 1115 waiver, MHA respectfully requests reconsideration of the application of the waiver's retroactive eligibility policy for all other MassHealth applicants. For many low-income uninsured patients, their first engagement with state healthcare programs can be during an instance when they need immediate care. While many patients apply as part of their health visit or stay, some patients elect to

postpone applying for state coverage until they become aware of their financial obligations – meaning after they have received a bill from a healthcare provider. This, of course, is longer than 10 days from when the care was provided. Massachusetts hospitals go to great effort to ensure uninsured individuals are aware of their coverage options, including employing hundreds of staff dedicated to assisting residents into health coverage programs such as MassHealth. For numerous reasons, some patients may not apply for coverage at the time care is provided; they may need more time to fully understand state coverage offerings, their financial obligations, their current insurance status with a commercial payer, and potential immigration implications, to name a few. Or they may be in a behavioral health crisis and unable to obtain the necessary information to apply. Hospitals do not delay the provision of care and, ultimately, uninsured patients will likely apply and be enrolled once they work with patient financial counselors to understand their circumstances and options. This education and application process can often take time that exceeds 10 days from receiving care.

To reduce potential medical debt for low-income uninsured patients and to financially support the healthcare providers who care for them, adequate retroactive eligibility is needed for those individuals who ultimately take the necessary steps to enroll into MassHealth. We respectfully request EOHHS amend the 1115 waiver’s retroactive eligibility provisions to align with the federal standard of three months. We believe that the experience during the COVID-19 emergency that permitted the full federal three-month retroactive coverage benefit has shown that this policy can be incorporated reasonably on a long-term basis. The nominal cost is greatly outweighed by the benefits this protection affords many low-income patients and their healthcare providers, especially safety net hospitals. The policy is also consistent with state and federal efforts to cover the uninsured, and to provide coverage for Medicaid beneficiaries that were previously uninsured and required immediate healthcare, but were in not position to apply in a timely manner.

In conclusion, MHA appreciates the opportunity to offer these comments as EOHHS looks to soon put forward the state’s 1115 Medicaid waiver extension request to CMS. We look forward to further collaborating and working with EOHHS to achieve a renewed 1115 waiver that will allow the commonwealth to succeed in our aligned efforts to ensure broad access to healthcare, continue the innovative work of ACOs, advance health equity, address the social determinants of health, and make needed investments in behavioral health, primary care, and hospitals, including safety net providers. If you have any questions or would like to discuss these comments further, please do not hesitate to reach out to us.

Sincerely,



Steve Walsh
President and Chief Executive Officer
Massachusetts Health & Hospital Association

September 20, 2012

MEMORANDUM

To: MassHealth

From: Joe Finn, President/Executive Director of the Massachusetts Housing and Shelter Alliance (MHSA)

Re: 1115 MassHealth Demonstration Waiver Extension

3.2: Health Related Social needs

MHSA generally supports the articulation of the expansion of Community Support Program for Chronically Homeless Individuals (CSP-CHI) that is outlined in 3.2 Health-Related Social Needs. This expansion ensures the widest scope of persons within Medicaid who may well benefit from low-threshold housing approaches and expands the ability of community-based housing providers to deliver the necessary services for successful tenancies. There is a significant amount of data nationwide that indicates the benefit of such approaches in providing better and more effective utilization of care for those housed. While some may debate cost-effectiveness, there is no debate left concerning its ability to dramatically change the utilization patterns of both medical and behavioral care for those housed:

[https://www.bluecrossmafoundation.org/publication/preventive-effect-housing-first-health-care-utilization-and-costs-among-chronically;](https://www.bluecrossmafoundation.org/publication/preventive-effect-housing-first-health-care-utilization-and-costs-among-chronically)

[https://www.bluecrossmafoundation.org/publication/estimating-cost-reductions-associated-community-support-program-people-experiencing.](https://www.bluecrossmafoundation.org/publication/estimating-cost-reductions-associated-community-support-program-people-experiencing)

We also support the further development of the Community Support program into the realm of tenancy preservation. The creation of a Community Support Program-Tenancy Preservation Program (CSP-TPP) would provide a critical resource for an evidence-based approach to keep people housed. Such a program has been demonstrated in Massachusetts to keep people from falling into homelessness as well as assist in preserving the tenancies of those who may have previously experienced homelessness. This has been particularly true for those persons experiencing serious mental illness. TPP, although quite limited due to funding, has been successfully implemented for well over a decade.

5.1: Eligibility

MHSA also supports the development of continuous eligibility as outlined in 5.1. The 24-months continuous eligibility recognizes the unique circumstances of those persons with behaviorally and medically-complex circumstances of homelessness. This particular reform would make up for deficiencies within the present system that result in loss of coverage for the various services that may lead them back into more effective utilization of care. Currently, there are no reliable homeless indicators that would overcome this current deficiency.

3.3: Providing MassHealth Service to Justice-Involved Individuals

Given the impact correctional and jail systems have had upon the problem of homelessness, MHSA supports this request. However, we feel that this particular reform if not partnered with specific housing initiatives for the same population, will prove costly and limit its potential for success. MHSA

strongly encourages that MassHealth develop a housing strategy for the same population with the appropriate state agencies.

1.2: Care Coordination

While MHSA affirms the above-mentioned expansions of CSP related products for those medically-complex persons experiencing homelessness, we believe the failure to fully develop a specialized care coordination model for this population limits the ability to utilize these resources to their fullest extent. Homelessness of this medically complex population is a statewide and transitory problem. It should not be fractured among a wide array of BHCPs but instead should have a single lead medical/behavioral health entity charged with identifying, locating and stabilizing such a population. Utilizing the Commonwealth's new Data Warehouse of those experiencing homelessness and additional MassHealth data, those most frequent users as well as those with serious conditions who have become lost can be identified. We have learned through the COVID crisis that a single entity competent in issues related to long-term homelessness can be successful in moving such persons into housing or other systems of non-congregate care. To do otherwise is simply to repeat the same mistakes that have kept our contemporary homelessness thriving and to only increase demand for emergency capacity. The current fragmented, multiple system of care has been tried and found wanting in relation to this population. The time is now to provide a unified, single specialized form of coordinated care that will incentivize coordination of care for those experiencing homelessness (which the present/presented structure does not) and that will use the unique tools created by MassHealth in partnership with other state agencies in a way to efficiently interdict this population. If this cannot be achieved within this waiver extension, MHSA strongly encourages MassHealth to establish a demonstration or pilot in order to test our assertion



September 20, 2021

Marylou Sudders
Secretary for Health and Human Services

Amanda Cassel-Kraft
Assistant Secretary for MassHealth

Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders and Assistant Secretary Cassel-Kraft:

We write as the co-chairs of the Middlesex County Restoration Center Commission (“Commission”) established under *An Act Relative to Criminal Justice Reform*, Chapter 69 of the Acts of 2018 (“Act”). The Act directs the Commission to research the gaps in behavioral health and criminal justice diversionary services that lead to disproportionate rates of arrest and hospitalization of individuals with behavioral health conditions, identify a model for behavioral health and social services that could fill these gaps, and then design and launch a pilot of such services over the course of four years. The Commission is now in its fourth year and has submitted two annual reports to the legislature documenting its findings. Should you wish to reference the reports they are linked below in the footnotes.^{1,2,3} The Commission is now at a critical juncture in this project and seeks to launch a pilot program in state fiscal year (SFY) 2022.

The Commission’s work has always been focused not only on investigating and establishing a restoration center but also on promoting a range of public health interventions designed to reduce the costly and traumatic institutionalization of some of our most vulnerable residents. We applaud the investments already made in the Commonwealth and in particular in the MassHealth program to implement the behavioral health for justice-involved individuals project (BH-JI) to help individuals transition from incarceration to community more effectively, the Emergency Service Provider (ESP) program to provide mobile and site-based mental health crisis response, the Behavioral Health Community Partner program to help improve management of behavioral health conditions in the community, the rollout of Medication-Assisted Treatment (MAT) statewide to individuals transitioning from incarceration to community struggling with opioid use disorder, and so many other programs helping justice-involved individuals with behavioral health needs. There have been other notable improvements in behavioral health services in

¹ <https://www.mamh.org/library/middlesex-county-restoration-center-commission-year-one-findings-and-recommendations>

² <https://www.mamh.org/library/middlesex-county-restoration-center-commission-year-two-findings-and-recommendations>

³ <https://www.mamh.org/library/middlesex-county-restoration-center-commission-year-three-findings-and-recommendations>



justice settings, including at the Middlesex County Jail & House of Correction. The need for this type of work has also become a subject of a nation-wide movement in the past year.

We write to you now in support of the inclusion of a proposal to provide MassHealth coverage to individuals detained or incarcerated in Massachusetts prisons and jails included in the Request to Extend the MassHealth Section 1115 Demonstration.

The Commission has extensively documented the disparities in health outcomes, racial equity, and recidivism among individuals with behavioral health conditions who become justice-involved. The work of the Commission is to prevent this justice involvement in the first place. As such, we hope to see investments enabled by this proposal in restoration centers that can prevent arrest and subsequent incarceration for individuals who simply require urgent and crisis behavioral healthcare in the community with wrap-around social supports; we have documented the evidence supporting this model extensively.

The Commission has also recognized the need for more specialized programming for such individuals inside of our jails and prisons in order to improve health outcomes and reduce recidivism for those individuals who do end up arrested and incarcerated. The Middlesex Sheriff's Office has become a national model for addressing the behavioral health needs of its population starting with its medication assisted treatment program, which provides both care & treatment during the carceral period as well as post-release navigation. As co-chairs of the Commission, we hope to see more investments in this type of programming in Massachusetts jails and prisons. We have seen in Middlesex the power of such programs to improve health outcomes and interrupt cycles of recidivism.

The proposal included in the 1115 Demonstration extension would be a game-changer when it comes to improving the behavioral and physical health and well-being of Massachusetts' justice-involved individuals and interrupting cycles of incarceration. We fully support the efforts of the Baker Administration in seeking this approval, and look forward to a favorable response from the Centers for Medicare and Medicaid Services (CMS).

We thank you for your tireless leadership and for your consideration.

Sincerely,

A blue ink signature of Peter J. Koutoujian, written in a cursive style.

Co-Chair, Sheriff Peter J. Koutoujian
Middlesex County

A blue ink signature of Danna Mauch, written in a cursive style.

Co-Chair, President and CEO Danna Mauch, PhD
Massachusetts Association for Mental Health

Request to extend the MassHealth Section 1115 Demonstration
Maternal Outcomes for Translational Health Equity Research
(M.O.T.H.E.R Lab)
September 20, 2021

Dear Centers for Medicare and Medicaid Services,

We are representatives and members of Maternal Outcomes for Translational Health Equity Research (M.O.T.H.E.R. Lab), founded by Dr. Amutah-Onukhaga, the Julia A. Okoro Professor of Black Maternal Health and Assistant Dean of Diversity, Equity, and Inclusion at Tufts University School of Medicine. Dr. Amutah-Onukhaga is also a member of the Racial Inequities in Maternal Health Commission. We are grateful to submit our request to extend the MassHealth Section 1115 Demonstration.

The mission of the M.O.T.H.E.R. Lab is to “address and eradicate inequities Black women face, through research, advocacy, and mentorship by confronting and dismantling the system that enables and perpetuates racism for Black women who give birth” and our goals align with the MassHealth 1115 Demonstration. The extension will allow us in Massachusetts to reduce and eliminate health disparities that disproportionately impact women of color. The extension will permit the continuation of initiatives and campaigns to address the health and social needs of women, with a direct focus on maternal health.

The current COVID-19 pandemic has exacerbated the disparities in Black and Brown women who currently make the one third of the front line workforce, most vulnerable to COVID-19 exposure whilst experiencing institutional racism and discrimination. Moreover, the National Community Reinvestment Coalition reports that in the first six months of the pandemic Black women faced a 2.3 year drop in life expectancy. According to the Massachusetts Commission on the Status of Women report entitled the “Impact of COVID-19 and Related Recommendations to Improve the Status of Women of Color” in May 2021, access to maternal and prenatal health care is lower for Black women and women of color have lost access to medical care and medical insurance at twice the rate of White women. 3 times more women of color have trouble finding affordable housing compared to White women. 13% of women of color stated that COVID-19 has negatively impacted their children’s access to education

Therefore, it is more important than ever to extend the MassHealth Section 1115 Demonstration. The extension will allow women to have Medicaid coverage 12 months after delivery. We are in a maternal health crisis as Black women are three to four times more likely to die during or after delivery than white women. According to the World Health Organization (WHO), the risks of surviving childbirth for Black women are similar to women in Mexico, where a substantial proportion of women live in poverty. In addition, Black women are at higher risk than white women to experience postpartum depression and anxiety, and vaginal bleeding. It is essential for all birthing people that have delivered to have access to post-delivery appointments for guidance and support during the transitional period post-birth. With the extension for coverage 12 months of delivery we can continue to reduce the risks of postpartum conditions.

The extension will also allow for doula care coverage. Doulas provide vital support during the entire pregnancy and delivery process, and there is an abundance of literature that shows that having a doula present can actively mitigate negative birth outcomes such as unplanned, non-medically necessary C-sections, low birth weight, and overall maternal mortality [2,3,4,5]. Recent literature indicates that Black women are 3-4 times more likely to experience pregnancy related deaths and more severe maternal health complications in comparison to white women. Doula care coverage would give women far greater emotional and informational support not only during delivery but in improving their prenatal and postnatal care.

Preventable-pregnancy related deaths must be eliminated and the utilization of doulas has resulted in shorter delivery times, greater rates of initiation of breastfeeding in women and an overall decrease in pregnancy-related complications with fewer caesarean sections performed in the delivery room [6]. We have recently published an article showcased on the Delaware Coalition Against Domestic Violence (DCADV) website to further substantiate our position, which can be found here:

<https://dcadv.org/blog/centering-the-role-of-doulas-in-the-fight-to-save-black-mothers.html> .

We have the utmost gratitude for the implementation of the current MassHealth Section 1115 demonstration during the Baker-Polito administration. The demonstration has resulted in the most smooth and integrated health care delivery that is based on value-based care and has increased the interconnectedness of both physical and behavioral care in Massachusetts. We hope that with the extension we can continue to provide the utmost health care to our community and save Black women.

Thank you, Centers for Medicare and Medicaid Services.

Signed,

MOTHER Lab

Dr. Ndidi Amutah-Onukhaga

Dr. Vanessa Nicholson

Tonia J. Rhone

Eimaan Anwar

Lauren Cohen

Siwaar Abouhala

Kobi Ajayi

Iman Ali

Elizabeth Bolarinwa

Keri Carvalho

Shubhecchha Dhaurali

Ebunoluwa Falade

Paige Feyock

Rachel Jackson

Sereena Jivraj

Anna Kheyfets

Marwah Kiani

Claire Kinnel

Blessing Chidi Lawrence

Pegah Maleki

Ameya Menta

Brenna Miller

Alison Moky

Nichole Moore

Kelechi Offor

Divine Ogieva

Heather Olden

Mansi Rana
Gabby Ruiz
Shantiera Taylor
Beverly Udegbe
Melissa Wu
Aver Yakubu

[1] “M.O.T.H.E.R. Lab Mission.” Maternal Outcomes for Translational Health Equity Research (M.O.T.H.E.R.) Lab, last modified in 2020, <https://motherlab.org/about-2/>

[2] American College of Obstetricians and Gynecologists. (2014). *Safe Prevention of the Primary Cesarean Delivery*.
<https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery>

[3] Hodnett, E. & Osborn, R. (1989). Effects of Continuous Intrapartum Professional Support on Childbirth Outcomes. *Research in Nursing and Health*, 12(5), 289-297.
<https://doi.org/10.1002/nur.4770120504>

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<https://doi.org/10.1111/j.1523-536X.2008.00221.x>

September 20, 2021

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

Amanda Cassel Kraft, Acting Assistant Secretary
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: My Care Family Response to Section 1115 Demonstration Project Extension Request

Dear Secretary Sudders and Assistant Secretary Cassel Kraft,

On behalf of My Care Family, the partnership plan of AllWays Health Partners and Merrimack Valley Accountable Care Organization, we are writing to provide comments on the MassHealth Section 1115 Demonstration Project Extension Request. These comments are framed from our experience thus far as a partnership of a critical safety net hospital, Lawrence General Hospital (LGH) and large FQHC, Greater Lawrence Family Health Center (GLFHC) along with our MCO, AllWays Health Partners, that are all committed to improving care for MassHealth members in our greater Lawrence, Lowell and Haverhill communities.

We are pleased that MassHealth is continuing to evolve the ACO model and believe you have identified many important areas for future investment and improvement within the goals you outlined. We hope you will reflect on our comments and incorporate our needs as you work on the details of the waiver proposal.

Financial

We must assert the ACO program be funded so that all aspects of the program can continue, and we have a reasonable chance it is sustainable.

This includes:

1. Adequate and actuarially sound premiums for our population including:
 - a. Addition of a substantial **social determinants of health direct add-on** of at least 20% to the PMPM for all members in high NSS7 areas to recognize SDOH community burden. The minimal weight of the Neighborhood Stress Score (NSS7) in the current model does not achieve the innovative goal of adjusting for socioeconomic health impacts, particularly for the 75% of our members who reside in the City of Lawrence. This community has substantially greater numbers of members who are foreign born, without a high school diploma, with limited English proficiency, low health literacy, and poor health as measured by the CDC's social vulnerability census tract data and has had the highest incidence of COVID in the state, reflecting these disparities.
 - b. **Adequate administration funding** to continue current programs and implement new requirements and that recognizes the value of MCO contributions to the program
 - c. **Transition funding** to recognize additional costs of building capacity to implement new provisions of the waiver and recruit and retain staff for the ACO workforce.
2. Supporting Safety Net Providers:
 - a. There must be **dedicated DSRIP replacement funding** provided directly to the ACO provider partner to support the infrastructure needed to manage this accountable care partnership

- b. locally and carry out the programs required and that result in population health improvements. The clinician led local ACO programs have been an important part of our success to date but as safety net providers, LGH and GLFHC cannot fund the minimum infrastructure required to continue ACO operations and lead these important programs.
- c. Eligibility and coverage: We support the eligibility changes proposed that will **support sustained member enrollment and coverage** and reduce frequency of member churn so that ACO investments made to improve outcomes will have both a health benefit and an ROI over time.
- d. Health equity: We agree that we must collectively assess our programs and ensure equitable distribution of resources across the population. There are opportunities to improve the collection and reporting of individual member social risk factors to better align our services with needs. We support the proposal for **health equity incentive payments** for ACO-participating safety net hospitals to work to improve this data collection as the basis for planning appropriate health equity initiatives. We are disappointed to see health centers being excluded from this opportunity for health equity incentive payments and would like to see them included along with the ACO-participating hospitals. Similar to the performance assessment on the ACO quality measure slate, we encourage MassHealth to reward efforts for both improvement and attainment. We also support allowing for variability in the metrics to align best with the characteristics and needs of our individual communities.

Primary Care Capitation

This alternative payment methodology for primary care could be beneficial for clinical care and allow for greater innovation within the Patient-Centered Medical Home model at Greater Lawrence Family Health Center. We are pleased to see that MassHealth plans to ensure the prospective payment system for FQHCs will be maintained through FFS reconciliation of the capitation. The draft request also signals an acknowledgement of the need to ensure that future payment approaches such as primary care capitation are aligned with FQHC requirements. We recommend MassHealth test the adequacy of the primary care capitation rates for two years before full implementation. We are concerned that small practices within our ACO may no longer participate due to greater risk if the primary care capitation is not set appropriately. Once again, to develop and implement the primary care cap would require administrative funding.

Health Equity/SDOH

My Care Family is expanding its Flexible Services program, rates of screening for Social Determinants of Health (SDOH) and has invested in the Unite Us/Unite Massachusetts platform for closed loop referrals to social service organizations in the community to address identified needs. We support the proposal to continue funding for and augment the Flexible Services program for housing and nutrition supports as an important resource for patients with health-related social needs. As we expand SDOH screening and identify needs, it is important to have an easy way to connect members to resources to help with the identified needs. We recommend MassHealth consider investing in a statewide platform that would support all ACOs for referrals to community agencies, for cost efficiency and administrative simplification, rather than each ACO making redundant investments in these platforms.

Care Coordination/CP Program

As the ACO with the highest rate of engagement within 122 days with our CPs, we are interested in how Mass Health will help us make CP's more accountable and distinguish our higher engagement success in our pmpm premium. My Care Family has been contracted with 6 Behavioral Health Community Partners and 2 Long Term Services and Supports Community Partner organizations. Volume has naturally consolidated among certain BH CPs based on capabilities, service levels and geography. We are working to better integrate care management with the PCMH model of care at GLFHC and believe that the ACO should be designated as the "lead entity" for care management and care coordination wherever possible as we move to the direct contracting CP model.

Pharmacy

We believe MassHealth's proposed direction on 340B could offer an opportunity to restore 340B savings and the vital role they play at GLFHC in sustaining clinical pharmacy services that lead directly to improved member health and outcomes. It is critical that the contemplated changes to use of 340B drugs yield the intended benefits. We are concerned about the lack of detail on this aspect of the demonstration request released to date. We urge MassHealth to continue to work with health centers and the Mass League to ensure that the Demonstration Extension supports the ability to utilize and realize the savings of the 340B program.

My Care Family supports maintaining its own contracted pharmacy benefits manager. We have been able to quickly adapt to formulary requirements through collaboration across AllWays, GLFHC clinical pharmacists and CVS Caremark. At the local level, we have focused on medication adherence to improve clinical outcomes, but it will be important to have enough lead time for major formulary changes, to communicate with clinicians and move members onto different medications as indicated. Major formulary changes should be limited in frequency as much as possible.

Behavioral Health

We support the administration's Behavioral Health Roadmap and goals to improve access to care which is greatly needed in our service area. It will be most important for MassHealth to create incentives to expand and diversify the behavioral health workforce for needed access to care across the Commonwealth. In particular, providing training and workforce incentives to direct BH clinicians to serve poorly resourced areas such as Lawrence, would be critical to improving access in areas underserved for behavioral health.

