Public Comments to Proposed Section 1115 Demonstration Amendment Request

May 12, 2017 – June 12, 2017

Konefal, Kaela (EHS)

From: Susan Corcoran <susanc@nhs-healthlink.org>
Sent: Wednesday, May 31, 2017 12:09 PM
To: Konefal, Kaela (EHS)
Subject: Comments for Demonstration Amendment
Attachments: Corcoran, Susan.vcf

I am writing to voice my opposition of losing 90 day provisional eligibility for Masshealth.

Losing Provisional Eligibility is a giant step backwards for Masshealth.

As an Certified Application Assister, I often see those applying when they are in great need of services. Having a portal (HIX) to access instant decisions has been highly beneficial to patients and providers. A patient that is seen in the ER and we get on Masshealth right away, can go home and fill a prescription. No access for RX would result in the patient returning to the ER... Health Safety Net cannot sustain this kind of process again.

The Provisional Eligibility also alleviated the issues with Masshealth backlogs of verifications to process. There are less people to answer phones, process verifs or expedite as it is now. Adding another layer of paperwork directly effects patient access to care. Again, this is a giant step backwards.

Health Safety Net decreased income guidelines and short retroactive period places burden on patients and hospitals. 150% of the FPL is ridiculously low. Increased deductibles for Partial Health only means less access to care for patients that cannot pay it as well as increased medical debt.

Susan Corcoran
Supervisor,
Patient Access Services
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Konefal, Kaela (EHS)

From: Smith, Bailey A. <BaileyA_Smith@DFCI.HARVARD.EDU>
Sent: Thursday, June 01, 2017 9:38 AM
To: Konefal, Kaela (EHS)
Subject: Comments for Demonstration Amendment

Hi Kaela,

I am writing in regards to the proposal of taking away transportation from our Careplus members. This would be a huge letdown to many of our patients who come in for treatment. We rely heavily on transportation benefits from MassHealth as many of our patients are left without any transportation options to get to the hospital for their treatments. Please reconsider this proposal!

Best,
Bailey

Bailey Smith
Senior Resource Specialist
Resource Support for THOR, NEURO, GU, MEL/CUT
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Transportation Options-Short Term Accommodations-Community Resources-Financial Assistance Programs

Konefal, Kaela (EHS)

From: Margery Phillips <mphillips@communityaction.us>
Sent: Friday, June 02, 2017 11:55 AM
To: Konefal, Kaela (EHS)
Subject: Comments for Demonstration Amendment

To Whom It May Concenr,

As a WIC Family Support Coordinator whose job is to connect WIC participants to available resources and a senior citizen depending upon Mass Health for my Medicare supplemental insurance, and according to my understanding of the relevant amendments, I would like to share my perspective.

I feel confident as a resident of Massachusetts that the state is one of the few that truly acts on behalf of the health needs of its citizens. Massachusetts health care was the model for the ACA, as I understand this. Therefore, if the proposed changes/amendments to Mass Health *can stand up in the face of the current federal administration's greed- based health care proposal*, then I support it. I support any amendments that will improve not only health care access for residents of Massachusetts, but actual health care; as it has been pointed out, "access" doe not always indicate "affordable". Many people who will have the proposed access to health insurance will not be able to afford to actually buy that insurance. If Mass Health can continue to expand health care for state residents in need while amending particular aspects of the program to insure the program's longevity and affordability (for the state), then I support these amendments.

Thank you for the opportunity to comment, and I do hope my comments make sense!

Margie Phillips

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Margie Phillips
WIC Program Family Support Coordinator
Community Action of the Franklin, Hampshire and North Quabbin Regions
413-376-1185 (leave a message please)
mphillips@communityaction.us

Konefal, Kaela (EHS)

From: Margery Phillips <mphillips@communityaction.us>
Sent: Friday, June 02, 2017 12:18 PM
To: Konefal, Kaela (EHS)
Subject: Additional comments on Demonstration Amendments

I just submitted a comment on the proposed Demonstration Amendments. I would like to add a comment in light of information that I now understand differently.

Upon rereading the amendments, I believe that Mass Health will not be actually expanding access, but that certain aspects of the program will be contracting and becoming less available to certain populations. While I understand that measures must be taken to assure the program continues and is affordable, I do not support discontinuing non-emergency transportation. I live in a small town in a rural area, and transportation is a big problem. This amendment must be changed so that people on Mass Health without access to transportation will still be able to get to the hospital and/or a health care professional's office. Discontinuing transportation will be disastrous for many people, and even for non-emergency cases will deter people from seeking much needed health care, which, in fact, can lead to death or more serious illness.

I have worked in humans services in the Northampton- Greenfield area for over 25 years and have seen the impact lack of transportation can have. Additional, conditional amendments are necessary to insure that Mass Health consumers have the ability to physically access health care providers.

Furthermore, provisional eligibility for 90 days MUST be preserved for all people regardless of income verification, as this can be a life saving measure. We cannot discriminate based upon the proposed conditions, as many health conditions are not immediately obvious and need early detection in order to inhibit progression and avoid death. A ninety day provisional period gives people the opportunity to visit a health care professional and get diagnosed. This is vital!! We should not be able to decide who can get health care, even on a temporary basis, and who will be refused. Income verification can be difficult to obtain for many, especially for low income people who have not worked in a while or whose former employers are no longer available. Health care is a human right, not a privilege, and if we are not going to adopt a single payer, universal health care system, we must do the next-best thing.

We should look to countries such as Holland, Sweden and Denmark, where I spent 10 years of my life, as role models for health care. Every citizen and resident of those countries has available health care, and they either pay nothing or very, very little. Tax money is used in ways that support people, not corporations or the military. If we are not going to change our priorities, we need to adjust our programs so that they reach as many people as need the care.

Thank you.
Margie Phillips

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Margie Phillips
WIC Program Family Support Coordinator
Community Action of the Franklin, Hampshire and North Quabbin Regions

Konefal, Kaela (EHS)

From: Peter Kuusisto <Peter.Kuusisto@chcfc.org>
Sent: Tuesday, June 06, 2017 2:59 PM
To: Konefal, Kaela (EHS)
Subject: Client Has A Comment on Proposed Changes to MassHealth

Dear Kaela Konefal,

My client, Robert Elwell, residing at address 146 7th St, Apt 2, Turners Falls, MA 01376 has a statement he would like included in the comments on proposed changes to MassHealth Care Plus.

He says "I haven't always used PT1 rides, but now that I have, I am able to make my appointments. Otherwise, with my disability, I sometimes forget when the appointments are and would otherwise miss the appointments. I was missing appointments before because I was concerned about biking in bad weather. Now that I have been using PT1 rides, I have not missed any recent appointments."

He also mentioned he did not have a disability determination through Disability Evaluation Services due to his ability to work. He is not ready to give that up yet, even though it is getting difficult.

Living in Turners Falls, he needs a ride to Greenfield for specialist visits and his primary care. He is very concerned that losing these rides would mean he could not afford to make it to his appointments. He realizes this will decrease his health outcomes and he won't be able to schedule as many appointments with his doctors.

Thanks,

Peter

Peter J. Kuusisto, Navigator
Outreach and Enrollment Coordinator
Lead Navigator
SHINE Counselor
The Community Health Center of Franklin County
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Greenfield, MA 01301
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CHCFC
Community Health Center of Franklin County

Konefal, Kaela (EHS)

From: cindy kuusisto <cwkuusisto@yahoo.com>
Sent: Tuesday, June 06, 2017 3:03 PM
To: Konefal, Kaela (EHS)
Subject: Limiting transportation

Dear Ms. Konefal

I am writing in concern for the proposed canceling of transportation to people who are unable to work and drive while not yet approved for disability coverage. I know first hand how difficult it is to get transportation to medical appointments when one has a diagnosis such as epilepsy, seizures and dysautonomia. All of these diagnoses require an individual to stop driving for an indefinite period of time with no transportation options. My daughter in law, previously a very active speech pathologist doing in-home early intervention, now has a chronic illness (dysautonomia) that has left her unable to work or drive for 1 1/2 years.

Reducing transportation supports can even further isolate sick individuals and limit their access to their medical care. Please reconsider limiting this important state support.

Respectfully,

Cynthia W. Kuusisto,
MSW, LCSW
Medical Social Worker

Konefal, Kaela (EHS)

From: Deborah Field <dfield@duffyhealthcenter.org>
Sent: Tuesday, June 06, 2017 12:28 PM
To: Konefal, Kaela (EHS)
Subject: Comments for Demonstration Amendment

As a provider of mental health care to homeless patients on Cape Cod, I am responding to proposed changes in provisional 90 d mass health coverage for adult applicants who need to submit verifications. This will postpone lifesaving treatment for persons with opioid use disorders seeking buprenorphine therapy. We are in the midst of an opioid epidemic and we need to remove all barriers to care for young patients with addiction before we lose an entire generation. This proposed change will also negatively impact care for persons with severe mental illness who would not otherwise be able to access affordable care for psychotic illness, depression, etc. including person recently discharged from hospital for suicidal ideation, new onset schizophrenia, postpartum psychosis, etc. If we cannot support 90 day period to obtain verifications, then how about 60 day?
Transportation services are essential to providing care to indigent populations living in rural areas- a limit on the number of rides per period makes more sense that a total elimination of this benefit. Health care cannot happen if the patient cannot get to their appointments.

Deborah Field, MD
Psychiatrist, Duffy Health Center
dfield@duffyhealthcenter.org

Massachusetts Artists Leaders Coalition

June 9th, 2017

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

Submitted by email to kaela.konefal@state.ma.us

Re: Request to Amend the MassHealth 1115 Demonstration and Related State Plan Amendments

Dear Assistant Secretary Tsai,

On behalf of the Massachusetts Artists Leaders Coalition's Steering Committee (1), I am submitting comments on MassHealth's proposed 1115 Medicaid Waiver Amendment. MALC is strongly opposed to eliminating the "90-day provisional eligibility for most adults over the age of 21 when income needs to be verified". Eliminating this provision will, with out a doubt, unfairly penalize our community. Even now with this provision in place, many Massachusetts artists of all disciplines often need the 90 days (and sometimes more than 90 days) to get their income properly assessed and approved by the current income assessment system in place.