Quality Program

We support including incentives for delivering high quality, equitable care to MassHealth members as part of the next waiver. We agree with aligning measures to proven frameworks, including the Massachusetts Quality Alignment Task Force, to minimize burden on providers and members. Measure specifications and benchmarks must be available prior to a measurement year however, to be able to plan and implement improvement strategies within the desired time frames, especially for non-standard measures. We appreciate the opportunity to earn incentives for pay for reporting initially and moving to pay for performance as appropriate for newer measures and for the measurement structure of recognizing improvement as well as attainment.

In summary, the ACO program represents a significant shift to value-based care and greater provider engagement for managing cost and quality for MassHealth enrollees. However, the financial risk it has carried is not sustainable, particularly for safety net providers. MassHealth should consider ways to reward ACO efforts not just on financial outcomes but on efforts that yield improvements in health care delivery, access to

programs that meet community need and system design over time. Overall, we applaud the goals of the Demonstration Extension proposal and appreciate the information provided to date. We remain committed to the ACO program; however, additional details are needed to determine how our organizations can continue to participate. Please keep in mind that there will be lead time needed to assess our risk, inform, and consult with our Boards and make an informed decision. We are happy to engage in further discussion. Thank you for the opportunity to submit our perspective and comments for your consideration.

Sincerely,

Andrea Sullivan, CEO, My Care Family

Dr. Guy Fish, CEO, Greater Lawrence Family Health Center

Deborah J. Wilson, President and CEO, Lawrence General Hospital

Steve Tringale, CEO, AllWays Health Partners



September 20, 2021

Marylou Sudders, MSW, ACSW
Secretary, Health and Human Services
Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Asburton Place, 11th Floor
Boston, MA 02108

Re: 1115 Demonstration Extension Request

Dear Secretary Sudders:

The National Multiple Sclerosis Society appreciates the opportunity to submit comments on the Massachusetts 1115 Demonstration Extension Request for the MassHealth program.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and the progress, severity and specific symptoms of MS in any one person cannot yet be predicted. There are an estimated one million people living with MS in the United States, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The National MS Society is committed to ensuring that Massachusetts Medicaid program, MassHealth, provides quality and affordable healthcare coverage. We applaud Massachusetts' focus on health equity in this proposal, and offering twelve-month and twenty-four-month continuous eligibility for incarcerated individuals and individuals experiencing homelessness, respectively, will improve continuity of care for individuals the serious and chronic health conditions. However, the National MS Society remains concerned with the continued elimination of retroactive coverage for all non-pregnant adults as this does not meet the objectives of the Medicaid program and will instead continue to create administrative barriers that jeopardize access to healthcare for patients with serious and chronic diseases.

The National MS Society offers the following comments on the 1115 Demonstration Extension Request for the MassHealth Program.

Continuous Eligibility for Justice-Involved Individuals and Individuals Experiencing Homelessness

The National MS Society strongly supports the proposal to provide twelve-month continuous eligibility to individuals upon release from incarceration to facilitate re-entry transition, as well as offer continuous eligibility of twenty-four months for individuals with confirmed status of homelessness for a specific amount of time. This proposal will help these high-risk populations access critical supports needed to treat physical and behavioral health conditions. For example, studies in Florida and Washington 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.¹

This policy change will improve continuity of care for individuals with the serious and chronic health conditions. People who receive treatment for a complex disease like MS, who rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions, cannot afford a sudden gap in their care. Battling paperwork requirements in an attempt to keep coverage should not take away from enrollees' or caregivers' focus on maintaining their or their family's health. In addition, for people with MS, this can cause disruptions in access to MS treatments and therapy that can trigger irreversible damage. Many Medicaid enrollees simply have nowhere else to turn for coverage if they lose access and as a result, become uninsured. Their medical needs, however, do not disappear. Additionally, continuous eligibility will reduce administrative burdens and promote health equity.

Retroactive Eligibility

Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. 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, such as MS, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

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.² Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, retroactive eligibility may be vital for a person with going through the process of being diagnosed. An individual may face multiple medical appointments, need access to an MRI, and may ultimately be prescribed an expensive MS disease-modifying therapy—but lack health insurance to cover the costs, despite being eligible for Medicaid.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.³ Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs.

The National MS Society is supportive of the reinstatement of 3-month retroactive coverage for pregnant women and children, however, the continued elimination of retroactive coverage for most other Medicaid beneficiaries does not promote the objectives of the Medicaid program. The National MS Society requests that MassHealth strongly consider reinstating 3-month retroactive coverage for all Medicaid beneficiaries.

The National MS Society applauds MassHealth for seeking to improve access to care by providing continuous eligibility for targeted adult populations, including the justice-involved and homeless population. Unfortunately, the continuance of eliminating retroactive eligibility for all non-pregnant adults does not advance the objectives

of the state's Medicaid program and will continue to make care unaffordable or inaccessible to Medicaid patients. The National MS Society requests that the State of Massachusetts extend retroactive eligibility coverage for all non-pregnant adults to three months.

Thank you for the opportunity to provide comments.

Sincerely,

Laura Hoch
Senior Manager, Advocacy
National Multiple Sclerosis Society
Laura.hoch@nmss.org

¹ Joseph Morrissey et al. Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness. *Psychiatric Services* 57, no. 6 (June 2006): 809-815. DOI: 10.1176/ps.2006.57.6.809, and Joseph Morrissey et al. The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness. *Psychiatric Services* 58, no. 6 (June 2007): 794-801. DOI: 10.1176/ps.2007.58.6.794.

² 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>

³ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)



September 20, 2021

Marylou Sudders, MSW, ACSW
Secretary, Health and Human Services
Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Re: 1115 Demonstration Extension Request

Dear Secretary Sudders:

Thank you for the opportunity to submit comments on the Massachusetts 1115 Demonstration Extension Request for the MassHealth program.

The New England Hemophilia Association (NEHA) and the New England Bleeding Disorders Advocacy Coalition (NEBDAC) provide education and advocacy about bleeding disorders in all six New England states. HFA and NHF 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 inherited 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, MassHealth, provides quality and affordable healthcare coverage. We applaud Massachusetts' focus on health equity in this proposal. Offering twelve-month and twenty-four-month continuous eligibility for incarcerated individuals and individuals experiencing homelessness, respectively, will improve continuity of care for individuals with the serious and chronic health conditions. However, we remain concerned with the continued elimination of retroactive coverage for all non-pregnant adults as this does not meet the objectives of the Medicaid program and will instead continue to create administrative barriers that jeopardize access to healthcare for patients with serious and chronic diseases.

NEHA, NEBDAC, HFA, and NHF offer the following comments on the 1115 Demonstration Extension Request for the MassHealth Program.

Continuous Eligibility for Justice-Involved Individuals and Individuals Experiencing Homelessness

Our organizations strongly support the proposal to provide twelve-month continuous eligibility to individuals upon release from incarceration to facilitate re-entry transition, as well as offer continuous eligibility of twenty-four months for individuals with confirmed status of homelessness for a specific amount of time. This proposal will help these high-risk populations access critical supports needed to treat physical and behavioral health conditions. For example, studies in Florida and Washington 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.¹

This policy change will improve continuity of care for individuals with the serious and chronic health conditions. For individuals living with an inherited bleeding disorder, even temporary delays or gaps in coverage can be devastating. Interruptions in coverage and treatment could result in joint- or even life-threatening bleeding episodes, with an intolerably high human toll (as well as higher state spending for care in an ER setting). Continuous eligibility for vulnerable individuals reduces the risk of such interruptions. Additionally, continuous eligibility will reduce administrative burdens and promote health equity.

Retroactive Eligibility

Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. 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, such as a bleeding disorder, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

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.² Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy.

Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.³ Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with the COVID-19 pandemic. Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs.

NEHA, NEBDAC, HFA, and NHF are supportive of the reinstatement of 3-month retroactive coverage for pregnant women and children. By contrast, the continued elimination of retroactive coverage for most other Medicaid beneficiaries does not promote the objectives of the Medicaid program. We request that MassHealth strongly consider reinstating 3-month retroactive coverage for all Medicaid beneficiaries.

Conclusion

NEHA, NEBDAC, HFA, and NHF applaud MassHealth for seeking to improve access to care by providing continuous eligibility for targeted adult populations, including the justice-involved and homeless population. Unfortunately, the continuance of eliminating retroactive eligibility for all non-pregnant adults does not advance the objectives of the state's Medicaid program and will continue to make care unaffordable or inaccessible to Medicaid patients. We therefore request that the State of Massachusetts extend retroactive eligibility coverage for all non-pregnant adults to three months.

Thank you for the opportunity to provide comments.

Sincerely,



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¹ Joseph Morrissey et al. Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness. *Psychiatric Services* 57, no. 6 (June 2006): 809-815. DOI: 10.1176/ps.2006.57.6.809, and Joseph Morrissey et al. The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness. *Psychiatric Services* 58, no. 6 (June 2007): 794-801. DOI: 10.1176/ps.2007.58.6.794.

² 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>

³ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", *Modern Healthcare*, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)



NORTH SHORE COMMUNITY HEALTH

September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
1 Ashburton Place
Boston, MA 02108

Re: Comments on Demonstration Extension Request

[Submitted via email to: 1115-Comments@mass.gov]

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of North Shore Community Health (NSCH), thank you for the opportunity to provide comments on the 1115 MassHealth Demonstration ("Waiver") Extension Request.

In CY2020, NSCH provided services to 12,426 patients through 68,830 visits with 10 service sites located in the three communities Salem, Peabody and Gloucester.

- Three full-time practice sites which provide medical, dental, behavioral health, and substance use disorder treatment services
- Two school-based health centers - the Teen Health Center at Salem High School, the Student Health Center at Peabody Veterans Memorial High School
- Five behavioral health-only sites at elementary and middle schools in Salem
- More than 90% of patients live at or below 200% of the federal poverty level
- Nearly 41% of patients identified as belonging to a racial and/or ethnic minority
- 35% are Hispanic/Latino
- 2% identify as GLBTQ
- 3% identify as Transgender
- 42% of patients reported that they are best served in a language other than English, with Spanish and Portuguese being the most prevalent languages

NSCH is proud to count ourselves as one of the founding health center members of Community Care Cooperative (C3), our ACO. The health center has learned much since C3's inception and has performed well to date.

We align with the Mass League's comments on the key issues of payment/primary care capitation, health equity incentives, workforce, and 340B. Of particular importance to our health center are the items below (not in order of importance):

Payment

While NSCH is directionally supportive of the proposed waiver extension request, given how essential Medicaid revenue is for NSCH (60% of our patients), the details on the amounts of payments are crucial. Most specifically, it is essential that the capitation payment model is developed and aligned with the FQHC payment methodology. This issue cannot be “tested” until we get there with more details. We need the details and commitments to alignment up front.

Equity

NSCH is absolutely committed to health equity and in fact has re-launched an initiative to return to a highly successful pre-COVID diabetes care management program which erased the racial/ethnic inequity in health outcomes for NSCH patients with diabetes. With sufficient resources in place to commit to this program and to addressing other health disparities in collaboration with C3, NSCH patients with other chronic diseases would benefit greatly and see improved health outcomes.

Clinicians at NSCH have learned a great deal over the last several years and have designed successful interventions to address health inequities. It is essential that NSCH clinical staff continue to build on what we have learned and with our C3 colleagues to further hone and expand the impact of our work.

Workforce

Like many CHC’s, NSCH has struggled to recruit and retain health care providers and other clinical support staff and this issue is especially acute right now. However, MA Health’s DSRIP-supported loan repayment program has been instrumental to the health center’s ability to attract and retain highly talented providers. To date, three primary care and four behavioral health providers are engaged in that program and, without it, NSCH may not be able to retain them. In addition, DSRIP funds supported NSCH’s launch of a highly successful NP residency which attracted diverse providers who are still employed at the health center.

340B

Prior to the implementation of the ACO’s, NSCH had a steady and growing 340B savings program which created funds for the health center to invest in projects, program and additional staff to better support our patients. With the restoration of those savings, NSCH could continue to make those investments.

Thank you for the opportunity to provide feedback about the 1115 waiver demonstration request and to share how the waiver has and will impact our health center. We look forward to continuing our work with MassHealth to provide high-quality, comprehensive care to patients.

Sincerely,



Margaret A. Brennan, MPH
President and CEO

Planned Parenthood League of Massachusetts

September 20, 2021

Secretary Marylou Sudders

Massachusetts EOHHS Office of Medicaid

Attn: 1115 Demonstration Comments

One Ashburton Place, 11th Floor

Boston, MA 02108

Submitted electronically via 1115-Comments@mass.gov

RE: Massachusetts' MassHealth Section 1115 Demonstration Extension Request

Dear Secretary Sudders:

Planned Parenthood League of Massachusetts (Planned Parenthood) is pleased to submit these comments in response to Massachusetts's request to address health equity and reduce existing disparities in the state by extending the state's MassHealth Section 1115 Waiver (Waiver extension). Massachusetts's draft Waiver extension includes proposals to: (1) reinstate 3-month retroactive coverage for pregnant individuals and children; (2) reduce race and ethnic-based disparities in maternal health outcomes through investing in accountable care organizations (ACOs) and introducing equity-based performance measures; and (3) implement 24-months continuous eligibility for homeless individuals.

In recent years, Planned Parenthood's four health centers in the state have provided health care and educational services to nearly 34,000 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.

Planned Parenthood League of Massachusetts

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, 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,¹ and roughly two-thirds of adult women enrolled in Medicaid are in their reproductive years.² 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 22 states, 50 percent or more of births are covered by Medicaid.³ Finally, the program is the largest payer of reproductive health care coverage in the country,⁴ paying 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 Massachusetts's draft Waiver extension. Importantly, Medicaid coverage of family planning services and supplies helps 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 disproportionately benefit from the draft Waiver extension; 31 percent of Black women and 27 percent of Hispanic women are enrolled in Medicaid, compared to 16 percent of white women.⁶

Due to Medicaid's outsized role for women of color, 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

¹ 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#>.

² "Medicaid's Role for Women," Kaiser Family Foundation (Mar. 28, 2019), available at <https://www.kff.org/medicaid/fact-sheet/medicaids-role-for-women/>.

³ In Massachusetts, Medicaid covers 35 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=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁴ 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/>.

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 *Id.* at "Why Protecting Medicaid Means Protecting Sexual and Reproductive Health."

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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 sexual and reproductive health care, Planned Parenthood is uniquely situated to provide input on policy proposals that affect the health of people, including 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 proposals: (1) reinstatement of 3-months retroactive coverage for pregnant individuals; (2) incentives for ACOs and safety net hospitals to help deliver the highest standard of care and work towards eliminating maternal health disparities; and (3) implementation of 24-months continuous eligibility for homeless individuals. While Planned Parenthood fully supports these proposals and applauds the state for pursuing these initiatives, we also urge the state to meaningfully take steps to address health equity and reduce disparities in MassHealth writ large and amend the draft Waiver extension to reinstate 3-months retroactive coverage for all individuals, not just those who are pregnant, and to implement at least 12-months continuous eligibility for all MassHealth enrollees.

I. Planned Parenthood Strongly Supports the State's Proposal to Extend Retroactive Coverage for Pregnant Individuals and Encourages the State to Extend that Coverage to All MassHealth Enrollees.

As Massachusetts is aware, federal law and policy 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 This provision helps safeguard enrollees' continuous access to care when there are delays in determining eligibility.

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. Planned Parenthood also underscores the importance of retroactive coverage during the COVID-19 pandemic, which has seen enormous increases in Medicaid enrollment¹⁰ due to the ongoing employment and income fluctuations

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/report-section/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care-issue-brief/>.

⁸ *Id.*

⁹ 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914.

¹⁰ Bradley Corallo and Robin Rudowitz, "Analysis of Recent National Trends in Medicaid and CHIP Enrollment," Kaiser Family Foundation (Aug. 16, 2021), available at <https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national->

Planned Parenthood League of Massachusetts

many individuals are experiencing.¹¹ Ensuring access to timely care for pregnant individuals and all Medicaid enrollees is more important than it has ever been.

For the reasons set forth above and retroactive coverage's importance to Medicaid enrollees, Planned Parenthood strongly supports Massachusetts's proposal for this program feature for pregnant individuals and encourages the state to amend its draft Waiver extension to apply retroactive coverage to *all* MassHealth enrollees.

A. Retroactive coverage increases access to timely care for pregnant individuals and will further improve maternal health outcomes in the state.

Retroactive coverage is particularly important for pregnant individuals. The policy allows them to access care earlier and bolsters critical provider participation in the Medicaid program because 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 than two-thirds of states reporting difficulty in ensuring provider participation in Medicaid.¹² Provider shortages are particularly acute for women and pregnant individuals, 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.¹³

Further, the shortage of OB/GYNs in rural areas and other underserved communities contributes to maternal health disparities.¹⁴ With half of U.S. counties lacking a single OB/GYN, our health care system is continuously failing to meet the health care needs of individuals of reproductive age, including women

[trends-in-medicaid-and-chip-enrollment/](#) (Data show that Medicaid/CHIP enrollment is increasing amid the coronavirus pandemic: from February 2020 to March 2021, enrollment increased by 10.5 million or 14.7 percent).

¹¹ Paul Shafer, et al., "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible for Coronavirus Treatment Costs," Health Affairs (May 8, 2020), available at <https://www.healthaffairs.org/doi/10.1377/hblog20200506.111318/full/>.

¹² "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>.

¹³ *Id.*

¹⁴ "ACOG Seeks to Expand Access, Increase Quality, and Improve Outcomes for Maternal Health in Rural Communities," American College of Obstetricians and Gynecologists (Jun. 3, 2020), available at <https://www.acog.org/news/news-articles/2020/06/acog-seeks-to-expand-access-increase-quality-and-improve-outcomes-for-maternal-health-in-rural-communities>.

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who are pregnant and postpartum.¹⁵ The provider shortage has the largest impact on communities that are already medically underserved, such as communities of color, people with low incomes, and rural communities. These populations are also more likely than the general population to experience complications during pregnancy, delivery, and the postpartum period. Notably, nearly half the towns in Massachusetts are rural,¹⁶ and many residents of Massachusetts who face challenges in accessing care live in rural areas.¹⁷

Yet, despite the shortages of OB/GYN providers, women often rely on their OB/GYN providers as their main source of care.¹⁸ Any policy, including the current lack of retroactive coverage, 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 MassHealth's success in improving health care delivery systems. Indeed, health care coverage is meaningless if patients are unable to receive care from quality providers in a timely manner.

Reinstating retroactive coverage for pregnant individuals is a necessary step in ensuring that these individuals are able to access timely care when they need it, and Planned Parenthood supports the state's proposal to restore this coverage.

B. Massachusetts should also extend retroactive coverage to all MassHealth enrollees.

Given the enormous impact retroactive coverage has on facilitating access to timely care, Planned Parenthood urges Massachusetts to reinstate this program feature for all MassHealth enrollees. Timely access to care is particularly relevant in the context of family planning care for all individuals, as only a few days without contraception can result in an unintended pregnancy. Moreover, STIs that go undetected and untreated can spread throughout communities and cause lifelong problems, including infertility and

¹⁵ Michael Ollove, "A Shortage in the Nation's Maternal Health Care," PEW (Aug. 15, 2016), available at <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/15/a-shortage-in-the-nations-maternal-health-care>.

¹⁶ "Where is rural Massachusetts?," Rural Commonwealth, available at <https://www.ruralcommonwealth.org/about-us/where-is-rural-massachusetts/>.

¹⁷ "Report to the Great and General Court and Executive Office of the Governor," Special Commission on Rural Access and Improving State-Sponsored Services in Massachusetts Rural Communities, Executive Office of Health and Human Services (Aug. 2013), available at <https://www.mass.gov/files/documents/2017/10/02/rural-services-commission-report.pdf>.

¹⁸ *Id.* at "States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance"; *Id.* at "Access to Care: Provider Availability in Medicaid Managed Care."

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pelvic inflammatory disease.¹⁹ Urinary tract infections are one of the most common infections women experience and are easily treatable, but without treatment, can result in emergency room care, which can cost a state nearly \$1,500 per patient.²⁰

In addition, data shows that retroactive coverage has positively impacted individuals in states that have kept this feature in their Medicaid programs. 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.²¹ Conversely, data show that the absence of retroactive coverage has increased financial burdens for people with low incomes, as well as safety net providers that serve those individuals. In Indiana, nearly 14 percent of the parent and caretaker relatives eligibility group needed retroactive coverage, and individuals in this group incurred medical costs averaging \$1,561 per person.²² These costs would have been paid for by Medicaid if retroactive coverage was in place.²³ Finally, sixteen percent of providers in Indiana experienced increases in the provision of uncompensated care after retroactive coverage was waived.²⁴

Reinstating retroactive coverage for all MassHealth enrollees is an essential step in ensuring that these individuals are able to access timely care when they need it, and Planned Parenthood encourages the state to extend the policy to all people enrolled in MassHealth.

¹⁹ Chlamydia: Fact Sheet, Centers for Disease Control and Prevention (Jan. 23, 2014), available at <https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm>.

²⁰ 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>.

²¹ 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>.

²² 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>.

²³ *Id.*

²⁴ 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>.

II. Planned Parenthood Strongly Supports the Proposed Incentives for ACOs and Safety Net Hospitals as a Vital Step Towards Eliminating Maternal Health Disparities.

Planned Parenthood strongly supports Massachusetts’s proposal to invest \$500 million in a five-year program aimed at dramatically reducing disparities in care quality at ACO-participating hospitals, with a particular focus on safety net hospitals in Massachusetts. In doing so, MassHealth would introduce equity-based performance measures and incentivize participating hospitals to meet these metrics. Planned Parenthood recognizes this as a necessary step towards ensuring every individual regardless of race or ethnicity receives the highest quality of care from their providers, leading to the healthiest outcomes for mothers and their babies.

Notably, Black women in Massachusetts are more than twice as likely to die from pregnancy-related causes than non-Hispanic white women.²⁵ This racial disparity in maternal health outcomes in our state mirrors the persisting health inequities documented across the United States, and is primarily driven by systemic racism. Systemic racism not only erects significant barriers to accessing health care, but it also substantially lowers the quality of care received by health care patients. Equally alarming, for every one maternal death, it is estimated that 100 women experience a “near miss,” or a serious obstetric emergency necessitating a lifesaving medical procedure.²⁶ Further, while Black women are more likely to experience an obstetric emergency, they are also more likely to give birth at lower performing hospitals compared to non-Hispanic white women.²⁷

Massachusetts’s proposal to help ACOs and safety net hospitals deliver the highest standard of care is a vital step towards eliminating maternal health disparities, in particular for Black women, and Planned Parenthood supports the state’s proposal for this funding.

III. Planned Parenthood Strongly Supports the Proposal for Continuous Eligibility for Homeless Individuals and Encourages the State to Extend this Protection to All MassHealth Enrollees.

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

²⁵ “Section 1115 Demonstration: Project Extension Request,” Commonwealth of Massachusetts: Executive Office of Health and Human Services, Office of Medicaid (Aug. 18, 2021), available at <https://www.mass.gov/doc/1115-demonstration-extension-request/download>.

²⁶ Elizabeth Howell, “Reducing Disparities in Severe Maternal Morbidity and Mortality,” *Clinical Obstetric Gynecology* (Jun. 1, 2019), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/>.

²⁷ *Id.*

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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 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, 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 US 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. This has only increased during the COVID-19 pandemic—

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 Alexa 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>.

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women accounted for all the job losses reported in the month of December 2020, with Black and brown women experiencing a disproportionate share of losses.³³ 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.³⁴ Continuous 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.

Finally, Planned Parenthood emphasizes that continuous eligibility has been deemed such an important feature to combat the COVID-19 pandemic that the Families First Coronavirus Response Act (FFCRA) enshrined it into law as a requirement for states opting to receive the enhanced federal medical assistance percentage (FMAP) matching rate.³⁵ Under FFCRA, states are required to keep their Medicaid enrollees continuously enrolled in their Medicaid programs through the end of the month in which the public health emergency (PHE) for COVID-19 ends. This requirement ensures that Medicaid enrollees are able to continuously access critical health services in a time of increased need. Planned Parenthood underscores that Massachusetts will be a model state in this respect, being one of only three states to offer Medicaid continuous eligibility outside of the FFCRA requirement.³⁶ If Massachusetts were to offer continuous eligibility to all of its Medicaid enrollees, the state would be providing a strong foundation to ensure that people with low incomes, including people of color, are guaranteed continuous access to care once the PHE ends and states are no longer required to comply with the FFCRA requirement.

For the reasons set forth above and continuous eligibility's importance in ensuring access to care for homeless individuals and all Medicaid enrollees, Planned Parenthood strongly supports Massachusetts plan for this program feature for homeless individuals and encourages the state to amend its draft Waiver extension to apply at least 12-months continuous eligibility to **all** MassHealth enrollees.

- A. Adding 24-months continuous eligibility for homeless individuals will increase this population's access to comprehensive Medicaid coverage and further improve their health outcomes.*

Planned Parenthood strongly supports Massachusetts's proposal to add 24-months continuous eligibility for homeless individuals. Importantly, the social determinants of health, defined by the World Health

³³ Annalyn Kurtz, "The US economy lost 140,000 jobs in December. All of them were held by women," CNN Business (Jan. 8, 2021), available at <https://www.cnn.com/2021/01/08/economy/women-job-losses-pandemic/index.html>.

³⁴ 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>.

³⁵ FFCRA, § 6008(b)(3).

³⁶ Montana and New York are the only other states with an approved Section 1115 waiver offering continuous coverage to adults.

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Organization (WHO) as the “conditions in which people are born, grow, live, work, and age, and the wider set of forces and systems shaping the conditions of daily life” have become a frequently discussed concept in relation to access to health care.³⁷ Accounting for up to 90 percent of a person’s health status, SDOH are far-reaching, and include factors such as safe and affordable housing, access to education, public safety, the availability of healthy foods, local emergency/health services, and environments free of harmful toxins.³⁸ Planned Parenthood emphasizes that while sometimes SDOH are discussed, researched, and pursued independently from racism, discrimination, and inequality, they are, in fact, intertwined. Indeed, SDOH are mostly responsible for health inequities and they are “shaped by the distribution of money, power and resources at global, national and local levels.”³⁹

Twenty-four months continuous eligibility for MassHealth coverage for homeless individuals is necessary to ensure that this population has stable access to care, which is especially important as homeless individuals face disproportionate rates of poor health outcomes. Significant research and data show that homelessness and housing instability (frequently moving, falling behind on rent, facing eviction) are detrimental to one’s health. The health impacts of homelessness and housing instability are myriad:

- People who are chronically homeless face substantially higher morbidity in both physical and mental health,⁴⁰ as well as increased mortality.⁴¹
- Unstable housing situations can cause individuals to experience increased hospital visits, lead to loss of employment and employer-provided health insurance benefits, dramatically increase the risk of an acute episode of a behavioral health condition, including relapse of addiction in adults, and are associated with increased likelihood of mental health problems in children.⁴²

³⁷ “Social determinants of health,” World Health Organization, available at https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

³⁸ “Social Determinants of Health,” Healthy People 2030, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, available at <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.

³⁹ *Id.* at “Social Determinants of Health,” World Health Organization.

⁴⁰ David L. Maness and Muneza Khan, “Care of the Homeless: An Overview,” *Am Fam Physician* (Apr. 2014), available at <https://www.aafp.org/afp/2014/0415/p634.html>.

⁴¹ Colette L. Auerswald, et al., “Six-year mortality in a street-recruited cohort of homeless youth in San Francisco, California,” *PeerJ* (Apr. 14, 2016), available at <https://peerj.com/articles/1909/>.

⁴² See Will Fischer, “Research Shows Housing Vouchers Reduce Hardship and Provide Platform for Long-Term Gains Among Children,” Center on Budget and Policy Priorities (Oct. 7, 2015), available at <https://www.cbpp.org/research/research-shows-housing-vouchers-reduce-hardship-and-provide-platform-for-longterm-gains>; see also Linda Giannarelli et al., “Reducing Child Poverty in the US: Costs and Impacts of Policies Proposed by the Children’s Defense Fund,” Urban Institute (Jan. 2015), available at <https://www.urban.org/sites/default/files/publication/39141/2000086-Reducing-Child-Poverty-in-the-US.pdf>.

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- When systemic barriers force people with low incomes to spend too much of their income on their rent, they cannot afford to pay for health care. In fact, many renters delay needed medical care because they are unable to afford it.⁴³
- People who are evicted from their homes, or even threatened with eviction, are more likely to experience health problems such as depression, anxiety, and high blood pressure than people with stable housing.⁴⁴ This exasperates the heightened risk women, particularly women of color, have for experiencing depression,⁴⁵ anxiety,⁴⁶ and high blood pressure.⁴⁷

Moreover, a recent study by Planned Parenthood shows that people of color, in particular Black women of reproductive age, are disproportionately affected by homelessness and housing insecurity, and are in need of continued access to comprehensive health coverage.⁴⁸ In Massachusetts, nearly 18,000 people

⁴³ “Renters Report Housing Costs Significantly Impact Their Health Care,” Enterprise (Apr. 3, 2019), available at <https://www.enterprisecommunity.org/news-and-events/news-releases/2019-04-renters-report-housing-costs-significantly-impact-their-health-care>; see also Munira Z. Gunja et al., “How the Affordable Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care.” Commonwealth Fund (Aug. 10, 2017), available at <https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/how-affordable-care-act-has-helped-women-gain-insurance-and> (noting that even though health insurance coverage gains through the Affordable Care Act have reduced the share of women skipping or delaying care because of costs, in 2016, 38 percent of women age 19 through 64 still reported not getting the health care they needed because of costs).

⁴⁴ Alison Bovell & Megan Sandel, “The Hidden Health Crisis of Eviction,” Children’s Health Watch Blog (Oct. 5, 2018), available at <http://childrenshealthwatch.org/the-hidden-health-crisis-of-eviction/>.

⁴⁵ Paul R. Albert, “Why is depression more prevalent in women?,” 40 J. Psychiatry Neurosci. 219-221 (Jul. 2015), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4478054/> (noting the higher prevalence of major depression in women than in men); National Institutes of Health, Office of Research on Women’s Health, “Women of Color Health Data Book” p.147 (Oct. 2014), available at <https://orwh.od.nih.gov/sites/orwh/files/docs/WoC-Databook-FINAL.pdf> (more women seek treatment for depression than men, though white, non-Hispanic women are more likely to receive treatment for depression than Latinx and Black women).

⁴⁶ “Anxiety Disorders,” Office on Women’s Health (last updated Jan. 30, 2019), available at <https://www.womenshealth.gov/mental-health/mental-health-conditions/anxiety-disorders> (reporting that women are twice as likely as men to get an anxiety disorder in their lifetime and noting that more American Indian/Alaskan Native women have generalized anxiety disorder than women of other races and ethnicities).

⁴⁷ *Id.* at “Women of Color Health Data Book” p. 121 (noting that Black women experience high blood pressure at a higher rate than Latinx or white, non-Hispanic women).

⁴⁸ “What about Her? — Assessing Social Determinants of Health Among Women of Reproductive Age,” Planned Parenthood Federation of America (2020), available at https://www.plannedparenthood.org/uploads/filer_public/33/97/33976d5a-f402-4b14-ab68-671aa58a0f00/210115-hcip-sdoh-what-about-her-update-v2.pdf (finding that Black, Asian/Pacific Islander, and Hispanic women of reproductive age are more likely to report needing SDOH-related support, with Black women reporting the highest need for support in almost all areas).

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were homeless on any given night in 2020.⁴⁹ Of these individuals, almost 13,000 were unsheltered⁵⁰ and Black and Latinx people experienced homelessness at disproportionate rates,⁵¹ accounting for 34.8 and 40 percent of Massachusettsans experiencing homelessness respectively.⁵² Finally, one in ten MassHealth enrollees faced homelessness or unstable housing in 2018.⁵³

In addition, in its 2017 report, the Massachusetts Youth Risk Behavior Survey found that LGBTQ students in Massachusetts were 2.8 times more likely to experience homelessness than were their non-LGBTQ peers. This is consistent with other youth-based studies, including the 2019 Massachusetts Youth Count, which surveyed 1,975 youth or young adults who were unstably housed, or experiencing homelessness and found that 24.7% of respondents identified as LGBTQ.

The COVID-19 pandemic exacerbated the housing crisis among individuals in Massachusetts. Before the pandemic, Massachusetts already ranked seventh and eighth in the nation for homelessness rates and severe housing cost burden respectively.⁵⁴ During the pandemic, data from the city of Boston's annual homeless census showed that the number of people who were unsheltered increased by 26 percent.⁵⁵

This alarming picture underscores the vital need for 24-months continuous eligibility for this population. As homelessness and housing insecurity continue to be widespread issues among Massachusettsans, continuous and comprehensive coverage for homeless MassHealth enrollees can provide a safe harbor and help these individuals access necessary care to combat the toll of homelessness on their health and overall wellbeing, and Planned Parenthood strongly supports this proposal.

⁴⁹ "State of Homelessness: State and CoC Dashboards," National Alliance to End Homelessness, available at <https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-dashboards/?State=Massachusetts>.

⁵⁰ Unsheltered homelessness includes individuals who sleep outside, in cars, or in other places not meant for human habitation such as abandoned buildings. See Samantha Batko, et al., "Unsheltered Homelessness: Trends, Characteristics, and Homeless Histories," Urban Institute (Dec. 2020), available at <https://www.urban.org/sites/default/files/publication/103301/unsheltered-homelessness.pdf>.

⁵¹ Joy Moses, "Demographic Data Project: Race, Ethnicity, and Homelessness," Homelessness Research Institute: National Alliance to End Homelessness, available at <https://endhomelessness.org/wp-content/uploads/2019/07/3rd-Demo-Brief-Race.pdf>.

⁵² *Id.* at "Section 1115 Demonstration: Project Extension Request."

⁵³ *Id.*

⁵⁴ "The Impact of COVID-19 Pandemic On Homelessness in the United States," United Way of the National Capital Area, available at <https://unitedwaynca.org/stories/effect-pandemic-homeless-us/>.

⁵⁵ Lynn Jolicoeur, "Annual Count Shows Homelessness in Boston Down, Unsheltered Population Up in Pandemic," WBUR News (Apr. 27, 2021), available at <https://www.wbur.org/news/2021/04/27/boston-homeless-census-shelter>; "City of Boston: 41st Annual Homeless Census," Department of Neighborhood Development (Apr. 27, 2021), available at <https://d279m997dpfwgl.cloudfront.net/wp/2021/04/2021-Census-Memo1.pdf>.

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B. Massachusetts should consider implementing 12-months continuous eligibility for all MassHealth enrollees.

Given the significant impact continuous eligibility has on ensuring continuous access to care, Planned Parenthood encourages Massachusetts to apply this program feature to all MassHealth enrollees. Planned Parenthood emphasizes that continuous eligibility is particularly important in ensuring access to essential SRH services for a full 12 months. Crucially, time is of the essence when accessing critical SRH services. As noted earlier, being unable to access SRH care can result in not only missed appointments, but also unintended pregnancies, undiagnosed STIs, and life-threatening cancers. People who utilize birth control and regular STI testing cannot afford to be without Medicaid temporarily even for a few days time, let alone a month or longer; such a disruption in coverage could have enormous consequences on an individual's health and lives, including educational and work commitments.

Continuous eligibility also ensures that individuals who may experience income fluctuations or are unable to keep up with burdensome paperwork requirements, are able to stay current on their medications and meet other health needs. A study by the Government Accountability Office (GAO) reinforces this positive effect, finding that enrollees covered by Medicaid for a full year reported fewer difficulties in obtaining necessary medical care and prescription medicine compared to those who were covered between one and eleven months.⁵⁶

By offering continuous eligibility to all MassHealth enrollees, Massachusetts would meaningfully increase access to timely SRH care and essential services, as well as continue in its goal to reduce disparities in the state, and Planned Parenthood encourages the state to amend its waiver application to include this program feature for all MassHealth enrollees.

IV. Conclusion

Planned Parenthood is pleased to submit these comments in full support of Massachusetts's MassHealth Waiver extension request and applauds the state for pursuing the requests discussed in this letter. Reinstating 3-months retroactive coverage for pregnant individuals will help to ensure that these individuals are able to access timely and necessary care that will positively affect their pregnancy outcomes. In addition, the proposed incentives for ACOs and safety net hospitals are vital steps to help deliver the highest standard of care and work towards eliminating maternal health disparities. Finally, applying 24-months continuous eligibility for homeless individuals will help to ensure continuous and stable access to care for a population that disproportionately suffers from poor health outcomes. All of

⁵⁶ *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, Government Accountability Office (Nov. 2012), available at <https://www.gao.gov/assets/gao-13-55.pdf>.

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these initiatives will help address existing racial disparities, in particular for Black and brown people and women of color.

While Planned Parenthood fully supports these initiatives and applauds the state for pursuing them, we also strongly encourage Massachusetts to meaningfully take steps in addressing health equity and reduce disparities for all MassHealth enrollees. Massachusetts should consider amending its draft Waiver extension to apply retroactive coverage and at least 12-months continuous eligibility to all MassHealth enrollees.

If you have any questions about the issues raised in this letter, please contact Mehreen Butt, Associate Director of Policy and Government Affairs, at mbutt@pplm.org or (781) 307-8710.

Sincerely,



Jennifer Childs-Roshak, MD, MBA

President

Planned Parenthood Advocacy Fund of Massachusetts

September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Acting Assistant Secretary Cassel Kraft:

On behalf of Point32Health, the combined organization of Harvard Pilgrim Health Care and Tufts Health Plan, I am writing to offer comments on MassHealth's 1115 Demonstration Extension Request (the 1115 waiver request). Our experience serving MassHealth members traces its roots back to Network Health, one of the original Medicaid Managed Care Organizations (MCOs). Currently, we are the largest MCO in the MassHealth program, serving more than 300,000 members across our products. We participate in four "Model A" Accountable Care Partnership Plans (ACPPs) with our provider partners, and we are one of two health plans participating in the statewide MCO program.

Point32Health covers more than 2.2 million members in five New England states across Medicaid, Medicare Advantage, dually-eligible, and commercial insurance products. Our purpose is to guide and empower healthier lives for everyone — regardless of age, health, race, identity or income. As part of that mission, we are deeply committed to the MassHealth program and to realizing the state's vision of more-coordinated, high-quality care for MassHealth members.

We broadly support the goals that MassHealth has outlined for this request. We applaud the state's continued commitment to the integrated accountable care model empowered by ACO-MCO partnerships, value the opportunity to build upon delivery system reform success with sustained funding for DSRIP-backed capabilities, and share MassHealth's view that investments in primary care, pediatric care, and behavioral health care are critical to improving health outcomes for members. We recognize the critical role that health-related social needs play in our members' overall health, and we are committed as an organization to addressing health inequities for all our members.

With these compelling goals in mind, we offer the comments below for your consideration. They include: a request for an expansion of the stated objectives; protection of key components of program success to date; the need for strengthened transparency; and an emphasis on flexibility. It is our belief that thoughtfulness on these issues will ensure that the next waiver will have the maximum benefit possible for members. Conversely, failure to adequately address these concerns could lead to the program falling behind on its promises.

Overview of the 1115 Waiver Request

With this 1115 waiver request, the State proposes to continue the movement toward value-based care by preserving and enhancing the Accountable Care Organization (ACO) program launched five years ago. We support these goals and appreciate that the MassHealth has reaffirmed the role of ACPPs in advancing these goals for the Commonwealth. We believe in the opportunities presented by integrated healthcare and payer-provider collaboration, including enhanced clinical programming, reduced total cost of care and improved health outcomes.

As part of the proposal to preserve some of the promising innovations and clinical programming that began under the last waiver, the State intends to transition 80% of the funding received through the Delivery System Reform Incentive Program (DSRIP) into base funding for the program. We support this policy and believe that the funding is critical to enable long-term delivery system reform that improves health outcomes at a lower cost. The DSRIP funding has supported a broad spectrum of services, including: care coordination, care management, community health workers, peer coaches, quality programming, flexible services program administration, interpreter services, and more. It's important for ACOs to continue to make investments that support ongoing programs and specialized services tailored to meet the needs of this population.

In addition, we support the investments that the State has outlined for strengthening primary care, pediatric care, behavioral health care, as well as continued innovation around social determinants, and a deep commitment to addressing health inequity throughout the system. Finally, we realize how critical supporting the Commonwealth's safety net is for MassHealth members, and we support the state's goals of maintaining our nation-leading position of near universal coverage. Of particular importance for our organization are the enhanced Health Connector subsidies funded through the waiver for people up to 300% of the Federal Poverty Level. As the largest health plan serving ConnectorCare members, we recognize how important these subsidies are for preserving affordability and coverage for that population.

Comments on Specific Issues

Below are our comments on nine specific issues for the state's consideration, which we respectfully offer with the following principles in mind:

1. The State must protect program stability with adequate ongoing funding that covers the direct cost of providing care to members, as well as the administrative and oversight functions required for such a complex program, with room for continuous innovation.
2. MassHealth should provide greater detail on funding level changes between this next demonstration and the current demonstration to assist market participants in better understanding and evaluating the proposal's potential to realize the State's goals.

3. Specificity and details related to programmatic changes, including their operationalization, are critical towards ensuring market buy-in and best positioning the market for success in realizing program goals.
4. For all the existing and new program mechanisms, MassHealth should embrace substantially increased transparency to ensure market confidence and robust competition.
5. Policy objectives should be outcomes-oriented and allow for flexibility in achieving the stated goals, and market participants should have the opportunity to participate in policy development.
6. Once the waiver is finalized, there should be clear and realistic timelines for implementation of new policies.

I. Design Balance between Model A and Model B ACOs

While we agree that both ACO models should be subject to consistent expectation of delivering value to Medicaid, this principle must be upheld with the necessary rigor, supported by a comprehensive valuation of the inherent differences between an MCO model and a state direct service model.

As stated above, we support the State's goal of continuing to move the delivery system toward value-based care and preserving the "Model A" ACPPs and the "Model B" Primary Care ACOs. We further believe that providers should be enabled to choose between the two ACO models based on which capabilities they chose to own internally and which capabilities they may want to partner with a payor to offer, rather than based on any inherent financial advantage that one model offers over the other. We strongly advocate for a level-playing field so that each model has an opportunity to deliver on the promise of improved patient outcomes at a lower cost.

The data that MassHealth has shared with the market to date about the financial performance of the two models is far too preliminary to draw conclusion from, let alone to make permanent funding changes to the program. In fact, data shared relative to medical and administrative spending of the two ACO models has been only from the initial year of the program, when there was significant volatility among MassHealth membership and many new primary care relationships were being formed. Credible conclusions cannot be made from this information.

We encourage MassHealth to develop and provide a detailed buildup of administrative cost components that will inform a rational accounting of resources for each of the two models. As examples:

- Model A ACOs perform traditional payer-functions such as enrollment, claims processing, utilization management, appeals and grievances, fraud waste and abuse investigations and more, that the state is performing on behalf of the Model B ACOs. MassHealth should itemize these functions and appropriately attribute State fixed and variable costs associated with providing these functions for purpose of comparison.



- MassHealth has set higher expectations for Model A ACOs, including more sophisticated and tailored data collection and reporting, enabling innovative pilot programs, leveraging greater contracting flexibility, more advanced use of alternative payment methodologies and greater innovation expectations. The incremental value of these elements should be incorporated into Model A cost buildup accordingly.
- The non-medical cost must also account for the risk being assumed. We appreciate MassHealth's effort over the last year to bring the ACPP funding model more in line with Model B, including the market-wide risk corridor and the implementation of concurrent risk-adjustment, as well as stop-loss protection for inpatient claims. That said, ACPPs are still assuming insurance risk in the program, which goes beyond market-wide funding inadequacy risk, while Model B ACOs are not. As a matter of principle, capitation rates must meet the requirements of actuarial soundness, which include an appropriate provision for underwriting gain to provide for the cost of capital and a margin for risk assumed by the MCO.

MassHealth must consider all the above factors as it seeks to develop balanced funding structure for both ACO models. For illustration, we have provided the framework below to show how the State should view any financial re-balancing. Since a significant portion of the former DSRIP funding will flow through the administrative component of the capitation rates, it is absolutely essential that the State calibrate the ACO financing appropriately to provide market confidence of stability and sufficient financing to meet the program requirements.

II. Risk Adjustment

We request that MassHealth adopt an open source model for its risk adjustment program, provide regular review of program efficacy, and based on model performance results, consider necessary refinements (e.g., separate programs for unique sub-populations).

For MassHealth to ensure adequate and reliable ACO funding in the future, there must be greater confidence that the risk adjustment model accurately captures the acuity of the population being served. We remain concerned that the current model lacks transparency and, at times, produces highly volatile results that we cannot easily explain or reproduce. Moreover, because the model has already been changed frequently, there is a sense of instability and a lack of market confidence about its performance.