The vast majority of artists of all disciplines have hard to determine income due to their work and employment patterns. Many artists do not hold one 9-5 job, but rather have many sources for their income (multiple part-time jobs that are semester based and not yearly based, freelance income, contract jobs, self employed income, grants etc.) and their income not only fluctuates from year to year, but from month to month. Many in our community have multiple jobs through out the calendar year which in turns means they will have multiple pay stubs and multiple W-2 forms at the end of the year from many different employers. Others artists are entirely self employed and don't have any pay stubs. Most artists, however, have what is called "combination income" (2) and this was well documented in Stand Up and Be Counted - a state-wide 2009 report on Massachusetts of all disciplines. Combination income means that they have income from one or more employers (paid and tracked at the end of the year with a W-2 form and have their taxes and social security taken out of their paycheck) and they also have self-employment income (sometimes documented at the end of the year via 1099 form and some not). This can make their applications very hard to verify/approve through no fault of their own. In fact the 2009 report stated: *"It is important to note that those who derive their income from combination sources face unique obstacles when applying for income- and need-based programs such as subsidized health care, leading, in practice, to discrimination against them in provision of service."* (2)

It is also very important to acknowledge that an artist's income often fluctuates, thus their last years tax forms many not reflect what their income is or will be for the current year. It is essential to understand how "fluctuating" income impacts the determination and redetermination process. Many who have fluctuating income may have no income or very little income for months at a time and may for one or two months out of the year get a "big pay check". This has proved very problematic as to how MassHealth and the Connector assess this type of income and it has at times blocked people out of MassHealth and other need based programs with similar income vetting processes. Fluctuating income patterns have often caused artists to be thrown off and/or to trigger a redetermination process for their subsidized health care (ie they get a big check or temporary job and it triggers this to happen). The "90-day provisional eligibility for most adults over the age of 21 when income needs to be verified" is vital for those with fluctuating income.

Even now, with out the proposed provisional change, there is a clear need to do the following: 1) create a special unit of experts to process applications from people with hard to determine income 2) have enough staff with the needed knowledge and skill sets needed on hand to process these applications 3) create a specific form and process to be used by artists and those who have multiple sources of fluctuating income, those who do not have regular pays stubs to assess their income, and/or for those who are self-employed to use 4) the need to dedicate several fax lines, several phone lines and a specific email for this special staff unit that those applying and the advocates helping them apply can use to communicate with this special unit. 5) create a safety net mechanism and an appeal process, so if the forms can't be processed in a timely manner the individual isn't negatively impacted, can still get health care, and is not financially penalized.

MALC would be willing in anyway to help MassHealth establish/create the above 1-5 suggestions.

We must stress again that MALC is strongly opposed to eliminating the "90-day provisional eligibility for most adults over the age of 21 when income needs to be verified". It will be cause much harm to our community who has waited and fought so hard for access to affordable health care.

Submitted on behalf of the MALC Steering Committee

by Kathleen Bitetti*

Visual Artist & Co-Founder of MALC

Massachusetts Artists Leaders Coalition (MALC)

PO BOX 382419, Cambridge, MA 02238

Email: MALC@artistsunderthedome.org

http://artistsunderthedome.org/malc/

*On a personal note, I have been advocating on artists health care issues since the mid 1980's when the HIV/AIDS crisis was fully impacting the artists community. Under my tenure as executive director of the Artists Foundation (1992-2009), the Foundation made affordable and accessible healthcare for artists a key cornerstone of our work. I also spearheaded and co-

authored both the 1994 report to Congress (3) and the 2009 Stand Up and Be Counted Report. I continue to do this needed artist health care advocacy through MALC and Health Care for Artists which is a member of the ACT II Coalition.

(1) MALC formed in the Summer of 2008. MALC's meetings are designed to bring together artist leaders of all disciplines and artist(s) run organizations, initiatives, and businesses around key issues facing Massachusetts artists working in all disciplines. Though participants may have different perspectives on how best to address the issues facing our community, we are all committed to improving the social and economic well-being of all Massachusetts artists. The overall goal is to empower our community, support our artist leaders, and mentor new artist leaders. We want to ensure that artists are at the policy-making table. To this end, was the working group for artists' issues for the statewide Creative Economy Council (CEC) (which ended in Dec 2016). MALC is now the co-lead with the City of Boston for the Commonwealth's Greater Boston Creative Economy Network (CEN).

(2) Below all from the 2009 Stand Up and Be Counted report:
http://www.artistsunderthedome.org/MA_ArtistsReport2009.pdf

P 2 Combination income refers to income that comes from W-2 income (a full-time job and/or multiple part-time jobs that are yearly, semester-based, and/or seasonal or any combination), grants, commissions, money earned from selling work/performing, 1099 income/freelance work, trust fund income, retirement income, and/or some self employment income.

P 5 The survey also provides data about a newly-identified population that surfaced during the implementation of the Massachusetts health care reform law: those with combination income. When individuals are assessed for income- and need-based programs they are typically asked if they are an employee (and if they have W-2 income) or if they are self employed (usually defined as having non W-2 income). .....It is important to note that those who derive their income from combination sources face unique obstacles when applying for income- and need-based programs such as subsidized health care, leading, in practice, to discrimination against them in provision of service.