We strongly recommend the State make the risk adjustment model and all its components publicly available, or at least available to its contracted ACOs, like the risk adjustment models for other major government programs (e.g., the ACA individual and small group markets and Medicare Advantage). It is critical that all market participants understand risk adjustment in a more comprehensive way, so they can determine whether it accurately measures and compensates for the health status of members. Moving forward, the State should commit to regular evaluations of the model's performance and a robust market engagement before making future changes. This, and fair and reasonable capitation rates that cover the costs of service delivery are critical to the stability of the MassHealth program for its beneficiaries.

III. Primary Care Sub-Capitation

An important step towards value-based primary care, the PCP sub-capitation is best positioned to succeed with 1) adequate total investment to support meaningful change; 2) vigilant design of tiering details which can only be achieved with deep market engagement; and 3) a focus on outcomes, which necessitates flexibility.

MassHealth has requested waiver authority to implement a new primary care sub-capitation program for all participating primary care providers in the ACO program. Under the proposal, providers would be paid a fixed amount for a certain bundle of primary care services based on one of three tiers that will vary depending on certain capabilities available at the provider practice site. There will be no reconciliation of the capitation payment to actual utilization at the end of the performance year.

We support the State's proposed investment in primary care and encourage the State to ensure that the funding stream is sufficient to truly enable the care delivery transformation contemplated in its request. The \$115 million annual investment will need to be spread across more than 1.5 million ACO lives. While this amount may replace some of the DSRIP funding being used to support primary care under the existing waiver, it does not seem to be enough to be transformative for primary care practices or primary care delivery, particularly in light of some of the programmatic expectations described below.

We encourage MassHealth to work with the market to define what set of services would be included in the capitation bundle and which would continue to be paid for through fee-for-service. We feel achieving the appropriate mix is important for stability of provider practices and consistent with the State's goals. Since the primary care sub-capitation payments will be risk adjusted, it is of critical importance that the methodology be open and transparent to the market and reflect the relative needs of ACO-specific populations like children and adolescents.

In its waiver request, MassHealth has said that it will have increasing care delivery expectations for the higher tiers of the sub-capitation program across these domains: behavioral health integration, screening for health-related social needs, meeting the unique needs of pediatric members, and providing expanded access to care. We would encourage the State to consider-ACO specific populations in how providers are tiered. For example, practices with higher volumes of Medicaid patients in their patient panels and practices with higher volumes of specialized populations like pediatric patients should be considered for higher tiers. As MassHealth considers how to achieve the care delivery goals described above, we recommend that requirements for the sub-capitation program not be overly prescriptive and focus on outcomes rather than process measures. We are concerned about disruption at the practice level if the requirements to participate are overly stringent. Provider systems should be given the flexibility to achieve policy goals across their networks or in concentrated geographic regions rather than at the individual practice site level. We feel this is particularly relevant in an ACP context in which a mix of services from the ACO, MCO, community resources and vendor resources might be available to members. For example, expanded telehealth capabilities is included as a consideration for higher-tier providers in the program under the auspices of expanded access. There are ways to address the goal of expanded access in which members would have access to a network of provider resources, even if those resources are not located at the specific practice site.

IV. Community Partners Program

We request broadened latitude for ACOs to design and implement their Community Partnership program, which should reflect the best fit with each ACO’s care management model, deliver targeted care for their unique populations, and maximize total cost of care performance.

MassHealth has requested the authority to continue the Community Partners (CP) program begun under the previous waiver while making changes for both the behavioral health CPs and the long-term services and support (LTSS) CPs. We appreciate that MassHealth is making a more direct connection between ACOs and CPs, including having the MCOs hold the contract with the CPs in the ACPP model. To date, we have found that working strategically with CPs that have a high volume of members and high capabilities is the most effective way to meet the needs of our population.

We have several recommendations to ensure the new relationship between CPs and ACOs works effectively for all parties. ACOs should be given the flexibility to develop unique workflows with the CPs based on their relationships rather than having uniform requirements across all ACOs and CPs. We expect this will greatly reduce administrative burden and be more responsive to members’ needs. ACOs should be able to use appropriate criteria to identify members who require CP services and make referrals that align not only with the needs of the members but also the ACO. As an ACPP that serves the majority of children in the MassHealth program, we encourage the State to require that CPs, or at least a subset have CPs, have expertise in serving a pediatric population, particularly the LTSS CPs. ACOs should be able to define a set of performance metrics that include outcomes, in addition to the process measures in place now. Such measures would include high-value activities like securing housing and successful transitions of care. MassHealth must also support the transition of CPs more directly into the ACO model with additional financial investment for oversight and performance monitoring in a much more direct way than exists now.

Lastly, as elsewhere in our comments, we encourage the State to provide ACOs with flexibility in how they provide services like care management and care coordination rather than being overly prescriptive in its program requirements. ACOs will receive funding for the CP services, and other services previously funded through DSRIP, in the administrative component of the capitation rates. As such, the ACOs should be able to choose which services they purchase with those dollars after considering what capabilities they possess internally and which they may want to partner to offer to members. Such strategies are very likely multi-party approaches that involve the ACO, the MCO, CPs and external vendors, and MassHealth should encourage innovation, particularly in the ACPP context.

V. Behavioral Health

We continue to advocate for a robust behavioral health provider network, accessible in a consistent manner to all MassHealth members, which relies on systemic correction of behavioral health reimbursement that must start with State benchmark rates.

We support the goals of increasing access to behavioral health services and improving the member experience when accessing these services, as outlined in the State’s Behavioral Health Roadmap

released earlier this year. Specific to the context of the ACO program, we support the streamlining of administrative processes such as provider credentialing, enrollment, and authorizations. We are hopeful that these policies will increase provider participation in MassHealth and make the member experience more uniform across ACOs. We are confident we can help the State make progress in those areas while maintaining our insourced model of behavioral health, which we are committed to as an organization. We firmly believe a carve-in approach is the best way to address whole-person care and facilitate the integration of physical health and behavioral health, particularly for providers looking to realize efficiencies by leveraging a minimal-payor contracting strategy.

In alignment with the Behavioral Health Roadmap, the waiver request outlines \$200 million in investments to expand access to services and improve integration. We support more robust behavioral health networks and continuity of care provisions. We believe the key to expanding access to behavioral health for MassHealth members lies in adequate reimbursement to cover the costs of providing care. We know from our ACO Partners that the cost to integrate behavioral health into primary care practices is substantially greater than the reimbursements generated, particularly because the demand for services comes primarily from Medicaid patients. Any approach to building a more robust behavioral health network, therefore, must include increases to MassHealth rates paid for preventive behavioral health.

VI. 340B Policy Changes

In the absence of critical details, we express significant concerns about the potential market disruption that could result from the 340B cost re-allocation. We encourage protection of budget neutrality at the provider entity level.

MassHealth has requested the authority to create a new reimbursement methodology for 340B entities with differential rates based on one of two tiers into which providers will be categorized. The waiver document states that this policy is intended to protect safety net providers financially while making payment methodologies between Model A and Model B ACOs more equitable. While we are supportive of consistent programmatic and financial expectations across ACO Models, there is not enough information in MassHealth's request for us to evaluate this policy change appropriately.

At a minimum, MassHealth should explain the criteria that will be used to assign providers to Tier 1 and Tier 2 for this policy, and what the revenue streams for 340B entities will look like both prior to and after the policy change for both ACO models. The range of reimbursements for 340B entities provided in the waiver request are very broad now and could result in significant financial loss for providers depending on what level is ultimately chosen. For that reason, we encourage MassHealth to make this policy revenue neutral at the provider entity level irrespective of which ACO model a hospital chooses. We are concerned about any negative financial impacts, intended or unintended, to our provider partners that participate in the 340B program.

VII. Health Equity

We strongly support MassHealth’s focus on health equity as a core waiver priority. We believe MCOs should play a central role in the market development of health equity data infrastructure.

MassHealth has requested the authority to implement a new \$500 million incentive program for ACOs to collect information about members’ health-related social needs, do stratified reporting based on social risk factors and ultimately reduce health disparities in targeted areas. Social health factors have been shown to materially impact a person’s overall health, and those challenges were only exacerbated by the Covid-19 pandemic during the last 18 months. We applaud MassHealth for the approach to health equity that provides a glide path to reducing health disparities and improving outcomes. These areas are of critical importance for MassHealth members.

We appreciate that the waiver request recognizes the foundational work that needs to be done around data collection and reporting for these efforts to be successful. The State should move forward with two key principles in mind. First, the timeline for transitioning from a pay for reporting program to a pay for performance program is very ambitious. MassHealth should engage with the market to identify areas where ACOs have real opportunity to impact member outcomes around health equity rather than those determined solely by underlying social factors. Second, the State should recognize that data collection and standardization is a joint responsibility of ACOs, MCOs and MassHealth itself.

We are already building these capabilities, and we feel MCOs can help the State succeed in these goals for several reasons. While providers see members in a single care setting, MCOs can follow members across the care spectrum and through interactions with several different provider types. Not only does this create more opportunity for the MCOs to collect and aggregate the information, but it creates a single source of truth for reporting purposes. MCOs have also enhanced their data collection and reporting abilities around health disparities during the pandemic as outreaching members in communities disproportionately impacted by Covid-19 to get them vaccinated has been a top priority. Finally, a recent State law, and corresponding regulations issued by the Massachusetts Department of Public Health, grants health plans permanent access to the Massachusetts Immunization Information System (MIIS). Pairing State data with health plan data collection should only enhance robustness in this area.

VIII. Quality Improvement

The next waiver should be seen as an opportunity to accelerate the maturity of the ACO quality program, as reflected in improved measure slates that better promote actionable opportunities, as well as more timely and reliable reporting.

As MassHealth moves forward with this demonstration extension request, we hope that this will be an opportunity to come together and jointly work to address quality in a more comprehensive manner. We appreciate that the State will incorporate health equity measurements into its quality measurement slate and that ACOs will be eligible for quality bonus payments based on their performance across those measures. We would encourage the state to pursue the full 5% quality bonus amount available under federal authority, which we believe could be a major catalyst for quality improvement. We would

encourage the State to allow ACOs flexibility in establishing quality measures that may be more actionable for the specific population the ACO serves. A mixture of a core measurement set and a menu of additional measures from which ACOs could choose could better align quality measurement with the ACO populations. We would also encourage the State to make reporting of ACO quality data, with corresponding market benchmarks, more timely and actionable so that ACOs can be responsive and, if necessary, redesign clinical programs to improve outcomes. Such efforts should include more opportunity to recoup quality payments during remediation.

IX. MCO Program Support

Members unaffiliated with ACOs should have access to comparable care and support that MCOs are well-positioned to deliver.

Currently, approximately 100,000 MassHealth members are served by primary care physicians not affiliated with an ACO through the MCO program. For several reasons, including size, region, payer mix, infrastructure, and organizational limitations, many of these providers will not be ready to participate as ACOs under the next waiver.

We do not believe members served in the MCO program should be forced to move to ACO-participating PCPs, nor do we believe that these members should be left behind in having their health needs adequately addressed. Indeed, we have encountered some of the most complex members through the MCO program, including high concentrations of members suffering from homelessness, serious mental illness, and substance use/opioid use disorders. Ensuring their access to essential benefits that are enabled for ACO members; namely, care coordination, care management, behavioral health integration, and flexible services, should be an ongoing commitment of the MassHealth program, and an explicit component of the waiver extension.

In the absence of risk-bearing ACOs, MCOs are well-positioned to provide member-centered population health management investment for this population. Leveraging learnings from the current waiver, MCOs should be expected to provide complex care management with integrated behavioral health and social intervention, robust transitions of care, and comprehensive quality management, including closing the health equity gap, among others. We therefore request that continuation of DSRIP-backed functions in the MassHealth program be expanded to include members in the MCO program, commensurate with the accountability described above.

Concluding Remarks

Thank you for your consideration of these comments and for your work in creating this waiver request. MassHealth has put significant time and thought into designing a comprehensive program that addresses the complex needs of the Medicaid population. At Point32Health, we remain committed to the goals of the waiver and to the ACO model itself. We are enthusiastic about participating in its refinement for the future, and we look forward to working together to innovate in care delivery and coordination for the Commonwealth's most vulnerable members.

Sincerely,



Kristin Lewis
Chief Government Affairs Officer



September 20, 2021

Office of Medicaid
Massachusetts' Executive Office of Health & Human Services
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108
submitted via email to 1115-Comments@mass.gov

Re: Comments and Recommendations for MassHealth's 1115 Demonstration Renewal

Dear Acting Assistant Secretary Amanda Cassel Kraft:

Project Bread is grateful for the opportunity to submit comments in **support of MassHealth's 1115 Demonstration Extension Request, including the flexible services program in the renewal request.** We appreciate the collaborative approach that MassHealth has taken to develop this renewal and support several new measures. Included in these comments are recommendations for areas that we believe can be further strengthened.

Project Bread is a statewide anti-hunger organization committed to connecting people and communities in Massachusetts to reliable sources of food while advocating for policies that make healthy food accessible. Project Bread believes racial justice is critical to our mission and that we cannot eliminate food insecurity in Massachusetts without addressing the social, political, and environmental inequities that drive disparities in food access and health outcomes.

According to the *American Journal of Medicine*, 80% of a person's health status depends on social determinants such as food access. Project Bread has long recognized hunger as a public health issue, and we have worked with hospitals and health centers for over 15 years to create screening protocols and refer patients to community resources and federal nutrition programs.

Project Bread has partnered with three accountable care organizations (ACOs) to provide nutrition support services under the flexible services program: Community Care





Cooperative, Boston Children's Hospital ACO and Boston Medical Center Health Net. Over the last 18 months, **we have supported more than 3,000 MassHealth members who had a physical or behavioral health condition and were experiencing food insecurity.** The Project Bread program takes a choice-based approach; members choose from a number of goods and services dependent on the specific barriers they face in accessing healthy foods. They can access grocery store gift cards, transportation assistance, procurement of kitchen supplies and appliances, cooking classes, nutrition coaching, and referrals for assistance accessing federal nutrition assistance programs. We are excited to report that preliminary data show our program is having a positive impact on food security, diet quality and health outcomes. **Twenty five percent of program recipients report that they are no longer food insecure after six months of program participation.** On average, participants report consuming an additional .9 servings of fruits and vegetables each day. And **99% of participants report that their health improved greatly (78.9%) or slightly (20.3%) as a result of the program.**

Project Bread is excited to be piloting this innovative work and to see its inclusion and expansion in the next request to the Centers for Medicaid and Medicare Services. In particular, we express our support for the following components that will increase our ability to serve MassHealth members.

1. First and foremost, we are supportive of the **focus on health equity and the continuation of the flexible services program.** Project Bread believes that the flexible services program is an essential tool for addressing disparities in health outcomes, as it allows MassHealth to begin addressing some of the social determinants that contribute to these outcomes.
2. **Household level nutrition support.** Families share food. When we can address the needs of the entire household, we can ensure that patients are not sacrificing their medical needs to feed their loved ones. Being able to track household size and serve all household members will also allow us to track program impact and outstanding service gaps with greater accuracy. We are grateful to MassHealth for taking this step to fully address the needs of members and consider the full breadth of the factors influencing their health and diet choices.





3. **Provision of childcare coverage.** Many of the members we serve have expressed regret that they cannot participate in a coaching session or cooking class because they are unable to find childcare. Project Bread believes that inclusion of this new support service will increase access to a variety of services for at least 10% of our clients.
4. **Extension of coverage to 12 months post-partum.** The year after birth is a vulnerable time for both mother and child. In particular, the nutrition of a woman during this time-period has a great impact on their ability to breastfeed, which in turn can impact the health and nutrition of their infant. Therefore, we are glad to see MassHealth put these health needs above any consideration of immigration status.

While there is much to celebrate about the Demonstration Extension, Project Bread recommends the following additions to further strengthen the ability of MassHealth and its partners to reduce health disparities and improve the lives of its members.

1. We urge MassHealth to reconsider renewing the Prep Fund in the Demonstration Extension. The Prep Fund is a critical tool that allowed Project Bread, and other social service organizations (SSOs), to build the technology infrastructure that is necessary to provide services to MassHealth members and effectively track outcomes. As ACOs look for additional SSO partners to meet the needs of their members, it is critical that similar financial support be available. This is especially true for smaller, community based SSOs, which are trusted members of the community with strong relationships and deep knowledge of local challenges and resources. In addition to financial support, the technical assistance made available through the Prep Fund is important for lesson sharing and troubleshooting. **We recommend that MassHealth make available both financial assistance for infrastructure development and technical assistance so that SSOs can have a space to share best practices and learn from one another.**
2. MassHealth has expressed an interest in standardizing the flexible services program but has offered limited information about the program design or timeline. Project Bread understands the need to identify which programs are having the





greatest impact on health outcomes and health equity. However, we are concerned that standardization of programming may stifle innovation. Additionally, program standardization may work against MassHealth's equity goals by limiting the number of organizations that are able to implement specific types of programs. **Project Bread recommends that the focus be placed on the development of shared metrics.** This would enable innovation and creativity in the ways in which members are served while ensuring that the same standards for health equity are being met by the diversity of programs.

3. Project Bread supports the concept of the Health Equity Incentives proposal, but we believe it does not go far enough in moving MassHealth towards its health equity goal. We believe the collection of demographic data and stratification is a baseline that all ACOs must meet to create a clear picture of the health disparities in our state and to reduce those disparities. **We recommend that demographic data collection and stratified reporting be required of all ACOs.** Incentive payments can be a tool to help ACOs complete this work and a reward for exceptional progress toward shrinking the health gap among their patient population.

We appreciate your consideration of our comments and look forward to continuing to work with MassHealth toward a healthy and food secure Massachusetts.

Sincerely,

Erin McAleer, President/CEO

Cc:

Gary Sing, Director of Delivery System Investment and Social Services Integration, Office of Payment and Care Delivery Innovation, MassHealth

Stephanie Buckler, Deputy Director of Social Services Integration at Massachusetts Executive Office of Health and Human Services

Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation, MassHealth





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September 1, 2021

MassHealth 1115 Waiver Team
Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108

Re: Comments on 1115 MassHealth Demonstration ("Waiver") Extension Request

Dear MassHealth 1115 Waiver Team:

On behalf of Reliant Medical Group, I would like to thank MassHealth for creating opportunities for our organization and other stakeholders to provide feedback in advance of the renewal of the Commonwealth's Section 1115 demonstration waiver. The members of our team who have participated in the Stakeholder Work Groups have appreciated the opportunity to share our perspective as a high-quality, value-based provider group. We strongly believe that the participatory process you have undertaken will help assure that MassHealth continues to succeed in its mission of addressing the health needs of the Commonwealth's most vulnerable residents.

In this spirit, I am writing to share some comments and recommendations designed to strengthen the Accountable Care Organization (ACO) program as part of the next 1115 waiver. Reliant Medical Group is committed to serving our MassHealth patients by maintaining our standing as a high-performing participant in the ACO program. The recommendations that follow are intended to assure the sustainability of the ACO program for provider organizations like Reliant that have developed the sophisticated infrastructure needed to provide integrated care to Medicaid beneficiaries in a value-based environment.

Creating a Full-Risk ACO Model

In Section III.1.1 of the 1115 Demonstration Extension Request, MassHealth is proposing to continue its Model A and Model B programs. As these models exist under the current waiver, ACOs do not have full dollar responsibility for the total cost of care. Instead, both models include fairly restrictive caps on surpluses and deficits, and carved-out risk for certain populations and categories of expenses. These approaches make sense as transitional models for prospective ACOs with limited experience in value-based arrangements. However, for ACOs with extensive experience in managing risk, the models offered by MassHealth have represented a significant step backwards in terms of financial and clinical accountability.

As part of the next 1115 waiver, we propose that MassHealth create a structure within Model A that includes real, full-dollar risk. This structure should be a true capitated model, with no separate risk corridors for defined populations or services, and no caps on surpluses or deficits, in alignment with MassHealth's vision of holding ACOs accountable and at financial risk for the total cost of members' care. ACOs under this structure also should be granted broad flexibility to manage MassHealth benefits for their patients using their choice of internally-managed and/or vendor-managed resources, consistent with a philosophy that responsibility and accountability should go hand-in-hand.

Such a structure would give high-performing, highly evolved ACOs like Reliant the incentive to pursue innovations, such as integrated behavioral health, that otherwise are not financially feasible under the limited ACO risk in place in the current waiver. This structure also would provide financial predictability for the Commonwealth; with ACOs under this structure accepting real risk for performance, MassHealth's risk would be limited to population growth and acuity changes. This full-risk structure would not be appropriate for all organizations. However, for organizations with the sophisticated capabilities needed to operate under full-dollar risk, a full risk structure within Model A would represent a realization of the Commonwealth's goal to transform the care delivery system for MassHealth patients.

Improving the Existing ACO Framework

In addition to requesting that MassHealth consider a full-risk Model A track as part of the next 1115 waiver, we also offer comments in the following areas:

1. Allowing flexibility in the enhancements to the Model A program
2. Expanding the Flexible Services Program to include additional domains for both childcare and transportation
3. Expanding the savings potential for ACOs that have demonstrated efficiency by removing the Network Variance Factor

The recommendations we offer in our comments support MassHealth's mission of arranging for affordable, high-quality care for Medicaid beneficiaries while also assuring the continued viability of the ACO program for care delivery organizations.

1. Allowing Flexibility in the Enhancements to the Model A Program

In Section III.2.1 of the 1115 Demonstration Extension Request, MassHealth proposes to make some refinements to the Model A program based on lessons learned, including implementing a primary care sub-capitation payment model for all participating primary care practices in the ACO program. As part of this shift to sub-capitation, MassHealth further intends to design expectations for participating primary care practices to incentivize specific care delivery improvements, including requirements around integrated behavioral health services, enhanced team-based models of care, expanded patient access to care, and improved care coordination.

While Reliant supports MassHealth's commitment to valuing care delivery improvements, we must also emphasize the importance of the new waiver allowing for flexibility in these requirements. These expectations cannot be so prescriptive as to limit the ability of ACOs to innovate and deliver customized care based on patients' needs. As one example, Reliant has observed that some of our younger, low-utilizing patients prefer receiving care via a virtual model rather than a traditional bricks-and-mortar primary care experience. An innovative virtual care model for a subset of the MassHealth population

who prefer that type of care would allow ACOs to be creative in their approach to expanding patient access and to better align with MassHealth’s vision of being able to “meet members where they are.” It is critical to assure that the expectations set by MassHealth do not preclude the ability of ACOs to experiment with such innovative, cost-effective, and patient-centered models of care.

Also, these expectations that MassHealth sets for primary care practices should be flexible enough to prevent ACOs with already advanced primary care capabilities from having to “reverse engineer” currently established processes that already work well for our patients. We are concerned that it would be disruptive to patient care if an ACO were required to redesign workflows established under the initial ACO waiver if the care delivery improvement requirements under the new waiver do not offer sufficient flexibility in design and implementation.

2. *Expanding the Flexible Services Program to Include Additional Domains for Both Childcare and Transportation*

Reliant is pleased that MassHealth seeks continuation of the Flexible Services Program. Across the Commonwealth, this program has allowed for new partnerships and improved integration among healthcare providers and the social services sector.

In Section III.3.2 of the 1115 Demonstration Extension Request, MassHealth proposes to include some adjustments to the Flexible Services Program improve program accessibility. In particular, Reliant supports MassHealth’s proposed changes to allow Flexible Services to be used for childcare to facilitate members’ access to nutrition and housing support services, similar to the existing allowance for ACOs to provide members with transportation to access their Flexible Services Program.

While these allowances in childcare and transportation address some of the barriers to members receiving nutrition and housing support services, Reliant would counter that childcare and transportation themselves are each critical social determinants of health. We urge MassHealth to take these allowances one step further and consider adding 2 new domains to the existing Flexible Services Program: a childcare domain and a transportation domain.

As MassHealth noted in the 1115 Demonstration Extension Request, recent research shows that access to childcare is a barrier to accessing and engaging in healthcare which disproportionately affects women. Under the current 1115 waiver, MassHealth has already identified lack of transportation as being a barrier to receiving care. Although there are existing MassHealth programs in place to support transportation and childcare, gaps remain in member eligibility to accessing these services and in the types of services provided. If childcare and transportation were expanded into their own domains, it would allow ACOs to partner with social service organizations to develop novel programs to further remove some of the barriers our patients face when seeking equitable care.

3. *Expanding the Savings Potential for ACOs that have Demonstrated Efficiency by Removing the Network Variance Factor*

Reliant has been grateful for MassHealth’s willingness to hear our concerns about the financial methodology of the ACO program, and to make modifications in prior years. In particular, we applaud the changes MassHealth made for the 2021 calendar year, including accounting for sub-capitated costs in the Network Variance Factor (NVF) calculation, expanding the medical cost risk corridors, and

moving towards a concurrent risk adjustment model. However, Reliant remains concerned that the upside savings potential for ACOs that successfully manage the total cost of care remains limited, particularly for ACOs which have demonstrated efficiency as a low cost provider and realized an unfavorable NVF adjustment.

In Section III.4.1 of the 1115 Demonstration Extension Request, MassHealth requests expansion of Safety Net Provider funding in order to preserve the Health Safety Net program and to support expansion of the number of hospitals eligible for Safety Net Provider Payments. Reliant supports MassHealth's commitment to making stability and sustainability of the safety net a core priority of the demonstration extension.

MassHealth has also stated additional providers would qualify for Safety Net status due to changes in payer mix, growing the number of eligible hospitals in the Safety Net Care Pool from 14 to 23. Since additional providers will have access to safety net funds, it seems there would be less need within the ACO program for NVF protections for ACOs with historically high costs. To that end, Reliant requests MassHealth eliminate the NVF in the next waiver and replace it with the market-based rate.

One of the key factors identified by MassHealth to improve value in ACO program delivery is to hold ACOs accountable for meeting increased standards related to cost growth management. For ACOs that have effectively managed cost and demonstrated clinical efficiency, the NVF has acted as a performance penalty and prevents ACOs from generating savings needed to sustain high performance. We request that MassHealth move to market-based rate setting methodology upon initiation of the new waiver, allowing high-performing ACOs to realize those additional savings.

Conclusion

Thank you for providing us the opportunity to share our feedback on the Section 1115 Demonstration Extension Request, and for your commitment to promoting high quality health care to some of the Commonwealth's most disadvantaged residents. My colleagues at Reliant and I look forward to continuing to collaborate with MassHealth on achieving our shared goals for Massachusetts. Should you have any questions regarding our recommendations, please contact Jonathan Chines, Vice President of Payer Contracting and Network Strategy, at 774-261-1413, or jonathan.chines@reliantmedicalgroup.org.

Sincerely,

Tarek Elsayy, MD
President and Chief Executive Officer

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services
Amanda Cassel Kraft, Acting Assistant Secretary, Executive Office of Health and Human Services
Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation, Executive Office of Health and Human Services



COMMONWEALTH OF MASSACHUSETTS

THE GENERAL COURT

STATE HOUSE, BOSTON 02133

September 20, 2021

Amanda Cassel Kraft, Acting Assistant Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Assistant Secretary Cassel Kraft:

We are contacting you on behalf of our constituent hospitals in western Massachusetts to seek your support for their efforts to address historic inequities in safety net hospital reimbursements through the upcoming MassHealth 1115 Medicaid waiver.

We share this letter with you as part of the formal public comment period required prior to the submission of the waiver to the federal government in November. The 1115 Medicaid waiver proposal as envisioned by your administration includes the goal of increasing funding to the so-called Medicaid Group 2 acute care hospitals by some \$20 million over the current level of funding, while adding an additional nine hospitals to the group. We appreciate this important step forward, but we believe this insufficient level of funding will continue the historic inequity between the Group 1 and Group 2 hospitals and exacerbate the financial hardship and struggle these hospitals have faced over the past decade. For our delegation, the issue is clear, this inequity embeds the notion that the provider community in our region continues to be disadvantaged versus those in the east, particularly in Boston.

The Group 2 hospitals in our region provide care to a Medicaid population that has grown substantially in the four western counties over the past decade. At the same time, the hospitals' commercial payer mix continues to decline, impacted by the reality of the population they serve in the five Gateway Cities of western MA with their challenged economic circumstances.

Contrast this with the situation in Boston where a two-tier hospital system has evolved with some hospitals enjoying very high commercial rates and others whose predominant work is providing care to the underserved. The former enjoying favorable commercial reimbursements while the latter receive the bulk of the Commonwealth's safety net funding. Moreover, the hospitals in our region are often the largest employers in their communities and help to drive economic activity by providing good jobs and career pathways for our constituents.

Our goal is not to seek parity with the Group 1 hospitals but to level the playing field in a modest way through this waiver with additional funding beyond what has been suggested for the Group 2 hospitals in your proposal. Once agreed to by the federal government, these methodologies are locked in for the next five years and that is our concern. Eight of the eleven hospitals we serve in the west are impacted by the reimbursements that come to the Group 2 hospitals (two others are in Group 1 and one is aligned with a major Boston hospital system that is ineligible for safety net payments).

We have witnessed the incredible transformation of care the Accountable Care Organization (ACO) model has brought to our region and to the Commonwealth and we share the goal of the administration of broadening other areas of the care continuum like behavioral health and primary care. We

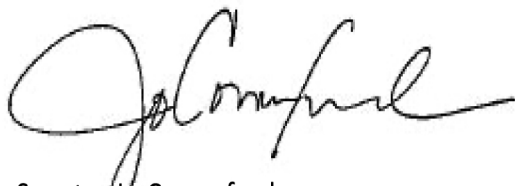
appreciate the work your office has undertaken as part of this important public policy that will impact millions of the citizens of the Commonwealth. We urge you to enlarge the commitment you have made to the state's Group 2 hospitals which serve the vast majority of our constituents.

Thank you for the opportunity to comment on this issue.

Sincerely,




Senator Eric Lesser
First Hampden and Hampshire District



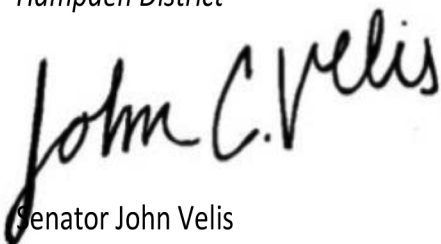
Senator Jo Comerford
Hampshire, Franklin and Worcester Hampden District



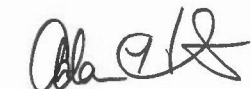
Senator Anne Gobi
Worcester, Hampden, Hampshire and Middlesex District



Senator Adam Gomez
Hampden District



Senator John Velis
Second Hampden and Hampshire District



Senator Adam Hinds
Berkshire, Hampshire, Franklin & Hampden District



Signature Healthcare – Brockton Hospital Comments on Massachusetts Section 1115 Demonstration Project Extension Request

We appreciate the opportunity to make public comment on the Waiver Extension Request and thank EOHHS staff and leadership for designing an extension that provides support for independent safety net providers in communities with large socially vulnerable populations.

SAFETY NET PROVIDER FUNDING

The stated goal in the Extension Request to sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals, is crucial - especially with Massachusetts ambitious delivery system reform that puts safety net hospitals at risk and responsible for the cost of care for very socially vulnerable populations. Current Safety Net Provider Funding for Signature only partially mitigates Medicaid cost reimbursement shortfalls which in turn helps maintains access. Currently the safety net provider payment (SNPP) provides funds to offset 1/4 of the \$50M in unreimbursed costs we reported in our 2020 UCCR. We would like to see substantially more safety net provider funding to ensure access and sustain our hospital, and cost inflation included as well.

We were disappointed to see flat safety net provider funding proposed in the August 18, 2021 Extension request for our Group 1 hospital, as the gap in unreimbursed costs is growing¹ for Signature as cited in the 1115 independent evaluation report, and inflation erodes its value annually as well. In addition, reimbursement for outpatient care has been cut by lower case weights for high volume services and remains lower than 2018 levels, even with the Group 1 safety net add-on to outpatient base rates.

In FY22 our safety net provider payment will be 72% of the value of the prior waiver's approved FY17 safety net provider payment, with 20% of that 72% at risk. This represents a reduction in sustaining funding of more than \$3.5M with another \$2.65M representing the 20% at risk. There is also no proposal to continue the DSTI glidepath which represents another \$0.5M. This \$6.65M in reduced safety net funding and increased risk represents a substantial loss of funds that sustain access for MassHealth enrollees. Signature is one of four out of six Group 1 hospitals that have experienced declines in safety net provider funding year over year (2018-2022) in the current waiver.

¹ Massachusetts 1115 Independent Evaluation Interim Report August 2021, page 329.
<https://www.mass.gov/doc/1115-demonstration-interim-evaluation-report/download>

Signature has been able to sustain operations with lower funding by continuously improving safety, quality, reducing cost, limiting replacement of equipment and facilities and enhancing 340 B revenue. As a result of our success in these initiatives, the remaining opportunities for efficiency improvement are very limited and we are experiencing wage and supply inflation as a result of the pandemic. We will not be able to sustain operations another 5 years on lower reimbursement, and we are not large enough to control inflation.

We request consideration for the safety net provider payment to have a base value at FY17 waiver funding level plus the DSTI glidepath and an annual inflation factor² for 2023 and factoring inflation in until 2027. Access depends on the financial underpinnings that support services at safety net hospitals.

ACO PARTICIPATION AND DOLLARS AT RISK

Despite our depth of experience managing risk under both commercial and Medicare contracting, three and a half years into our Medicaid ACO experience, we have experienced deficits in 5 out of 6 risk categories in both 2018 and 2019 (RC2-Child risk category had a modest surplus). In the pandemic year 2020, there was a deficit building in the first quarter of the calendar year which became modest ACO surplus in all but the RC10 risk category. This one-year surplus resulted not from success in managing or coordinating care but from the State's requirement that we curtail all elective volume and patients fearing the hospital in a community that ranked very high in COVID cases per capita.

Despite the reality that value-based contracting for a churning population who can elect to receive their care anywhere without limitation, is not entirely within our health systems control, we will continue our efforts to achieve the prospect of a potential surplus. But we request a higher safety net provider payment with the portion at risk reduced to 10% from its current 20%. Our patients simply require greater than average support because they endure so many barriers to health. To adequately support our community, we need to address more unmet needs and increase our investment in translators, transportation, social support, and behavioral health. Current, high risk (greater than 10%) exposure on sustaining safety net payments precludes us from being able to address the unmet needs that would reduce cost long term that simply can't be met with our current low reimbursement. The potential for savings the state seeks by putting us at greater performance risk could be better spent by allowing those funds to flow directly into the care and support of our patients.

The proportion of dollars Signature has at risk in total is not proportional to the limited capacity we have as a community hospital to absorb losses resulting from many factors out of our control. Proportionally we think the current level of risk is too high. A fixed dollar risk and a maximum percent of 10% would be more appropriate given what we now know about the

² PWC health industries research shows a 6.5% increase in 2022, 7% in 2021 and over 5% in years 2020 to 2017. <https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html>

challenges of setting a sound PMPM with a membership that churns substantially in and out of coverage, and the adverse selection we experienced in 2019 when redeterminations of eligibility were more aggressively done.

We welcome an opportunity to engage in some modelling surrounding the risk level we can tolerate and still maintain access and programs.

DSRIP SUCCESSOR FUNDING REQUIRED

We are concerned about the proposal having no discrete DSRIP successor funding dedicated to our ongoing quality outcomes success and care coordination which has had a strong ROI. For the past five years we have had on average \$2.8M a year of which \$390k on average was at risk. This funding allowed us to hire dedicated case workers, care managers, and social workers and clinical providers to engage patients in getting care at the right setting and limited ER use and avoidable admissions. This infrastructure has proved critical and is reflected in our high quality score. On page 28 of the Extension proposal it states that “MassHealth” intends to sustainably fund proven elements of the various care coordination program but it is not clear how much funding will be directly available to the safety net provider hospital in the ACO.

We would like to see a certain dollar value PMPM identified and provided to us directly. Our calculations indicate that we would need \$12.59 PMPM with average ACO enrollment in DSRIP successor funding provided directly to us, rather than trued up later because it has been rolled into a primary care subcap, especially given the deficits we have experienced and the extremely limited surplus (1 risk category 2 years in a row were only surpluses). If these dollars for care coordination were inside the cap it could easily be spent paying claims given the inadequate PMPM to date.

DISABILITY FUNDING & HEALTH EQUITY INCENTIVE PAYMENTS

Signature receives \$3M in disability payments, net of the assessment, which is a critical source of funding. If the new \$100M in health equity funding were 50% apportioned to the Group 1 hospitals it seems like we would not realize any new money, and this funding would be more substantially at risk in the out years than our current disability payment.

Comparing health outcomes of socially vulnerable populations to a reference population such as a commercial health plan, and closing the gap that may exist between the two without new funding does not reflect what we have learned about the time and effort required by the health care providers to appeal to MassHealth populations, overcome obstacles to schedule them, and have them show for appointments. It takes an aggressive integrated delivery system with staff who have acquired tools now (e.g. patient ping) to achieve this.

Closing health equity gaps caused by structural racism should include discrete new funding resources to identify and remedy them. If the proposed \$100M in health equity funding for providers were distributed similarly to the current safety net provider payment among the group 1 hospitals, we would realize little more than we receive for funding now for disability payments. We would therefore urge additional dollars for health equity be dedicated and higher than the current disability payment. We have learned from our ACO experience and our work on diversity and equity that to provide equitable outcomes, our patients require more support, more follow up, more access, more education, more behavioral health, more language support, and more collaboration with other agencies. As an institution relying on a high percentage of government payments and low commercial rates we do not have the funding to adequately support their additional needs.

XXXXX

From: Radha Inguva <ringuva@stateside.com>
Sent: Tuesday, August 24, 2021 1:20 PM
To: 1115 Waiver Comments (EHS) <1115WaiverComments@mass.gov>
Subject: Comment Period - Extension Request

CAUTION: This email originated from a sender outside of the Commonwealth of Massachusetts mail system. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

Good Morning,

My name is Radha Inguva and I am a regulatory counsel with Stateside Associates. I am contacting you regarding the 1115 Waiver Extension that is being submitted to CMS. I would like to formally request an extension to the comment period deadline. Several of our stakeholders are just hearing about this and the extension would allow us enough time to prepare for a meaningful conversation. We would greatly appreciate any extension.

Thank you for your consideration. I look forward to your prompt response.

Sincerely,

Radha Inguva, Esq.
Regulatory Counsel & Team Lead
Health Care Team
1101 Wilson Boulevard
Sixteenth Floor
Arlington, Virginia 22209
Direct: (703) 525-7466 ext. 202
Mobile: (702) 682-2859





September 20, 2021

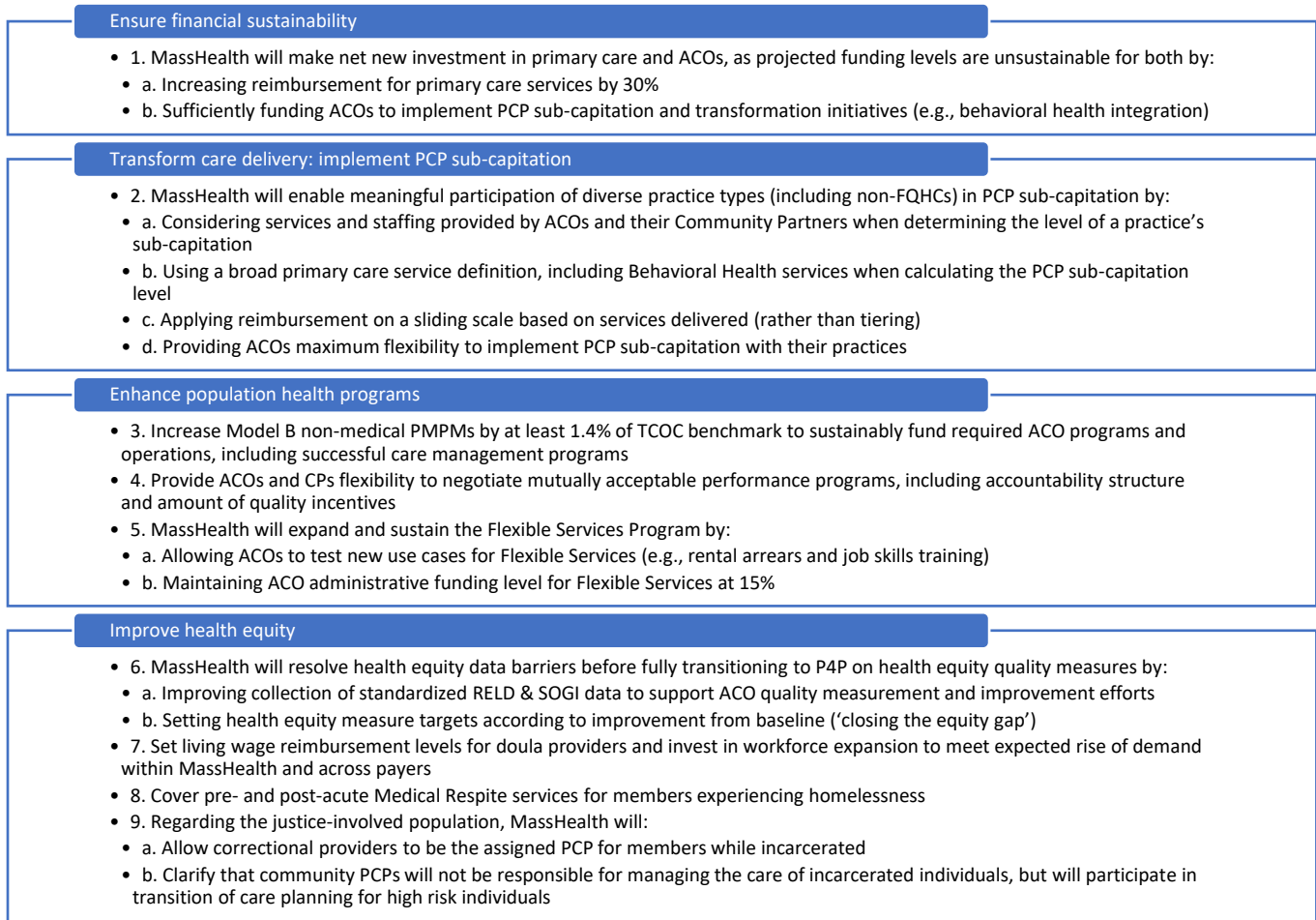
Marylou Sudders
Secretary, Health and Human Services
Commonwealth of Massachusetts
1 Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders,

Steward Health Care System (“Steward”) is pleased to comment on MassHealth’s proposed extension of its current 1115 demonstration waiver to the Centers for Medicare and Medicaid Services (CMS). In general, Steward supports MassHealth’s vision for its 1115 demonstration waiver extension. We propose the following recommendations to strengthen the ACO program and safety net hospital providers. For background information on Steward, please refer to the Appendix of this letter.

SECTION I. STEWARD’S RECOMMENDATIONS TO ENHANCE AND SUSTAIN MEDICAID ACO PERFORMANCE IN THE 1115 DEMONSTRATION WAIVER EXTENSION PERIOD (2022-2027)

The figure below summarizes nine specific recommendations that aim to enhance and sustain Medicaid ACO performance in the next waiver period.





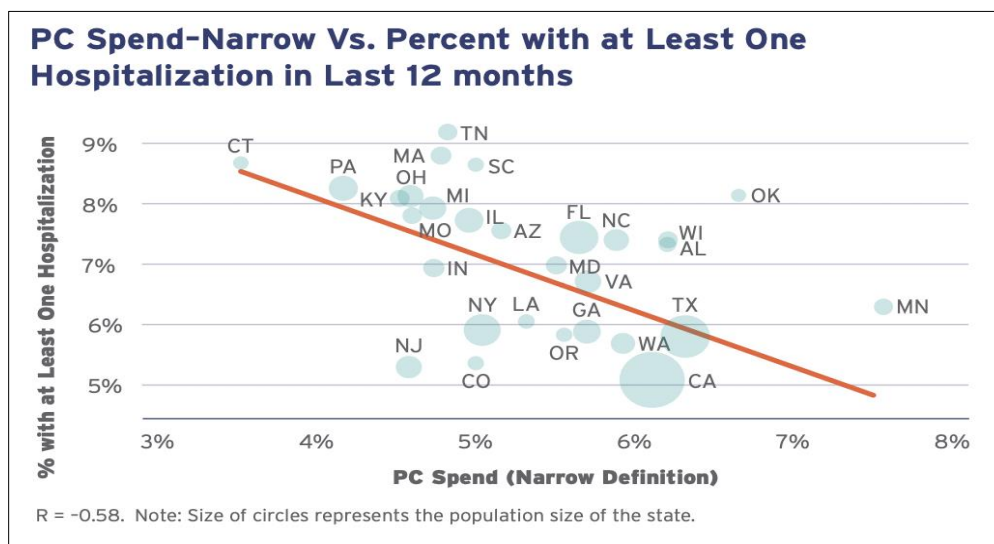
The rationale for each recommendation above is detailed in the following section.