P 11 Nearly half (49.4%) of the 3,125 artists who answered the question reported that they had combination income; one-quarter (23.8%) reported that they were fully self-employed, and just over one-fifth (19.7%) reported that were salaried employees/had W-2 income only.

(3) Info about the 1994 Report to Congress - From Stand Up and Be Counted report:

P1 Advocating for health care and health insurance options for artists has been a primary focus of the Artists Foundation since 1992, when the national debate around health care reform that took place during the first years of the Clinton Administration did not deal with the needs of artists and others with non-traditional streams of income. In 1994, the Artists Foundation coauthored the Artists Health Care Task Force: A Report to Congress, with the Boston Mayor's Office of Cultural Affairs and Boston Health Care for the Homeless. That report documented the health care and health insurance coverage challenges faced by artists of all disciplines.

Link to Artists' Health Care Task Forces' 1994 Report to Congress
The following is an excerpt from the report (pp 11-18)- III Artists and the Economy:

http://www.kathleenbitetti.com/Pages/CongressReport.html

Konefal, Kaela (EHS)

From: Teri Anderson <terianderson@fhcareers.org>
Sent: Sunday, June 11, 2017 4:19 PM
To: Konefal, Kaela (EHS)
Subject: Comments on Demonstration Amendment

Dear Ms. Konefal:

The Franklin Hampshire Career Center would like to express its concern about the proposed elimination of the non-emergency transportation benefit for MassHealth Care Plus members. The Franklin and Hampshire Counties are one of the most rural regions in MA with little or no public transportation available throughout a majority of the two counties. As a result Franklin Hampshire low-income residents will be adversely and disproportionately impacted by the rule change. In addition, over half of the communities in the region do not have access to broadband infrastructure making it impossible to receive medical services via teleconferencing.

We know first hand how challenging it is for low-income and unemployed residents to access workforce education, training, and job search assistance services at our Career Centers. In addition, regional transit authorities are also proposing route reductions as a result of inadequate funding. This combined with elimination of free transportation to medical appointments will make it extremely difficult or impossible for Franklin Hampshire residents without access to an automobile to obtain medical care.

We encourage you to retain free medical transport services for all MassHealth Care Plus members especially in rural areas or in cases where patients have no other means of transportation available.

Thank you for your consideration.

Sincerely,

Teri Anderson, Executive Director
Franklin Hampshire Career Center
One Arch Place
Greenfield, MA 01301
413-774-4361 x 322
terianderson@fhcareers.org

Kaela Konefal
EOHHS Office of Medicaid
One Ashburton Place, 11thFloor
Boston, MA 02108

Dear Ms. Konefal:

The American Lung Association in Massachusetts appreciates the opportunity to comment on Massachusetts' 1115 Waiver Amendment.

MassHealth CarePlus are the lifeline for Massachusetts' working poor. Individuals and families depend on MassHealth CarePlus for live-saving treatments. Removing the non-emergency transportation benefits would harm the health of individuals that rely on these programs to get them to their healthcare appointments. Ending this benefit will be especially harmful for lung disease patients who need regular access to medication and treatment to breathe.

The Lung Association wants all Massachusetts residents to have access to affordable, quality healthcare, especially low-income residents that depend on MassHealth CarePlus. We encourage you to revise the policies in the proposed waiver prior to submitting it to the Centers for Medicare and Medicaid Services (CMS).

Removal of Non-Emergency Transportation Benefits

The proposed waiver would remove the non-emergency transportation benefit from MassHealth CarePlus enrollees for all services except substance-use disorders (SUD) services. This change will negatively impact lung disease patients enrolled in MassHealth CarePlus. Non-emergency transportation benefits help patients get to appointments and get the treatments they need.

Lung disease patients often need frequent treatment and appointments with their doctors to maintain a normal life. Lung cancer patients need to get to chemotherapy infusions. Patients with asthma need to keep doctor's appointments to ensure they are on the most appropriate treatment to control the symptoms of the diseases and COPD patients need to go to pulmonary rehabilitation appointments.

Non-emergency transportation benefits allow patients to get to their appointments- keeping them healthy and preventing more expensive disease in the future. The MassHealth CarePlus program is not private insurance, but rather a program with its own specific needs. For the best health outcomes for Massachusetts residents, the non-emergency transportation benefit helps ensure the appropriate treatment is received at the right time.

The Lung Association encourages the state to reconsider the proposal to remove the non-emergency transportation benefit for the MassHealth CarePlus program. Thank you for reviewing our comments. We appreciate the opportunity to provide feedback.

Sincerely,

Jeff Seyler
President and CEO
American Lung Association of the Northeast

ABH

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Vicker V. DiGravio III PRESIDENT / CEO
Karin Jeffers, LMHC CHAIR

June 12, 2017

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

Submitted by email to kaela.konefal@state.ma.us

Re: Request to Amend the MassHealth 1115 Demonstration and Related State Plan Amendments

Dear Assistant Secretary Tsai,

As you may know, the Association for Behavioral Healthcare (ABH) is a statewide association representing more than 80 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, 1.5 million residents annually, and employing over 46,500 people. Thank you for the opportunity to comment on the proposed changes to the MassHealth Section 1115 Demonstration and Related State Plan Amendments.