I.A Ensure financial sustainability

1. MassHealth will make net new investment in primary care and ACOs, as projected funding levels are unsustainable for both by:
 - a. Increasing reimbursement for primary care services by 30%
 - b. Sufficiently funding ACOs to implement PCP sub-capitation and transformation initiatives (e.g., behavioral health integration)

According to the Kaiser Family Foundation, Medicaid reimbursement for primary care in Massachusetts is 70% of Medicare rates.¹ To correct this payment disparity and ensure provider engagement in the PCP sub-capitation program, MassHealth should increase reimbursement for primary care services by 30%. In addition, MassHealth should leverage federal funds to make net new investments (front-loaded in early years of waiver period) in ACOs to implement and administer PCP sub-capitation and further value-based payment goals, including behavioral health integration with primary care practices.

These dual investments may be funded with the anticipated transition of approximately 80% of DSRIP grant funding to ongoing base funding for ACOs and/or the approximately \$85B in projected costs that the 1115 waiver demonstration is saving the state and federal government. Furthermore, MassHealth cannot afford not to make these investments. States that have invested in primary care generally have lower rates of ED use, ambulatory care-sensitive hospitalizations, and total hospitalizations (as illustrated in the graph below); as primary care spending increased, ED visits and IP utilization decreased. Greater use of primary care is associated with lower overall costs, higher patient satisfaction, and lower mortality; further, investing in primary care has been shown to lead to fewer deaths from heart disease and cancer, as well as decreased rates of low birthrate and infant mortality.²



¹ Kaiser Family Foundation. (2016). Medicaid-to-Medicare Fee Index. *State Health Facts*. Retrieved from <https://www.kff.org/medicaid/state-indicator/medicaid-fee-index>

² Patient-Centered Primary Care Collaborative and the Robert Graham Center. (2019). *Investing in Primary Care: A State-Level Analysis*. https://www.pccpc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf



I.B Transform care delivery: PCP sub-capitation

2. MassHealth will enable meaningful participation of diverse practice types (including non-FQHCs) in PCP sub-capitation by:
 - a. Considering services and staffing provided by ACOs and their Community Partners when determining the level of a practice's sub-capitation
 - b. Using a broad primary care service definition, including Behavioral Health services when calculating the PCP sub-capitation level
 - c. Applying reimbursement on a sliding scale based on services delivered (rather than tiering)
 - d. Providing ACOs maximum flexibility to implement PCP sub-capitation with their practices

Steward's provider network is diverse in terms of geography (statewide), practice size (ranges from sole proprietorships to large, multi-specialty groups), ownership (employed vs. affiliate), and type (private group, FQHCs). To ensure all practices can meaningfully participate in PCP sub-capitation and extend the benefits of primary care transformation to patients, MassHealth should build on the existing ACO program by considering the services provided by ACOs and their Community Partners when determining the level of a practice's sub-capitation. For small and medium sized practices, in particular, the ACO is best positioned to deploy specific services (e.g., Health-Related Social Needs screenings) and staffing (e.g., CHWs) either centrally at the ACO-level or embedded in practices to meet MassHealth's objectives for transforming primary care, such as better integration with CPs and quality improvement (including reduction of health disparities).

To maximize the impact of PCP sub-capitation on care delivery and population health outcomes, MassHealth should use a broad primary care service definition³, including Behavioral Health (BH) services when calculating the sub-capitation amount (specifically, primary care service codes billed anywhere plus MBHP encounters billed by Steward PCPs). Primary care sub-capitation is likely to be most effective if BH services are integrated because BH comorbid conditions are prevalent among the Medicaid population and patients with a BH comorbidity are high utilizers. According to the Center for Health Information and Analysis (CHIA), 62% of hospitalized Medicaid adults had a comorbid BH condition; in addition, patients with any BH comorbidity have longer inpatient stays (5.7 days vs. 4.3 days) and nearly double the readmission rates (20.4% vs. 10.5%) than those without a comorbid BH condition.⁴

Finally, given the diversity of services provided across primary care groups, MassHealth should implement a sliding scale for enhanced reimbursement under the PCP sub-capitation program. A sliding scale model will provide an appropriate incentive for practices to provide the highest level of service possible, given their available resources, even if it does not advance them to a higher tier.

³ New England States Consortium Systems Organization. (2020). *The New England States' All-Payer Report on Primary Care Payments*. <https://nescso.org/wp-content/uploads/2021/02/NESCSO-New-England-States-All-Payer-Report-on-Primary-Care-Payments-2020-12-22.pdf>

⁴ Center for Health Information and Analysis. (2020). *Behavioral Health & Readmissions in Massachusetts Acute Care Hospitals (SFY 2018)*. <https://www.chiamass.gov/assets/docs/r/pubs/2020/Behavioral-Health-Readmissions-2020-Report.pdf>



I.C Enhance population health programs

3. Increase Model B non-medical PMPMs by at least 1.4% of TCOC benchmark to sustainably fund required ACO programs and operations, including successful care management programs

Since performance revenue is not sufficient to cover required ACO programs and operations (e.g., Contact Center), MassHealth should increase non-medical PMPMs to sustainably fund Model B ACOs, including successful care management programs. Even after controlling for population mix and acuity, Model A ACOs cost 6% more (\$29 PMPM), on average, than Model B ACOs – this difference is driven entirely by higher administrative payments to Model As.⁵ In addition, Model B ACOs outperform Model As on TCOC and Quality. In 2018, all three Model Bs achieved cost savings (vs. 5 of 13 Model As). Model Bs also performed better on quality measures. Through its settlement and program evaluation results, Steward has demonstrated the significant impact of its population health programs on cost, utilization, and quality performance in the first two years (2018-19) of the ACO program. For example, Steward’s Behavioral Health Care Management program reduced inpatient hospital cost and utilization, and the impact was more pronounced among members with SUD.

4. Provide ACOs and CPs flexibility to negotiate mutually acceptable performance programs, including accountability structure and amount of quality incentives

With MassHealth’s proposal to transition full accountability of the CP program to ACOs, MassHealth must ensure the CP program is sustainably funded and efficiently structured. Further, MassHealth should provide ACOs and CPs flexibility to negotiate mutually acceptable performance programs, including accountability structure and amount of quality incentives. Steward has significant experience designing and implementing incentive models for providers, which have led to cost savings and quality improvements across payers, including MassHealth. ACOs, including Steward, are well-positioned to design such programs collaboratively with CPs to ensure incentives are aligned across all provider types.

5. MassHealth will expand and sustain the Flexible Services Program by:

- a. Allowing ACOs to test new use cases for Flexible Services (e.g., rental arrears and job skills training)
- b. Maintaining ACO administrative funding level for Flexible Services at 15%

Across the MassHealth ACO program, Steward has one of the most ambitious Flexible Services Program in terms of its geographic footprint and scope of services. Steward currently offers both housing- and nutrition-related services to eligible members statewide through innovative partnerships with nine Social Service Organizations and two health centers. Given the complexity of the Flexible Services Program operation and need to comply with requirements related to health assessments, reporting, and program evaluation, among others, Steward recommends that MassHealth maintain ACO administrative funding level for the program at 15%.

While we support MassHealth’s proposal to extend the Flexible Services program into the next waiver period, we have identified critical gaps in goods and services that would increase the efficiency and effectiveness of the program. We recommend that MassHealth allow ACOs to test new use cases for Flexible Services, including rental arrears to prevent eviction and job / skills training to ensure members can sustain housing and food security after FSP services end. When appropriate, using FSP funds to pay for rental arrears would be more cost efficient and less disruptive to the member experience than the current program allows. We recognize that federal funds

⁵ Executive Office of Health & Human Services. (2021). *MassHealth Delivery System Restructuring: 2019 Update Report*. <https://www.mass.gov/doc/masshealth-restructuring-2019-update-report/download>



have been made available to prevent eviction during the COVID-19 public health emergency (PHE), however, these funds are time-limited; ACOs and their SSO partners require additional tools and funding to prevent eviction after the PHE ends.

I.D Improve health equity

6. MassHealth will resolve health equity data barriers before fully transitioning to P4P on health equity quality measures by:
 - a. Improving collection of standardized RELD & SOGI data to support ACO quality measurement and improvement efforts
 - b. Setting health equity measure targets according to improvement from baseline ('closing the equity gap')

Significant health equity data collection and standardization barriers exist. The availability of complete, standardized race/ethnicity data (~40% missing in MassHealth data) has emerged as a critical gap to quality measurement and improvement. The availability of SOGI data is even more limited. ACOs with diverse network participation are challenged to fill in the gaps directly with data collected by participating PCPs and hospitals. For example, PCP practices in Steward's Medicaid ACO use many different EMRs with different standards for collecting demographic information (e.g., each EMR uses different option sets for race and ethnicity), making aggregation and analysis of combined data not feasible for quality measurement. Despite the fact that Steward is one of the largest ACOs in the MassHealth program based on membership, we are not able to detect statistically significant racial/ethnic disparities across at least seven of the ACO quality measures due to incomplete data and/or small sample sizes. We are seeking to close the data gap by using imputed race/ethnicity data (via DSRIP TA Project) for population-level analyses, however, these data cannot be used for member-level intervention, which is necessary for ACOs to reduce racial/ethnic disparities in quality measures. Steward requests that MassHealth work with ACOs to resolve these data barriers before fully transitioning from pay-for-reporting to pay-for-performance (P4P) on health equity quality measures by improving its collection of standardized RELD & SOGI data (for example, through the eligibility determination and re-determination process). Upon transition to P4P, Steward recommends that MassHealth set health equity measure targets according to improvement from historical baseline ('closing the equity gap') rather than establishing an absolute target rate for ACOs to meet or exceed to earn performance incentives.

7. Set living wage reimbursement levels for doula providers and invest in workforce expansion to meet expected rise of demand within MassHealth and across payers

Steward was the first Medicaid ACO to launch a comprehensive community-based doula program in the MassHealth program and is proud of results to date, including reductions in pre-term birth, NICU utilization, and NTSV c-section rates, among the high-risk population the program serves. We support MassHealth's proposal to cover doula services as a health plan benefit, and request that MassHealth set living wage reimbursement levels for doula providers and invest in workforce expansion to meet the expected rise of demand within MassHealth and across payers.

8. Cover pre- and post-acute Medical Respite services for members experiencing homelessness

Total Cost of Care (TCOC) for members identified as homeless enrolled in Steward's Medicaid ACO is, on average, three times higher than TCOC for members who are not homeless. Steward recommends that MassHealth cover pre- and post-acute Medical Respite services for members experiencing homelessness. Models of respite care in Massachusetts and other states have proven to reduce TCOC by decreasing hospital length of



stay and readmission rates for this vulnerable population. Research has demonstrated medical respite programs reduce the cost of inpatient hospitalization by reducing length of stay by two days⁶ and that homeless patients discharged to a medical respite program experience 50% fewer hospital readmissions within 90 days of being discharged compared to patients discharged to their own care.⁷

9. Regarding the justice-involved population, MassHealth will:

- a. Allow correctional providers to be the assigned PCP for members while incarcerated
- b. Clarify that community PCPs will not be responsible for managing the care of incarcerated individuals, but will participate in transition of care planning for high-risk individuals

We acknowledge MassHealth’s proposal to maintain coverage for the justice-involved population to improve care delivery, outcomes, and equity for this vulnerable population. To enable ACO’s implementation of this program change, we recommend that MassHealth allow correctional providers to be the assigned PCP for members while incarcerated. Specifically, MassHealth should waive PCP exclusivity requirements for correctional providers to facilitate continuity of coverage and care for this population. To operationalize this recommendation, MassHealth would enroll and credential correctional providers as PCPs that can participate in all ACOs; members would be disenrolled from their community PCP upon incarceration and assigned to the correctional provider while remaining a member of their ACO. With this design, the correctional provider could communicate with the ACO for the purposes of intake, release planning, and transition back to the member’s community PCP. Furthermore, to avoid member and provider confusion, we request that MassHealth clarify expectations that community PCPs will not be responsible for managing the care of incarcerated individuals (which will instead be the sole responsibility of the assigned correctional provider), but that community PCPs will participate in transition planning for high-risk individuals (e.g., SUD) alongside ACO care management or CP staff once a release date is determined.

SECTION II. STEWARD’S HOSPITAL-SPECIFIC RECOMMENDATIONS

Steward appreciates MassHealth’s recognition of the critical role safety net hospitals play in providing necessary, accessible, high-quality, health care services in their communities. Sustainable and predictable funding is critical to support the operational needs of hospitals that are heavily reliant on public payer financing. Steward supports the proposal to increase the pool of eligible Group 2 hospitals and to increase the supplemental payment funding for this cohort. This plan reflects trended increases in the public payer mix for this class of hospitals over time and provides greater balance and fairness in designating support for all safety net hospitals.

Steward supports MassHealth’s plan to dedicate a significant portion of new hospital funding to address health care disparities. The COVID-19 pandemic has had a disproportionate impact on underserved populations and illuminated the historical prevalence of health care disparities by race, ethnicity, geography, and income. Hospitals will continue to play an important role in reshaping this imbalance. Incenting hospitals to make measurable progress in closing disparities is an important tool in restructuring the MassHealth program to create a more equitable health care system. Steward strongly urges these incentives to be weighted based on Medicaid payer mix – those hospitals with a proportionately higher Medicaid mix should be eligible for a greater share of the incentive and those hospitals with a proportionately lower Medicaid mix should be eligible for a lesser share of the incentive. Steward suggests that eligibility and accountability be scaled so

⁶ Shephard, D., & Shelter, D. (2018). [Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternate Levels of Medicaid Coverage](#). *Journal of Health Care for the Poor and Underserved*, Volume 29 (Issue 2 May 2018), pp. 801-813.

⁷ National Health Care for the Homeless Council. (2011). *Policy Brief: Medical Respite Care: Reducing Costs and Improving Care*. <https://nhchc.org/wp-content/uploads/2019/08/RespiteCostFinal.pdf>



that in the initial years, measures are tied to key reporting metrics, and in later years, measures are tied to both reporting and performance metrics. This approach will allow for hospitals to build capabilities and develop the infrastructure necessary to make incremental progress over the duration of the waiver period.

Lastly, Steward strongly supports increased alignment among MassHealth ACOs and ACO-participating hospitals. Quality incentives for hospitals, including but not limited to, disability access, patient experience, and care coordination, can strengthen tighter integration and provide a better member experience for MassHealth patients.

Thank you for the opportunity to provide input on MassHealth's proposed extension to its 1115 demonstration waiver. We hope MassHealth will seriously consider incorporating these recommendations into its final waiver extension request to CMS, and that CMS will expeditiously approve MassHealth's proposal.

We look forward to continuing to serve MassHealth members in the years to come.

Sincerely,

A handwritten signature in blue ink that reads "Harrison Bane".

Harrison Bane
President, North Region
Steward Health Care System

A handwritten signature in blue ink that reads "John E. Donlan".

John E. Donlan
President
Steward Health Care Network & Steward Medicaid Care Network

A handwritten signature in blue ink that reads "Joseph M. Weinstein, M.D.". The signature is written in a cursive style.

Joseph M. Weinstein, M.D., FACP, FACC
Chief Physician Executive
Steward Health Care Network



APPENDIX

I. BACKGROUND

Once a collection of struggling hospitals in Massachusetts, today Steward is the largest private, tax-paying health system in the country. In Massachusetts, we have a robust physician network and operate eight community hospitals and one teaching hospital, with over 4,000 providers caring for over 400,000 patients annually. Steward's Primary Care ACO, Steward Health Choice, includes primary care providers (PCPs) from across the Commonwealth. Steward's network of employed and affiliated PCPs forms the core of our nationally recognized model of integrated health care delivery. Among the largest groups in Steward's network is Steward Medical Group (SMG), our physician-led multispecialty practice organization of employed physicians. In addition to these employed providers, our network features diverse affiliates with significant experience in delivering health care to Medicaid patients. Affiliates include six community health center sites, Cape Cod Healthcare ACO, nearly 100 providers in central Massachusetts, and a multitude of independent primary care provider affiliates across eastern Massachusetts, with several large pediatric practices in the Fall River, North Shore, Methuen, and Newburyport communities.

Our vision for our Medicaid ACO program and ACO-participating hospitals aligns closely with MassHealth's stated goals and reflects Steward's overall mission. Through this program, we aim to:

- Deliver world-class health care where members live
- Advance the Quadruple Aim: improve members' health – including health equity – while improving members' experience and quality of care, reducing total costs and improving providers' administrative burden
- Actively engage a continuum of providers to address the needs of the communities we serve, including physical health, behavioral health, long-term services and supports, and health-related social needs
- Enhance and operate a scalable, sustainable, and replicable model that uses sophisticated incentives to engage and align priorities among both ACO providers and members
- Use data and technology to effectively identify needs of both members and providers and efficiently target resources to meet these needs

II. STEWARD'S VALUE PROPOSITION FOR THE MASSHEALTH ACO PROGRAM

Steward is a large scale, high value, high performing ACO relative to its peers in the MassHealth program.

Steward has participated in MassHealth's ACO program since the pilot launched in 2016 and is currently the second largest ACO in the full-scale program with over 150,000 members enrolled as of September 2021. In 2018, Steward's Total Cost of Care (TCOC) was ~5% lower than the market average⁸, even after controlling for population and pricing differences across ACOs. In addition, Steward saved the Commonwealth of Massachusetts \$21.4M by reducing TCOC by 3.7%. Steward sustained this high level of performance in 2019, maintaining TCOC at ~3% lower than the market average⁹ and generating \$8.9M in savings to the Commonwealth by outperforming the TCOC benchmark by 1.3%.

⁸ Executive Office of Health & Human Services. (2020). *MassHealth Restructuring: 2018 Baseline Report*. <https://www.mass.gov/doc/masshealth-restructuring-2018-baseline-report-0/download>

⁹ Executive Office of Health & Human Services. (2021). *MassHealth Delivery System Restructuring: 2019 Update Report*. <https://www.mass.gov/doc/masshealth-restructuring-2019-update-report/download>

Thank you for giving Sturdy Memorial Hospital and other hospitals in the Commonwealth the opportunity to comment on the 1115 MassHealth Demonstration Extension Request. We appreciate the opportunity to provide feedback to the Commonwealth regarding this essential program and the important work it will accomplish for Massachusetts' most vulnerable residents.

Sturdy Memorial has been a participant in the Massachusetts Health & Hospital Association's (MHA) Hospital Assessment Workgroup. The workgroup has engaged in thoughtful discussion and consideration of EOHHS's proposal. Sturdy Memorial appreciates the time and effort put forth by all members of the workgroup.

Sturdy Memorial supports adding a flat amount to provider Medicaid rates as opposed to a percentage increase to the standard base rates. A flat rate add-on is a more equitable way to distribute funds to providers. In addition, a flat amount would be easier to implement. A percentage-based add-on payment would require more maintenance from year-to-year and would result in greater disparities among hospitals. Hospitals with higher rates (for whatever reason – not necessarily relevant to the waiver funding) would receive greater additional funding than hospitals with lower Medicaid rates.

Sturdy Memorial supports the use of Medicaid GPSR, not NPSR, as reported in the Medicaid cost report to determine quality incentives. Hospitals often do not report NPSR in the same manner as their peers, as is evident by the new supplemental schedule required for the 2020 Medicaid cost report. There are inconsistencies in CHIA data across all hospitals in the Commonwealth because hospitals record supplemental revenue in several different ways and do not file their cost reports uniformly. The use of GPSR would ensure that like numbers are used in calculations for all hospitals.

The current proposal for the state tax is not uniform. In the current extension request, large systems would be given a greater discount than their smaller counterparts. Most often, these larger systems receive better payment rates from commercial insurers due to their size and clout. The methodology offering large systems a discount on the tax would be unfairly shifting the assessment more towards smaller institutions that are not part of a "system". In addition, this discount may incent smaller providers to consider merging with one another, should merging lead to a decrease in their tax rate, causing further disparities in the assessment paid by each hospital.

Sturdy Memorial supports the inclusion of a hospital's entire payer mix when determining which hospitals receive safety net care pool (SNCP) payments. Under current methodology, only hospitals with 20% or greater Medicaid volume and less than 50% commercial volume would be considered Group 1 or Group 2 hospitals and, as a result, receive SNCP payments. This methodology ignores Medicare volume, which is routinely reimbursed at rates lower than commercial payers. A calculation encompassing all payers should be used to determine this designation.

Sturdy Memorial supports MHA's alternate funding approach, which increases the assessment, which, in turn, increases additional federal matching funds. MHA's proposal would ensure no hospital or health system experiences a financial loss under the new waiver and would benefit every hospital in the Commonwealth.



September 20, 2021

Amanda Cassel Kraft
Acting Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Assistant Secretary Cassel Kraft:

Thank you for the opportunity to comment on MassHealth's 1115 waiver extension request. As the community foundation for Greater Boston, the Boston Foundation seeks to support and drive real change. The draft waiver application represents an opportunity to do just that: the proposal's focus on equity promises to transform healthcare, while improving the health outcomes of MassHealth members.

In our work we strive to center equity and were pleased to see the multiple ways in which the waiver application also placed equity at the center. Building on the Commonwealth's historic commitment to extending coverage, this proposal creates continuous and extended care for MassHealth members, and describes a commitment to marginalized populations, including the homeless and incarcerated.

Another important statement within the waiver application includes the commitment to address challenges that exist between healthcare and good health, including health related social needs (HSRNs), community partnerships, and cross sector collaboration. We applaud MassHealth for maintaining and expanding its commitment to the Flexible Services Program, equipping providers with tools to address housing and nutrition needs, and to provide family-level nutrition support.