ABH is concerned that the proposal cuts most of the non-emergency medical transportation (NEMT) services for MassHealth CarePlus members. ABH is grateful to the Baker administration for their continued commitment to addiction treatment as the proposal does exempt transportation to substance use disorder services from the waiver request. For many MassHealth members, lack of access to reliable transportation is a barrier to accessing the community-based care that they need. Approximately 13,000 MassHealth CarePlus members utilized the NEMT benefit for travel to non-SUD services last year.

Non-Emergency Medical Transportation

Adults who are eligible for Medicaid under the Affordable Care Act (ACA)'s expansion must receive a benefit package that includes non-emergency medical transportation (NEMT)[1]. Through the 1115 Waiver Amendment, MassHealth proposes to waive the NEMT benefit for MassHealth CarePlus enrollees, except for transportation to substance use disorder (SUD) services. ABH strongly urges MassHealth to reconsider eliminating the NEMT benefit for MassHealth CarePlus members.

[1] 42 C.F.R. § 440.390.

Transportation Barriers Lead to Delayed or Missed Care for Consumers
Low-income consumers, such as those enrolled in MassHealth CarePlus, may not have access to reliable and affordable transportation,[2] impacting their ability to access health care services. This issue may be particularly acute in areas of the state that do not have reliable or affordable public transportation systems, such as areas of Western Massachusetts and the Cape and Islands.

A number of studies suggest that transportation barriers often lead to delayed or missed care for patients. Estimates show that nearly 3.6 million people nationally miss or delay medical care each year because they lack available or affordable transportation. Approximately 25 percent of lower-income patients have missed or rescheduled their appointments due to lack of transportation[3] and Medicaid enrollees are disproportionately impacted by transportation barriers. Only six-tenths of one percent of those with private insurance reported that transportation was a barrier to accessing timely primary care treatment, compared to seven percent of Medicaid beneficiaries.[4] Because of statistics like these, a January 2016 report by the United States Government Accountability Office concluded that the NEMT benefit "can be an important safety net for enrollees as research has identified the lack of transportation as affecting Medicaid enrollees' access to services."[5]

In addition, while we greatly appreciate that the MassHealth CarePlus program will continue to cover transportation for SUD services, many people who struggle with SUDs also have co-occurring mental health disorders, and require mental health services to move forward in their recovery. These mental health services may be provided separately from the SUD services, and lack of transportation would impose a barrier to recovery.

Providing Non-Emergency Medical Transportation is Cost-Effective
In addition to helping consumers access the health care services they need, providing the NEMT benefit is cost-effective. Evidence shows that adults who lack transportation to medical care are more likely to have chronic health conditions.[6] Without adequate transportation, these conditions are likely to go unmanaged and eventually lead to costly emergency care and treatment that could have been prevented. While NEMT makes up less than one percent of total national Medicaid expenditures, emergency room visits result in 15 times the cost of routine transportation.[7] It is also

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[2] P. Hughes-Cromwick and R. Wallace, *et al.*, *Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation,* Transit Cooperative Research Program (Oct. 2005), Retrieved from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.
[3] S. Syed, B. Gerber, and L Sharp*Traveling Towards Disease: Transportation Barriers to Health Care Access*, Journal of Community Health (Oct. 2013). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215.
[4] P. Cheung, J. Wiler, and et. al., *National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries,* Annals of Emergency Medicine (July 2012), Retrieved from http://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext.
[5] U.S. Government Accountability Office, *Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage* (Jan 2016). Retrieved from http://www.gao.gov/assets/680/674674.pdf.
[6] R Wallace, P. Hughes-Cromwick, et al, *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, Transportation Research Record: Journal of the Transportation Research Board (Dec 2004) retrieved from http://www.researchgate.net/publication/39967547.
[7] Community Transportation Association. Medicaid NEMT Saves Lives and Money. Retrieved from http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf.

worth noting that Massachusetts currently receives 86% in federal reimbursement for MassHealth CarePlus spending.

We urge MassHealth to reconsider the elimination of the NEMT benefit for travel to most services in the MassHealth CarePlus program.

If you have any questions or comments, I am happy to address them at your convenience. Thank you for your consideration.

Sincerely,

Vicker V. DiGravio III

Vicker V. DiGravio III
President/CEO

BOSTON PUBLIC HEALTH COMMISSION

Building a Healthy Boston

June 12, 2017

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

Submitted by email to kaela.konefal@state.ma.us

Re: Request to Amend the MassHealth 1115 Demonstration and Related State Plan Amendments

Dear Assistant Secretary Tsai,

On behalf of the Boston Public Health Commission (BPHC), thank you for the opportunity to offer our comments on the proposed MassHealth Notice of Submission of a Request to Amend the MassHealth Section 1115 Demonstration and Related State Plan Amendments. The BPHC is the country's oldest health department, and is an independent public agency providing a wide range of health services and programs. Public service and access to quality health care are the cornerstones of our mission – to protect, preserve, and promote the health and well-being of all Boston residents, particularly those who are most vulnerable. We have concerns with two changes proposed in the 1115 Waiver Amendment: 1) cuts to non-emergency medical transportation services for MassHealth CarePlus members, and 2) the elimination of provisional eligibility for most adult applicants, both of which represent steps backwards in access to care for low-income Massachusetts residents.