We commend MassHealth for including pediatric care as a core goal of this waiver application. Children and youth make up nearly 40% of MassHealth's membership and as such it is only appropriate that MassHealth's policies, programs, and financial investments support healthy development, from pre-natal through adulthood. The emphasis on team-based care—including clinical and non-clinical staff—will

dramatically improve a family's ability to access the care they need. Enlisting community health workers, family partners, and others in that care team will be essential to this, and we were pleased by their inclusion in the waiver application. As a grantmaking organization, we invest in children and their families because we know that early interventions have powerful benefits to a person's ability to be healthy, and to thrive throughout their lifetime.

Finally, we applaud MassHealth for prioritizing maternal health equity. We strongly support MassHealth's pending 1115 waiver amendment to extend postpartum coverage from 60 days to 12 months for all pregnant and postpartum members, regardless of immigration status. We were pleased to see additional maternal policies included, especially coverage for doulas and enhanced care coordination for high-risk pregnancies. Doula-led care has been identified as a promising model that improves maternal health outcomes: given the stark racial inequities in maternal health, this is an important step toward equity and justice.

We are grateful for MassHealth's hard work and commitment to creating an equity-minded system of healthcare. We offer our support for this waiver application and look forward to the implementation of the bold ideas within.

Sincerely,



Elizabeth Pauley

Associate Vice President, Education & Health

September 14, 2021

EOHHS Office of Medicaid
Attn: 1115 Demonstration Comments
One Ashburton Place, 11th Floor
Boston, MA 02108

Via email: 1115-Comments@mass.gov

To Whom It May Concern:

We reviewed the MassHealth Section 1115 Demonstration Extension Request announced on August 18, 2021 and commend the Commonwealth on its goal to make reforms and investments in behavioral health, specifically the expansion of diversionary behavioral health and substance use disorder services.

As an independent, not-for-profit organization, The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care. We accredit a variety of health care organizations, including behavioral health care and human services, hospitals, ambulatory health care, home based care, to name a few. Our Behavioral Health Care and Human Services Accreditation Program accredits the full spectrum of substance use and mental health service providers within the following settings named in the proposed 1115 waiver expansion: inpatient, outpatient and community-based diversionary services, including (but not limited to) crisis stabilization, intensive day and outpatient treatment, assertive community treatment and community support services.

We respectfully request the consideration of behavioral health care and human services accreditation by the Joint Commission as a prerequisite for providers wishing to participate in the demonstration. This eligibility requirement would prove beneficial when incurring an influx of providers as the demonstration aligns itself with the *Roadmap for Behavioral Health Reform*. As the waiver extension proposal discusses, “with investments totaling over \$200 million per year over the next several years, the Commonwealth will significantly strengthen the delivery of outpatient, urgent, and crisis treatment.”

Founded in 1951, The Joint Commission evaluates and accredits more than 22,500 health care organizations and programs in the United States. Joint Commission accreditation is considered a “seal of approval” that tells regulators, consumers and other stakeholders that a program is committed to providing access to quality services by continually striving to improve services, assess delivery of services, and achieve excellence through education and training. The Joint Commission provides



a comprehensive evaluation of an organization's compliance with state-of-the-art standards. These standards, that are performance focused and organized around functions, are developed by experts in the field. In addition, all accredited behavioral health care and human services organizations are required to utilize measurement-based-care to improve the outcomes achieved by the individuals and population they serve. To earn and maintain The Joint Commission's accreditation award, an organization undergoes an on-site survey by a Joint Commission survey team at least every three years.

Again, we respectfully request the inclusion of behavioral health care and human services accreditation by the Joint Commission as a prerequisite for providers wishing to participate in the demonstration. At your request, we will make ourselves available to speak with you and your colleagues to provide a better understanding of the Joint Commission's standards and survey process. In the meantime, please contact me, mgandhi@jointcommission.org, 630-792-5305, or my colleague, Mary Wei, Senior Associate Director, State Relations, at mwei@jointcommission.org or 630-792-5269 with any questions you may have. We look forward to hearing from you.

Best regards,

Megha Gandhi

Megha Gandhi, MPH
State Relations Manager
The Joint Commission

Cc: Julia Finken, Executive Director, Behavioral Health Care & Human Services
Mary Wei, Senior Associate Director, State Relations



September 20, 2021

Submitted via: 1115-Comments@mass.gov

Mr. Aditya Mahalingham-Dhingra, Chief, Office of Payment and Care Delivery Innovation
EOHHS Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108.

Re: Comment on MassHealth 1115 Demonstration Waiver Extension Proposal

Dear Chief Mahlaingham-Dhingra:

Thank you for the opportunity to provide input and comment on the State of Massachusetts' 1115 Demonstration Waiver Extension proposal.

Founded in 2013, Unite Us is a technology company that provides an end-to-end solution to connect health and social care. We leverage human capital and health information technology to develop, maintain, and support coordinated care networks in communities across the United States. Our goal is to ensure every individual, no matter who they are or where they live, can access the critical services they need to live healthy and productive lives.

Through our products and community-centered approach, Unite Us seeks to increase equitable access to health and social services, address the fragmentation of services that makes our health and social systems challenging to navigate, and confront institutionalized barriers to equity such as poverty, racism, and discrimination. Our diverse range of stakeholders include community based organizations, health plans, health systems, hospitals, and government entities.

Unite Us has successfully built and scaled coordinated care networks in 42 states across the country, with numerous state and local government partnerships such as with North Carolina's Department of Health and Human Services, Virginia's Department of Health, Governor Sununu's Office in New Hampshire, Rhode Island's Executive Office of Health and Human Services, Louisiana's Department of Children and Family Services and others.

Our network in Massachusetts, Unite Massachusetts, has been developed in partnership with Brighton Marine and My Care Family, the Merrimack Valley Accountable Care Organization. The network is supported by a Massachusetts-based Unite Us team focused on community engagement, network health and optimization, and customer success. Originally a military-focused network, known as Greater Boston Coordinated Veteran Services, Unite Massachusetts expanded in 2021 to serve any and all Massachusetts residents in need. To support the expansion, Unite Massachusetts broadened its reach, now incorporating partners from Essex, Middlesex, Suffolk, and Norfolk counties.

Support for 1115 Waiver Extension Proposal

Unite Us commends the Massachusetts Executive Office of Health and Human Services (EOHHS) for developing the MassHealth Section 1115 Demonstration extension proposal (“Proposal”). As a company whose mission is to serve our communities by helping them address our social determinants of health (SDOH), Unite Us broadly supports MassHealth’s mission to expand Medicaid eligibility, offer new services, and utilize innovative service delivery systems through this Proposal. We share the same goals to improve the quality of care and health outcomes, increase efficiency, and reduce costs to the system. Through this Proposal, MassHealth will have the opportunity to elevate the value of community-based social care, better address SDOH, and advance health equity. Unite Us broadly supports the Proposal and encourages continued efforts in Massachusetts and nationally to incentivize, require and pay for social care.

Unite Us strongly supports the intense focus on addressing long standing health disparities and inequities impacting specific segments of the Medicaid population in Massachusetts, like minority maternal health and healthcare for justice-involved individuals. It is only through a program-wide lens of equity that MassHealth will reach an understanding of, and solve for, SDOH impacts on vulnerable populations. For example, Unite Us appreciates that MassHealth proposes to augment interventions in primary care to reduce barriers to care for expectant and new mothers and birthing parents, change care coordination policy to prioritize supports offered to traditionally underserved and under-resourced populations, and increase involvement from community-based organizations with unique cultural and linguistic competencies.

Unite Us also strongly supports the Proposal’s health equity payments program, which is designed to strengthen the commitment to addressing structural racism and reducing health disparities. We cannot stress enough how important data, data collection, and data research and evaluation will be to the health equity payments program. Despite industry-wide recognition of the importance of collecting comprehensive data at the community level, incomplete datasets continue to be a challenge and negatively impact analysis and inferences. Unite Us believes that accurate high quality information that can be disaggregated by specific categories is essential to tracking disparities and underlying social determinants as well as guiding the design and application of culturally-specific approaches.

Unite Us supports the successful Community Partners (CP) program initiative under the current DSRIP allocation, which funds care coordination activities sponsored by Long Term Services and Supports (LTSS) and Behavioral Health (BH) providers. Therefore, we are encouraged by MassHealth’s decision to continue the CP program by shifting the management of the program from the state to the Accountable Care Organizations (ACOs) structure and suggestions for future innovations. More specifically, Unite Us supports the Proposal’s plan to tier care coordination services and to mandate care coordination services manage transitions to social services providers.

Care Coordination and Health Equity

The Proposal attempts to sustainably fund care coordination activities undertaken by ACOs and CPs by providing non-medical administrative funding at actuarially-sound levels. The Proposal would also require ACOs to make downstream payments for care coordination to CPs. In

addition, this new funding model would be supported by streamlining care coordination policy; the Proposal suggests a three-tiered approach to cover different population segments (baseline, enhanced, and specialized). Within the baseline and enhanced care coordination tiers, MassHealth proposes to further standardize care coordination policy by setting requirements for target populations, minimum required elements (screenings and referrals), and formation of a common framework for quality and outcome monitoring. Unite Us is supportive of this portion of the Proposal and MassHealth's recognition that comprehensive whole-person care requires broadening the traditional model of care coordination to include addressing the social needs of individuals.

Building off the investments made in care coordination and health-related social needs in the current demonstration, the Proposal also aims to further enhance and streamline care coordination activities in primary care settings. According to the Proposal, all primary care practices will also be expected to screen and provide referrals for adult and pediatric oral health services, behavioral health, and health-related social needs. Through our experiences building and maintaining coordinated care networks, Unite Us believes that it is invaluable to require such clinical and social care linkages. Furthermore, we believe that through the use of a closed-loop referral system, such as the one that powers our networks, Medicaid programs can realize additional cost savings, advance health equity, and improve outcomes for all.

As an example, Carrot Health, which is a SDOH data and analytics subsidiary of Unite Us, has developed a proprietary tool called the Social Risk Grouper (SRG) which classifies and organizes SDOH to help the healthcare industry understand, identify, measure, and quantify the social barriers and circumstances in which people live. The SRG is a composite score driven by four components: behavioral, social, economic, and environmental. The SRG Score, applied to every adult in the U.S., has a range of 0 to 99, with 0 being the lowest social and economic risk and 99 being the highest. Within the four components are 11 Social Risk categories, including loneliness, housing instability, health literacy, food insecurity, financial insecurity, discord at home, unemployed, uninsured, low socioeconomic status, transportation needs, and unacculturation. Through external literature and Carrot Health's own data analysis, these 11 categories show a demonstrable impact on health outcomes.

Across the country, when we control for age, gender, and other confounding attributes, we observe that a 10-point increase in SRG equates to a 9% increase in total cost of care. Underlying social and economic challenges manifest in accelerated disease progression, inappropriate use of the healthcare system (specifically emergency department and hospital services), and higher rates of adverse health events. Addressing those social and economic challenges would have a profound effect on the Medicaid program and help the state realize additional savings to be put back into the system in the form of additional program benefits.

Finally, Unite Us is strongly supportive of the Proposal's initiative to provide health equity incentive payments to ACOs, ACO-participating acute-care hospitals, and public hospitals. Unite Us deeply appreciates this data-driven approach. Using complete and accurate data to benchmark and reward progress toward closing care gaps is at the heart of everything we do.

Approach to Care Coordination, Referral Tracking, and Data-Collection

To achieve its stated goals related to health equity, Unite Us recommends that MassHealth consider adopting a scalable technology solution that would enable collaboration and care coordination across health and human service sectors by supporting the ability to: (a) send and receive electronic referral, (b) seamlessly communicate in real-time, (c) securely share client information, (d) view and analyze aggregated and disaggregated community-level and individual-level SDOH-related data, (e) track social intervention outcomes by category of service and demographic groups, and (f) invoice for social care -- a solution that would not only support individual ACOs but that could also work at scale and help facilitate a statewide implementation.

Our coordinated care networks demonstrate that a robust, collaborative, and holistic state-wide approach to identifying and addressing unmet social needs not only improves individual health and quality of life, but also improves community health, reduces healthcare costs, and promotes health equity. For example, our technology solution powers a public-private partnership in the Bronx, NY through Public Health Solutions focused on addressing food insecurity; program participants screen for SDOH-related barriers, coordinate services, including deliver food aid and enrollment in SNAP/WIC enrollment, and track outcomes and analyze data. Over a ten month period spanning portions of 2018-2019, the program supported 871 families. 86% of referrals made through the program closed with a documented outcome and 57% of those referrals resulted in enrollment in SNAP or WIC. In addition, participants were mostly on Medicare or Medicaid (76% of participants) and required more than one referral-type (56% of participants required enrollment in FNS and referral to an emergency food pantry). Program evaluators estimated healthcare related savings at around \$1.1 million on an initial investment of \$705,000. (*The Food and Nutrition Services Bundle: Findings from a Pilot Project*. Hennessey, et al. Nov 2019. Public Health Solutions)

Furthermore, through the procurement of a single platform, the state can ensure that care coordination and health equity program requirements, operations, and data are standardized and returned to the state for the purposes of assessing quality, value, and progress.

The Unite Us Platform currently serves as foundational, multi-sector, community-embedded infrastructure in 42 states. The web-based technology platform not only allows previously siloed partners to collaborate and coordinate care, but also provides communities with the ability to:

- **Identify needs**, through our dynamic data-powered toolkit that proactively identifies individuals social care needs;
- **Enroll in services**, through referral tracking and completion, accountable care coordination, social needs screenings, and self-referral assistance request fulfillment;
- **Serve the individual**, through our community-wide and web-based platform that connects health, human and social service providers on a single network;
- **Measure network impact**, with real-time social care data analytics that empower local decision makers with key insights; and
- **Invest in social care**, through a comprehensive solution that enables social care funding and payment for specific interventions at scale.

Unite Us's platform is flexible and can be utilized by providers, plans, administrative organizations, health information exchanges, and government. Our suite of interfaces and

integration tools connect health and social care applications and empower communities with more seamless connectivity across platforms, leading to deeper connections and integrated referral workflows with community and social care providers. For instance, Unite Us' Interoperability team partners with EHR providers like Epic on advancing a vision for robust standards-based exchange for deeper workflow integration for whole-person care teams and creation of comprehensive health and social history for clients.

Additionally, Unite Us' use of a Master Person Index (MPI) enables identity resolution across multiple domains and systems to ensure that the person in question is the same patient, client, or member in different settings. MPIs support the creation of a single and complete record of care, minimizing the need for a client to retell their story and facilitating more seamless and comprehensive care management.

In the health and social sector, local organizations have traditionally been tied to time-limited grant funding and often operate at a deficit, impacting both the service and resource quality, as well as breeding workforce burnout. To facilitate sustainable improvements in our system of health and social services, Unite Us has developed a Payments product specifically to enable funding entities to pay for social care at scale, providing needed resources for organizational and workforce capacity building, and elevating the importance and value of community-based care. Tools like these, which track and invoice social care services for reimbursement, allow states to optimize Medicaid waiver services that address the social determinants of health and even offer the ability to braid multiple funding streams to deliver integrated and coordinated care.

Unite Us also has extensive experience with the targeted populations the Proposal highlights, expectant and new mothers, children and families, and patients struggling with substance use disorder. We work with community-based organizations, health systems, and government partners to ensure these populations, particularly those at risk of poor health outcomes, have a chance at a safe and healthy life. To that end, we have found the below tenets to be particularly important when caring for these populations:

- **Increase access to high-quality, clinical care** for mothers and their children, through credible social service partners in the community.
- **Address the social determinants of health** before health concerns arise, by linking pregnant women and mothers of young children to food, transportation, employment, and other social service providers.
- **Maintaining client dignity and privacy** by utilizing protected viewing permissions that ensure 42 CFR Part 2 compliance and that only those providing substance use services to the client can see the details of their care history.
- **Advance whole person care** by hosting a diverse range of organizations and programs that meet clients where they are. Programs and providers may include harm reduction agencies, outpatient clinics, inpatient treatment programs, needle exchange programs, overdose prevention classes, telehealth programs and group support.
- **Leverage evidence-informed interventions** such as home visitation programs, breastfeeding support by lactation consultants, smoking cessation programming, prenatal care providers, and more.

- **Developing individualized treatment plans** that reflect a client’s personal journey and incorporate clinical care and wraparound services such as vocational training, housing, counseling, and education.
- **Empower novel interventions** that address the unique needs of BIPOC mothers and babies and inform new evidence-based practices.
- **Collaborate with public health departments** to support place-based advocacy and programming for more equitable access to care for underserved populations.
- **Share data** that may reveal insights around community-level inequities and lay the groundwork for the reallocation of investments.

Conclusion

Unite Us broadly supports the Proposal put forth by MassHealth. It will allow MassHealth to implement innovative health equity initiatives and improve health outcomes for all beneficiaries. It also will underpin transformative proposals that further a whole-person approach to care delivery, specifically for marginalized and at-risk populations, including justice-involved and expectant and new mothers. Unite Us also especially appreciates the emphasis the Proposal places on addressing unmet social needs as the country recovers from the pandemic.

Unite Us urges MassHealth to consider the benefit of adopting a scalable technology solution that would enable collaboration and care coordination across health and human service sectors. A single statewide solution would provide MassHealth with enhanced capabilities, including standardization in identifying unmet social needs, addressing these needs with linkages to community services via secure technology platforms, capturing and leveraging community-level data for effective policy-making, and driving system transformation through payment flexibility for social care.

Thank you for the opportunity to submit comments, and for your continued leadership and support to provide more holistic and equitable care in Massachusetts. If you have any questions or if there is any additional information Unite Us can provide, please do not hesitate to contact me at eric.beane@uniteus.com.

Sincerely,

/s/ Eric J. Beane

Eric J. Beane
Vice President, Government and Regulatory Affairs
Unite Us
eric.beane@uniteus.com



September 20, 2021

Submitted via: 1115-Comments@mass.gov

Marylou Sudders, Secretary
Massachusetts Executive Office of Health and Human Services (EOHHS)
Office of Medicaid,
Attn: 1115 Demonstration Comments,
One Ashburton Place, 11th Floor,
Boston, MA 02108

Re: MassHealth Section 1115 Demonstration Extension Request

Dear Secretary Sudders;

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 request to extend the 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 ultimately curing HIV and AIDS. ViiV specializes in the development of therapies for HIV infection and is devoted exclusively on advancing science into HIV treatment, prevention and care. From its inception, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. ViiV is proud of the scientific advances in the treatment and prevention of this disease. These advances have helped to transform HIV from a terminal illness to a manageable chronic condition. In collaboration with the HIV community, ViiV remains committed to developing meaningful HIV treatment and prevention advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care, prevention, and treatment.

ViiV is proud to be part of the solution to the nation's success in reducing the number of new HIV cases and increasing viral suppression rates,^{2, 3} yet unfortunately, health care disparities remain a significant obstacle in providing accessible and high-quality care for people with HIV. Nationally, the rate of black men living with HIV is 5.6 higher than their white counterparts and 17.4 times higher for

¹ "MassHealth Section 1115 Demonstration Extension Request," Commonwealth Of Massachusetts Executive Office Of Health And Human Services, Office Of Medicaid, Section 1115 Demonstration Project Extension Request, Posted on August 18, 2021 <https://www.mass.gov/doc/1115-demonstration-extension-request/download> (Accessed September 14, 2021)

² AIDS Vu: United States <https://aidsvu.org/local-data/united-states/> Accessed July 27, 2021

³ AHEAD: Ending the HIV Dashboard. Viral Suppression [Data | AHEAD \(hiv.gov\)](https://www.aheadhiv.org/data/) Accessed July 29, 2021.

black women as compared to white women.⁴ Hispanic and Latino / Latina men and women also experience higher rates than their white counterparts who are living with HIV.⁵ In addition, over ten-percent of people with HIV also face obstacles related to social determinates of health, including poverty, housing, and food insecurities.⁶

The Medicaid Program Should Join DHHS Efforts to End the HIV Epidemic

An estimated 1.2 million people in the United States are living with HIV and at least thirteen percent are unaware that they have the virus.⁷ Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of diagnosed and undiagnosed people with HIV are retained in medical care, according to the Center for Disease Control and Prevention (CDC).⁸

Since the earliest days of the epidemic, Medicaid has played a critical role in HIV care. Nationally, Medicaid is the largest source of coverage for people with HIV.⁹ In fact, more than 42 percent of people with HIV who are engaged in medical care have incomes at or below the federal poverty level.¹⁰ The program is an essential source of access to medical care and antiretroviral therapy (ART) drug coverage for people with HIV. This medical care and drug treatment not only preserves the health and wellness of people with HIV and improves health outcomes, but it also prevents new HIV transmissions. Medicaid is also a significant provider of HIV prevention, specifically pre-exposure prophylaxis (PrEP).¹¹

In 2019, the U.S. Department of Health and Human Services (DHHS) released the “Ending the HIV Epidemic: A Plan for America (EHE).”¹² This plan proposes to use scientific advances in antiretroviral therapy to treat people with HIV and expand proven models of effective HIV care and prevention.¹³ The plan coordinates efforts across government agencies to stop the HIV epidemic and focuses its efforts on local areas. The EHE Initiative is not only a landmark policy by all federal health agencies, it is also supported by the HIV community and the President’s Advisory Council on HIV/AIDS (PACHA).¹⁴ Massachusetts has an important role to play in EHE efforts, as Suffolk County is one of the priority jurisdictions in the EHE plan.¹⁵

In order to promote the state and federal goal to end the HIV epidemic, it is imperative that state Medicaid programs participate in local and national efforts and promote policies that contribute to

⁴ AIDS Vu: United States <https://aidsvu.org/local-data/united-states/>. Accessed July 27, 2021

⁵ Id.

⁶ Id.

⁷ Centers for Disease Control and Prevention. Volume 26 Number 2 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC <https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-26-no-2/index.html> Published May 2021. (Accessed June 2, 2021)

⁸ Centers for Disease Control and Prevention. Volume 26 Number 2 | HIV Surveillance | Reports | Resource Library | HIV/AIDS | CDC <https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-26-no-2/index.html> Published May 2021. (Accessed June 2, 2021)

⁹ Kaiser Family Foundation. Medicaid and HIV, <http://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/>

¹⁰ Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection— Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition. June 2019. <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf> (Accessed September 14, 2021)

¹¹ Kaiser Family Foundation. Medicaid and HIV, <http://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/>

¹² HIV.gov “Ending the HIV Epidemic” <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview> (Accessed: April 20, 2021)

¹³ Id.

¹⁴ Presidential Advisory Council on AIDS (PACHA) Resolution in Support of “Ending the HIV Epidemic: A Plan for America” <https://files.hiv.gov/s3fs-public/PACHA-End-HIV-Elimination-Resolution-passed.pdf> (Accessed September 14, 2021)

¹⁵ HIV.gov “Ending the HIV Epidemic” <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview> (Accessed: April 20, 2021)

HIV public health goals. We therefore encourage the EOHHS and State of Massachusetts to work to advance the goals of the EHE goals into the MassHealth program. Therefore, in providing our comments, ViiV wishes to bring to the state's attention some opportunities for the MassHealth waiver renewal to align with the goals of the nation's public health effort to end the HIV epidemic, as well as to continue to advance the care, treatment, and prevention needs of their enrollees with HIV and those at risk for acquiring HIV.

1. Open Access to Antiretrovirals

In order to promote the goals of the EHE plan, it is imperative that state Medicaid programs promote policies that contribute to HIV public health goals, such as preserving continuous access to comprehensive health care, including antiretroviral therapy (ART). We note that MassHealth has proposed implementing a fully unified pharmacy formulary across its fee-for-service and managed care programs¹⁶ in order to improve continuity of care between health plans. For the HIV population, this may include the state's HIV Drug Assistance (HDAP) program (i.e. ADAP). ViiV Healthcare urges MassHealth to develop an open formulary for ART treatment in all state managed care and fee for service plans so that an appropriate treatment decision can be made between a patient and their healthcare provider without being subjected to a health plan's formulary or prior authorization process for non-preferred agents.

Treatment of HIV is a dynamic area of scientific discovery, and treatment protocols are changed and updated to reflect advances in medical science. In clinical settings, health care providers work closely with patients to select HIV treatment options with great specificity for each patient. Effective treatment of HIV is highly individualized and accounts for a patient's size, gender, treatment history, viral resistance, coexisting illnesses, drug interactions, immune status, and side effects. In fact, the DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV (DHHS Guidelines)¹⁷ state that, "Regimens should be tailored for the individual patient to enhance adherence and support long-term treatment success."

One of the values offered in HIV care is that effective treatment of HIV not only improves health outcomes of people with HIV, but also can prevent transmission of HIV to others. Reduced transmissions not only improve public health, but also save money. Preventing new transmissions offers a substantial fiscal benefit to the state. In studies sponsored by the NIH, investigators have shown that when treating the HIV-positive partner with antiretroviral therapy,¹⁸ there were no linked infections observed when the infected partner's HIV viral load was below the limit of detection. It is estimated 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.¹⁹ A recent study of commercially insured people with HIV compared to individuals without HIV found that mean all-cause costs were almost seven times higher in those with HIV, culminating in an average discounted incremental cost of \$850,557 in

¹⁶ Mass.gov, 1115 MassHealth Demonstration ("Waiver") Extension Request, page 6, <https://www.mass.gov/info-details/1115-masshealth-demonstration-waiver-extension-request>, (Accessed September 14, 2021)

¹⁷ DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines> (Accessed September 14, 2021)

¹⁸ Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. *The Lancet* 2019; 393(10189):2428-2438. Available at: [https://doi.org/10.1016/S0140-6736\(19\)30418-0](https://doi.org/10.1016/S0140-6736(19)30418-0) (Accessed September 14, 2021)

¹⁹ Skarbinski, 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.

cumulative costs from ages 25-69.²⁰ Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to \$4.5 million by preventing further transmission to others. These savings can only occur if people with HIV have access to medical care, receive treatment, and remain adherent to their prescribed therapy.

ViiV also encourages EOHHS to promote awareness of this separate but dual benefit of HIV “treatment as prevention” (TasP)²¹ to its accountable care organizations (ACOs), managed care organizations (MCOs), health care providers, and service organizations. The fact that achieving and maintaining viral suppression for people with HIV can also prevent new infections is an important point of understanding for those in public health and health care. EOHHS should also consider requirements for the MCOs and ACOs to cover new FDA-approved therapies for people with HIV. These treatments represent new options that could greatly benefit some patients, such as those who have multi-drug resistance to currently available ARVs, and the first ever long-acting HIV treatment.²² It is vital that the state ensure patients who could benefit from these options have access to them.

2. Social Determinants of Health (SDOH)

ViiV appreciates EOHHS’s goals to address certain “health-related social needs” within the MassHealth population through the Flexible Services Program.²³ The social determinants of health (SDOH) play a huge role in effective care and treatment for people with HIV and are an important part of the EHE. People with HIV often face a variety of medical challenges that impede access to, engagement in, and adherence to HIV care and treatment. In 2020, the DHHS released The HIV National Strategic Plan (HIV Plan),²⁴ which includes a focus on the role of SDOH, health disparities, and inequities in ending the HIV epidemic. The HIV Plan notes that SDOH can represent a significant barrier to health care access, and states that: “Inequities in the social determinants of health are significant contributors to health disparities and highlight the need to focus not only on HIV prevention and care efforts, but also on how programs, practices, and policies affect communities of color and other populations that experience HIV disparities.”²⁵ ViiV offers the following recommendations on these issues:

a) Model SDOH on the Proven Interventions of the Ryan White Program

As a best practice example in addressing the SDOH that states can look to, ViiV urges policymakers to review and model elements of the Ryan White HIV/AIDS Program (RWHAP) that have proven to be effective in supporting optimal patient care and driving treatment success in HIV. The success of specific RWHAP interventions could help to inform the state’s goals for

²⁰ Cohen JP, et al. Estimation of the Incremental Cumulative Cost of HIV Compared with a Non-HIV Population. *PharmacoEconomics - Open* (2020) 4:687–696. <https://doi.org/10.1007/s41669-020-00209-8>. (Accessed September 14, 2021)

²¹ HIV.gov, “For HIV, Treatment is Prevention,” <https://www.hiv.gov/blog/hiv-treatment-prevention>. (Accessed September 14, 2021)

²² HIV.gov “Long-Acting HIV Prevention Tools” <https://www.hiv.gov/hiv-basics/hiv-prevention/potential-future-options/long-acting-prep>. Accessed on August 12, 2021

²³ “MassHealth Section 1115 Demonstration Extension Request,” Commonwealth Of Massachusetts Executive Office Of Health And Human Services, Office Of Medicaid, Section 1115 Demonstration Project Extension Request, Posted on August 18, 2021 <https://www.mass.gov/doc/1115-demonstration-extension-request/download> (Accessed September 14, 2021)

²⁴ National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 <https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf> Accessed on August 12, 2021

²⁵ Id.

SDOH efforts and help to refine requirements for the managed care plans, and the program's data could also provide a basis for measuring outcomes of these interventions.

The RWHAP over the last 30 years has developed a model of successfully addressing the complex needs of HIV/AIDS patients and producing unparalleled success in health and medical care among this population.²⁶ The RWHAP provides services that demonstrated success in supporting the health and well-being of patients. These services offer best practice examples for how interventions focused on the social determinants of health can contribute to medical success. The RWHAP provides medical support services such as medical case management, medical transportation, and medical nutrition services, as well as oral health and dental care.²⁷ The program also offers individual support services including food services, meal delivery, housing, transportation, legal services, linguistic services, case management, childcare, psychosocial and mental health services, rehabilitation and respite care, and substance abuse services. As a result of the program's services, in 2018, 87.1 percent of Ryan White HIV/AIDS Program clients were reported to be virally suppressed compared to the national average of 65.5 percent amongst those diagnosed with HIV.²⁸

b) Housing

The Housing Opportunities for Persons with AIDS (HOPWA) program can also offer an example of how addressing the SDOH can have a significant impact on health care improvement in a population with a complex condition. The HOPWA program was created in 1992 to address the housing needs of people with HIV.

The HIV Plan notes that housing instability or homelessness represents a significant barrier to health care access, and that people with HIV experiencing unstable housing or homelessness have lower rates of viral suppression, and therefore require services to support engagement in care and viral suppression.²⁹

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, inadequately housed compared to "housed" people with HIV, and 93 percent found worse rates of adherence to antiretroviral treatment among those who were homeless or unstably housed.³⁰ 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.³¹

²⁶ HRSA.gov, HRSA HIV/AIDS Bureau, "About the Ryan White HIV/AIDS Program," <https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/about-ryan-white-hiv-aids-program> Accessed July 6, 2021.

²⁷ HRSA.gov, "Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds Policy Clarification Notice (PCN) #16-02, Replaces Policy #10-02" https://hab.hrsa.gov/sites/default/files/hab/Global/service_category_pcn_16-02_final.pdf Accessed on August 12, 2021

²⁸ United States and 6 dependent areas, 2019. *HIV Surveillance Supplemental Report 2021*;26(No.2). Published May 2021. Page 20, <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Accessed on August 12, 2021

²⁹ National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 <https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf> Accessed on August 12, 2021

³⁰ The National Center for Innovations in HIV Care, "Housing as a Determinant of HIV Health Outcomes: Results from a Systematic Review of Research 1996-2014 & Implications for Policy and Program," <https://targethiv.org/sites/default/files/supporting-files/Housing%20and%20HIV%20Health%20Outcomes%20Final.pdf> Accessed on August 12, 2021

³¹ Id.

Additionally, among homeless people with AIDS who received supportive housing, there was an 80 percent reduction in mortality.³² 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 AIDS Housing Coalition, “It is clear that housing improves health outcomes of those living with HIV disease and reduces the number of new HIV infections. The end of HIV/AIDS critically depends on an end to poverty, stigma, housing instability, and homelessness.”³³ Therefore, ViiV urges EOHHS to work with Massachusetts Ryan White program officials and with HOPWA to learn from the data the program has collected on effective interventions, and to seek best practices in addressing SDOH challenges for Medicaid populations.

3. Reducing Health Disparities

ViiV appreciates Medicaid’s effort 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 identity³⁴ and commends the agency’s efforts to improve continuity of care by proposing to provide MassHealth Services to Justice-Involved Individuals.³⁵ HIV sero-prevalence among incarcerated individuals is 1.5%, approximately three times greater than among the general U.S. population. People living with HIV/AIDS are disproportionately involved in the criminal justice system and often have complex medical, mental health, and substance abuse needs³⁶

Health disparities by race and ethnicity are particularly sobering for people with HIV. For example, in Massachusetts, the prevalence of Black males living with an HIV diagnosis is over 5 times higher than White males and nearly 23 times more likely for black women compared to white women. Disparities among Hispanic and Latino men and Latina women are also considerably higher than their white counterparts.³⁷ Therefore, ViiV urges policymakers to collaborate with people with HIV and HIV stakeholders to develop strategies that identify, address and combat disparities and inequities of care for people with HIV in state programs, as well as for populations that are at high risk for HIV.

4. PrEP

ViiV supports coverage of pre-exposure prophylaxis (PrEP) to all at-risk populations. Unfortunately, PrEP is an underutilized biomedical tool to reduce the incidence of new HIV cases. According to DHHS, of the approximately 1.2 million people in the U.S. indicated for PrEP, only 18 percent are

³² The National AIDS Housing Coalition <http://nationalaidshousing.org/housing-and-health/> Accessed on August 12, 2021

³³ The National AIDS Housing Coalition <http://nationalaidshousing.org/> Accessed on August 12, 2021

³⁴ “MassHealth Section 1115 Demonstration Extension Request,” page 5, Commonwealth Of Massachusetts Executive Office Of Health And Human Services, Office Of Medicaid, Section 1115 Demonstration Project Extension Request, Posted on August 18, 2021 <https://www.mass.gov/doc/1115-demonstration-extension-request/download> (Accessed September 14, 2021)

³⁵ “MassHealth Section 1115 Demonstration Extension Request,” P. 59, Commonwealth Of Massachusetts Executive Office Of Health And Human Services, Office Of Medicaid, Section 1115 Demonstration Project Extension Request, Posted on August 18, 2021 <https://www.mass.gov/doc/1115-demonstration-extension-request/download> (Accessed September 14, 2021)

³⁶ HIV among persons incarcerated in the USA: a review of evolving concepts in testing, treatment, and linkage to community care. Westergard et al. https://www.medicine.wisc.edu/sites/default/files/HIV_among_incarcerated_persons_Westergard.pdf Accessed on August 12, 2021

³⁷ AIDS Vu, Local Data: Massachusetts, <https://aidsvu.org/local-data/united-states/northeast/massachusetts/> (Accessed September 14, 2021)

receiving it.³⁸ Data also shows a significant lack of PrEP uptake among women. According to the CDC, only 7 percent of women in the U.S. who could benefit from PrEP were prescribed PrEP in 2018.³⁹

In 2018 Massachusetts, 8,812 individuals used PrEP in the state, but 93.8 percent of those were male, and only 6.1 percent were female.⁴⁰ This is a missed opportunity as females accounted for 28.5% of the new HIV infections in Massachusetts.⁴¹ In total, the state's PrEP coverage ratio was only 33.4 percent.⁴²

When taken properly, PrEP can reduce the risk of acquiring HIV from sex by 99 percent and reduces risk by 74 percent among those who inject drugs.⁴³ PrEP also has the potential to address HIV specific disparities and, possibly, other disparities in health care. For instance, studies have shown a correlation between increased PrEP uptake and decreases in new HIV diagnoses in the U.S., and PrEP use is also associated with increased engagement in ongoing health care.⁴⁴

In 2019, the USPSTF assigned a "Grade A" rating to PrEP as an intervention.⁴⁵ Under the Affordable Care Act (ACA), preventative services with a USPSTF Grade A or B recommendation must be covered without cost-sharing in the Medicaid expansion markets.⁴⁶ In addition, the Departments of Labor, Treasury and Health and Human Services recently issued guidance to clarify that PrEP and related costs must be covered by insurers without cost-sharing.⁴⁷

ViiV encourages Massachusetts to align with EHE prevention goals by encouraging PrEP coverage by all payers and promoting PrEP utilization by at-risk populations. We also encourage the state to consider how MassHealth will incorporate innovative HIV treatments and preventive therapies in the future, especially those that are administered by physicians or other health care professionals.⁴⁸

5. Improving Health Quality

On pages 85-86 of the demonstration waiver,⁴⁹ MassHealth outlines a quality performance slate for each Managed Care Program consisting of select HEDIS Measures: <https://www.mass.gov/info->

³⁸ National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025, page 1, <https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf>, (Accessed August 27, 2021)

³⁹ CDC.gov, "HIV and Women: PrEP Coverage" <https://www.cdc.gov/hiv/group/gender/women/prep-coverage.html> (accessed September 9, 2021).

⁴⁰ AIDS Vu, Local Data: Massachusetts, <https://aidsvu.org/local-data/united-states/northeast/massachusetts/> (Accessed September 14, 2021)

⁴¹ AIDS Vu, Local Data: Massachusetts, <https://aidsvu.org/local-data/united-states/northeast/massachusetts/> (Accessed September 14, 2021)

⁴² CDC.gov, "Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 Dependent Areas", (Table 6b) , 2018, <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-25-2.pdf>, (Accessed August 27, 2021)

⁴³ "HIV Risk and Prevention: PrEP (Pre-Exposure Prophylaxis)," <https://www.cdc.gov/hiv/risk/prep/index.html>. (Accessed July 27, 2021)

⁴⁴ National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025, page 19-20, <https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf>, (Accessed August 27, 2021)

⁴⁵ US Preventive Services Task Force, "Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis" June 2019. <https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis>. (Accessed on August 12, 2021)

⁴⁶ "PACHA Highlights Need to Address HIV PrEP Coverage Disparities," April 7, 2021, <https://avalere.com/insights/pacha-highlights-need-to-address-hiv-prep-coverage-disparities>, (Accessed on August 12, 2021)

⁴⁷ Department of Labor, DOL.gov, "FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 47," <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-47.pdf> (Accessed July 28, 2021)

⁴⁸ HIV.gov "Long-Acting HIV Prevention Tools" <https://www.hiv.gov/hiv-basics/hiv-prevention/potential-future-options/long-acting-prep> (Accessed on August 12, 2021)

⁴⁹ "MassHealth Section 1115 Demonstration Extension Request," Commonwealth Of Massachusetts

[details/masshealth-quality-reports-and-resources](#). ViiV encourages MassHealth to promote reporting on the HIV viral load suppression (VLS) and, to include this measure in the Managed Care Plan Quality Performance Annual Report. Reporting on VLS is an important way to incorporate EHE goals into Medicaid and also to drive improvements in state and federal alignment and beneficiary health outcomes, and is part of the Medicaid Adult Core Set.⁵⁰

The “HIV Viral Load Suppression (VLS)”⁵¹ HIV quality measure signifies that a patient has reached the goal of HIV treatment, which is viral suppression. When a patient becomes virally suppressed, it means that the virus has been reduced to an undetectable level in the body with standard tests.⁵² The National Institute of Allergy and Infectious Diseases (NIAID) recently supported research that demonstrated that achieving and maintaining a “durably undetectable” viral load not only preserves the health of people with HIV, but also prevents sexual transmission of the virus to an HIV-negative partner.⁵³ This builds a strong case for implementing a process and outcome HIV-focused, quality measures to encourage testing, linkage to care, and ongoing treatment so people with HIV can achieve viral suppression and ultimately improve their health outcomes.

Since Medicaid is the largest source of health care coverage for people with HIV, it is imperative for Medicaid programs to prioritize HIV care and viral load suppression by measuring and reporting VLS in order to align with the EHE strategies of rapid treatment and HIV transmission prevention.⁵⁴ Several state Medicaid programs have linked HIV quality measures to managed care performance, thus incentivizing achievement of viral suppression for their people with HIV. For example, the New York State’s Ending the Epidemic Plan recommends that HIV providers, facilities, and managed care plans report and monitor viral suppression rates and provide financial incentives for performance.⁵⁵ Consequently, New York State’s Department of Health requires Medicaid managed care organizations to report HIV-specific measures, including the VLS outcome measure, and awards financial incentives based on performance on these HIV measures.⁵⁶ New York’s managed care efforts have significantly improved viral suppression rates among Medicaid beneficiaries. By linking many people with HIV to care, managed care organizations report that more than 40 percent of their Medicaid beneficiaries who were identified as unsuppressed, have now achieved viral suppression.⁵⁷

Louisiana’s Medicaid managed care program, Bayou Health, has included the VLS outcome measure in its contracts with managed care plans. To further drive improvement, managed care organizations have incorporated resources from the Louisiana Office of Public Health’s (OPH)

Executive Office Of Health And Human Services, Office Of Medicaid, Section 1115 Demonstration Project Extension Request, Posted on August 18, 2021 <https://www.mass.gov/doc/1115-demonstration-extension-request/download> (Accessed September 14, 2021)

⁵⁰ Medicaid & CHIP Scorecard, Medicaid.gov, <https://www.medicare.gov/state-overviews/scorecard/index.html> (Accessed July 30, 2021)

⁵¹HIV/AIDS Bureau Performance Measures, “HIV Viral Load Suppression,” <https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/coremeasures.pdf> (Accessed May 15, 2020)

⁵² National Institutes of Health (NIH) “Ten things to Know about HIV Suppression” <https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv-suppression> Accessed on August 12, 2021

⁵³ NIAID, “HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention” National Institute of Allergy and Infectious Diseases <https://www.niaid.nih.gov/diseases-conditions/treatment-prevention>, Accessed on August 12, 2021

⁵⁴ Kaiser Family Foundation. (October 1, 2019). Medicaid and HIV. Retrieved from <https://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/>, (Accessed on August 12, 2021)

⁵⁵ New York State Department of Health. 2015 Blueprint. Retrieved from https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf. Accessed on August 12, 2021

⁵⁶ NASHP. December 2017. Prioritizing Care: Partnering with Providers and Managed Care Organizations to Improve Health Outcomes of People Living with HIV. Retrieved from <https://nashp.org/wp-content/uploads/2017/09/HIV-Affinity-Provider-MCO-Engagement-Brief.pdf>. Accessed on August 12, 2021

⁵⁷ New York State Department of Health. Ending the Epidemic Progress Report: March 2018. Retrieved from https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Executive_Summary_2018_.pdf.

STD/HIV Program into disease management programs after the state added measures to their contracts. The Medicaid managed care plans will continue to support the ambitious HIV care and treatment programs that have achieved 57 percent viral suppression among people with HIV in Louisiana.⁵⁸

Optimal outcomes for people with HIV can only occur if systems are measured and are able to benchmark their performance against the current standard of care in the HIV care continuum. The use of HIV-related quality measures will promote standards of health care coverage that support adherence to current HIV clinical and federal guidelines.⁵⁹ We strongly urge EOHHS to focus on the HIV VLS as a core measure in the Medicaid Adult set, therefore encouraging the state of EOHHS to report on this measure.

Conclusion

Thank you for your consideration of our comments. We hope that EOHHS and the state of Massachusetts will work together to further the goal of ending the HIV epidemic and use this initiative to advance these objectives. Please feel free to contact me at steve.f.novis@viivhealthcare.com with any questions.

Sincerely,



Stephen Novis
Director, Government Relations & Advocacy
ViiV Healthcare

⁵⁸ Louisiana HIV/AIDS Strategy 2017-2021, published by the Louisiana HIV Planning Group; August, 2016. Accessed at <https://www.louisianahealthhub.org/wp-content/uploads/2018/10/LouisianaHIVAIDSStrategy.pdf>. Accessed on August 12, 2021

⁵⁹ HIV Medicine Association. Tools for Monitoring HIV Care: HIV Clinical Quality Measures (Updated) February 2015. Available at: http://paetc.org/wp-content/uploads/2015/04/Tools_for_Monitoring_Issue_Brief_update-April-2015.pdf. Accessed April, 14, 2020.

I think that the MassHealth team did an extraordinary job with this 1115 Demonstration. They engaged a broad network of stakeholders and listened to all feedback. The proposal they have put together is comprehensive and impressive. This proposal appropriately focuses on replacing fee-for-service with value-based care. This proposal wisely rewards primary care transformation and increases resources for both primary care and behavioral health. This proposal begins to dismantle systemic racism that has historically been part of health care systems by re-allocating resources based on social determinants of health. The recent NASEM report recommends that primary care be considered a public good for all residents and this MassHealth proposal moves us many steps in that direction. For all these reasons, I wholeheartedly support this 1115 Demonstration.

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WellnessCampaign.org

Pronouns: He/Him/His