Non-emergency medical transportation

MassHealth proposes to eliminate non-emergency medical transportation for adults (21-64) in the CarePlus program except travel to substance use disorder services. Boston's Emergency Medical Services (EMS) is a community-based public safety and public health service that provides and manages the integrated 9-1-1 pre-hospital care system for the City of Boston, and maintains and improves safety and healthcare in the community. While Boston EMS does not provide non-emergency or scheduled transport, it certainly benefits the department's service population.

In addition to providing emergency care, Boston EMS strives to serve the BPHC's public health goals through taking a holistic view of our role within the continuum of care and factors that influence the wellbeing

of our patient population. Transportation services are vital to ensuring that consumers are able to access the care they need, functioning as a key social determinant of health. Public transportation or a taxi service does not serve as adequate replacements for necessary medical supervision. Transportation barriers have been shown to lead to delayed or missed care, resulting in increased risk of health complications and costly interventions. We also know that eliminating barriers to care helps to ensure that vulnerable populations can afford and attend medical appointments. Therefore, we know that providing non-emergency medical transportation is both cost-effective in the long run and an essential element in mitigating health inequities.

Provisional Eligibility

Current policy and practice enables MassHealth to make real-time eligibility determinations based on self-declared income. When income cannot be verified electronically, applicants are allowed to enroll for a 90-day provisional eligibility period, during which time they are required to verify the self-declared income. Through this 1115 Waiver Amendment, MassHealth proposes to discontinue its authority to provide 90 days of provisional MassHealth eligibility for adults ages 21 and older when income is unverified, except for the following populations: pregnant women with attested modified adjusted gross income at or below 200% FPL; adults 21 through 64 years old who are HIV positive and have income at or below 200% FPL; and adults 21 through 64 with breast or cervical cancer and have income at or below 250% FPL. We appreciate that children and youth under age 21 will also continue to be eligible for provisional coverage. However, under the proposal, affected adults will not receive an eligibility determination until they have submitted proof of income, and their proof of income is manually processed by MassHealth. It is our understanding that the removal of provisional eligibility will also apply to those adults who appear eligible for the Health Safety Net (HSN).

As part of BPHC, The Mayor's Health Line (MHL) works to ensure Boston residents' ability to access services and programs that promote health and wellness. The MHL staff are state-certified Navigators. In their role as Navigators, MHL staff answer questions about health insurance eligibility; help residents apply for and enroll in MassHealth and Connector plans; and connect clients to medical and social services. Staff also offer case management, assisting clients who are facing many life challenges and barriers to care. MHL clients often have continuously changing employment, multiple forms of employment, or are paid in cash. This constellation of factors means that the online system is rarely able to verify income (by matching with Department of Revenue) in real time.

Under the proposal, affected adults will not receive an eligibility determination until they have submitted proof of income and the proof is manually processed by MassHealth. This change means that instead of real-time

determinations for eligible applicants, determinations will be delayed until paperwork is processed. Paperwork delays will likely be exacerbated by a variety of factors, including lengthy telephone call wait times, outdated technology for document submission, lost documents, and delays processing documents once they are received. The Health Insurance Exchange (HIX) computer system's inability to "stop the clock" on benefit termination when required documents are submitted by a deadline but not yet processed means enrolled members with outstanding documents will be competing with uninsured applicants for processing priority.
This will add another challenge to a population already burdened by health inequities and barriers to care. This proposal will delay getting timely decisions for affected adults, particularly those who need immediate care. These types of delays do not just affect MassHealth but the Health Safety Net and ultimately all the services provided by the state and health care providers. Currently, it is taking over two months for verification documents to be processed according to enrollment assisters. Consumers and assisters report submitting documents multiple times (receiving fax confirmation of receipt), only to have consumers' benefits terminated because the required documents were not received by MassHealth. This is a common occurrence for MHL clients.

It is important to provide all residents with equitable access to insurance coverage. We support and promote the adoption of new strategies and technologies to improve and streamline the way in which MassHealth services are provided, but these changes should be made in a way that will improve benefits rather than remove access. Increased resources to expedite processing both in terms of staff and technology would greatly improve the underlying challenges associated with the current verification process.

Thank you for your time and attention to these important matters of public health and health care access. The Boston Public Health Commission will continue to ensure that all residents have an opportunity to access services and programs that promote health and wellness. If you have any questions regarding these comments, please contact Heather Gasper, Director of Intergovernmental Relations at 617-534-2288 or by email at hgasper@bphc.org.

Sincerely,

Monica Valdes Lupi, JD, MPH

June 12, 2017

Kaela Konefal
EOHHS Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Kaela.konefal@state.ma.us

Re: Comments for Demonstration Amendment

I am writing to you today to urge you to not include the waiver of the requirement for NEMT transportation as part of the Medicaid plan for the Commonwealth.

NEMT is a necessary transportation service available to individuals who have no other option to get to follow up appointments, dialysis, and therapies. It is an option that is a part of a family of service options a community can provide holistically. If one option, especially one that is vital to health survival, is isolated and removed, the whole cannot work effectively for the individual, the family, or the community. This solution is a self-centered financial solution that does not consider detrimental personal or program outcomes.

Medicaid NEMT is the largest of the non-FTA programs, surpassing many of the Federal Transit Administration programs. If this NEMT waiver is granted, CMS will have the ability to operate independently from all other federal agencies and departments providing transportation options and will not work cooperatively within the holistic system. This will create a financial burden for the rest of the 80 programs that currently share the responsibility. This shift will cause confusion, hardship, and is not a part of the good faith process already being realized through the Coordinating Council on Access and Mobility (CCAM).

If programs like yours begin to take matters into their own hands without considering impact, we will end up with a patchwork of broken options that will never fully serve the community or the individual. People who need health care transportation will end up with no resources.

I would hope that you could as least hold off a decision until the CCAM completes the federally mandated strategic planning process. I would also hope you would press the CCAM to study the potential impact of such a decision. Separately we can serve a few, together we can move communities to better health.

Best regards,

Kristen Joyner
Executive Director
South West Transit Association

AARP® Real Possibilities
Massachusetts

June 12, 2017

Kaela Konefal
EOHHS Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Request to Amend the MassHealth Section 1115 Demonstration

Dear Ms. Konefal:

AARP is the nation's largest nonprofit, non-partisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. On behalf of the nearly 38 million members nationwide and 800,000 members here in the Commonwealth, thank you for the opportunity to provide our comments to these proposed amendments.

This Demonstration Amendment seeks authority to limit non-emergency transportation in the MassHealth CarePlus program, except for transportation to substance use disorder (SUD) services. The proposed amendment explains that the rationale for the change is to align CarePlus with ConnectorCare and commercial insurance which do not cover non-emergency transportation.

While the amendment states that cost savings are not the main driver of this proposal, the rationale motivating this change is not clear to us. AARP is concerned that the elimination of non-emergency transportation would cause undue hardship to the 14,000 individuals that would be affected.

In 2006, the National Academy of Sciences issued a "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation." The study looked at 12 specific preventive services and chronic conditions and found the costs of transportation for the target population resulted in reduced health care spending in for four conditions, was highly effective in improving morbidity and mortality for six conditions, and moderately effective in the remaining two.

Not including coverage for non-emergency transportation is especially harmful for the rural population in Massachusetts. We believe this lack of coverage will likely lead to more missed appointments and failure to complete preventive services and as a result, would prove counterproductive to the goal of improving health outcomes. AARP urges the Executive Office of Health and Human Services to reconsider this change and continue to provide non-emergency transportation as a covered benefit in the MassHealth CarePlus program.

A second amendment to the MassHealth 1115 Demonstration proposes to change the current practice of providing coverage during a temporary period pending receipt of paper documentation of income. Instead, eligible adults who need to verify income on paper will have to wait until MassHealth workers manually process the paperwork before they can be found eligible.

AARP would like to raise serious concerns with this proposed change, especially as it affects individuals who want and need Home and Community Based Services (HCBS). States have long had the option to allow qualified entities to enroll eligible children or pregnant women provisionally or presumptively. This policy is widely viewed as an effective way to move the enrollment process into the community where trusted organizations can identify and enroll eligible people.

Under a provisional or presumptive access policy, applicants for Medicaid HCBS are temporarily assumed to be eligible and may begin receiving services immediately, when the need arises, rather than waiting for the often-lengthy Medicaid eligibility verification processes to be finalized. This is especially critical for people who are in crisis or undergoing hospital discharge, as failure to connect these individuals with HCBS in a timely manner can result in unnecessary hospitalizations and nursing facility admissions.

Thought leaders in long-term care have endorsed presumptive eligibility as a compassionate, commonsense approach to connecting vulnerable individuals with Medicaid-funded HCBS in a timely manner. For example, the 2011 version of the "*State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*" by AARP, the SCAN Foundation, and the Commonwealth Fund, researchers wrote that "[f]ailing to serve new beneficiaries in HCBS settings can have negative impacts for an extended duration", and they endorsed state adoption of presumptive eligibility policies to "...quickly establish that a person will be able to qualify for public support for HCBS, thereby preventing unnecessary nursing home admissions".

As one example, in Washington State, officials have estimated that it costs less than $100,000 per year to provide services to people who are ultimately found to be ineligible for Medicaid, but that cost is "far exceeded by savings generated by diverting clients from institutional care."

AARP strongly urges the Executive Office of Health and Human Services to reconsider this change and continue the practice of provisional eligibility in the MassHealth program.

Thank you for your consideration. Please do not hesitate to contact Jessica Costantino, Director of Advocacy, AARP Massachusetts, if you have any questions or need additional information.

Very truly yours,

Michael E. Festa
State Director

Sandy Albright
State President

MASSACHUSETTS
Health & Hospital
ASSOCIATION

June 12, 2017

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

Re: Comments on 1115 Demonstration Amendment Request

Dear Assistant Secretary Tsai:

On behalf of our member hospitals and health systems, the Massachusetts Health & Hospital Association (MHA) offers these comments for your consideration as the Executive Office of Health and Human Service (EOHHS) prepares to submit its proposed amendment on the state's 1115 Medicaid waiver to the Centers for Medicare and Medicaid Services (CMS).

Non-Emergency Medical Transportation
MassHealth enrollees currently are entitled to benefits that include non-emergency medical transportation, this includes adults covered in MassHealth CarePlus as part of the Affordable Care Act (ACA) Medicaid expansion. The EOHHS waiver amendment seeks a "waiver of Assurance of Transportation (i.e., Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53) in order to enable Massachusetts to provide benefit packages to individuals enrolled in MassHealth CarePlus that do not include non-emergency transportation, except for transportation to SUD services."

MHA is very concerned with this proposed change to the commonwealth's Medicaid waiver and we respectfully request that MassHealth not include this proposal in the amendment request. Non-emergency medical transportation is an important service that is necessary to ensuring continuity of care for all MassHealth enrollees, especially those with chronic medical and behavioral health conditions. Many low-income patients do not have access to reliable and convenient transportation that will ensure access to healthcare providers in their community. Many of these appointments are critical to maintaining a patient's health so there is not a relapse and/or readmission back into an acute care or post-acute level setting. Without access to non-emergency transportation, these patients could often choose to simply forgo needed services.

Non-emergency medical transportation is also often necessary when a patient is transferred from a hospital to a non-acute settings and/or a community based placement. In many cases, the patient or their family does not have the ability or resources needed to assist the patient in being transported from one location to another. It should also be noted that public transportation may not be suitable for certain patients in most cases including patients that need wheelchairs for even a temporary period. Instead, MassHealth should continue to provide coverage for its MassHealth CarePlus enrollees to use wheelchair vans, taxis, and stretcher cars provided that they can meet documentation standards demonstrating the need for such services. It is important to note that in all cases, the state has specific medical necessity standards for which the provider and the patient must be able to demonstrate the need for a non-emergency transport.

With the roll out of the MassHealth Accountable Care Organization (ACO) program, we are very concerned that this proposal contradicts the goals of the program, in particular the achievement of savings through reductions in unnecessary hospital admissions and improved care management and coordination. Ensuring that qualified MassHealth beneficiaries have a service that can take them to and from providers is essential to the success of this program. We imagine that access to community partners would also be affected. As a result, if a patient forgoes treatment for their chronic medical condition, not only will have consequences for the patient in the long-run but it also will impeded the ability of ACO's to coordinate care and achieve successful outcomes related to the provision of medically necessary care and the avoidance of care delivered in more expensive settings. It will also be complicated for ACOs to determine how to best manage these transportation issues when many MassHealth patients will continue to have transportation benefits and a subset of the MassHealth population will not.

We also believe the elimination of this benefit conflicts with the MassHealth ACO's program recognition that social determinants have an effect on the health of the MassHealth population. Lack of transportation to a medical provider is similar to a lack of housing and nutrition since it will negatively affect the ability of enrollees to access health care services and stay healthy. The loss of non-emergency transportation would run counter to this important effort to address social determinants through the ACO program and waiver.

Finally, we question the financial rationale behind this coverage elimination. We recognize that through this policy, MassHealth is seeking to make MassHealth CarePlus less attractive to those with commercial insurance. However, we disagree that non-emergency transportation is the deciding factor in such decisions and we encourage MassHealth to instead continue with its efforts to make it easier for MassHealth enrollees with employer coverage to access the premium assistance program. Since this benefit cut is targeted at the ACA Medicaid expansion population, MassHealth would forfeit the substantial federal revenue that comes to the state for these services. In 2018, the federal matching rate for MassHealth CarePlus is 89.6% and this

will eventually cap out at 90%. We therefore disagree with a financial rationale for eliminating these services especially given the many concerns and issues we have cited that would affect enrollees, providers, and the success of the ACO initiative.

Provisional Eligibility

MassHealth applicants currently are given 90 days provisional eligibility to verify certain information related to their application for coverage, including income, residency and citizenship. The EOHHS waiver amendment seeks to withdraw this authority when income verifications are needed for adults 21 years of age and older with exceptions for pregnant women with incomes up to 200% FPL, those with HIV who have incomes up to 200% FPL, and those with breast and cervical cancer with incomes up to 250% FPL.

MHA understands that MassHealth has introduced this change due to program integrity concerns. While we recognize and share those concerns, we also believe it is important that low-income applicants in need of health coverage are able to access that coverage as soon as possible.

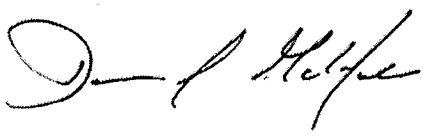
If the proposed policy does go forward, we respectfully request MassHealth to bolster its efforts to process applications so applicants do not have to wait longer than necessary for a determination. MHA supports the specific recommendations by the Affordable Care Today (ACT!!) Coalition, of which MHA is a long-standing member. These include:

- *Set up a dedicated fax line or other method to expedite processing if proof of income, similar to the identify-proofing fax line or the earlier 3-day period to fax verifications to the Central Processing Unit (CPU) for Virtual Gateway applications..*
- *Prior to the Health Insurance Exchange (HIX) system, most paper applications were processed within 2-3 weeks. Retain that timeframe for processing paper applications and staff-up to meet it.*
- *Staff-up to meet greater call volume and larger volume of requests for expedited processing.*
- *Improve telephone access when people call to have a notice translated by adding more language options and other effective processes.*
- *Coordinate with the Health Connector to allow MassHealth applicants to submit documents at Health Connector walk-in sites.*
- *Give higher priority to HIX enhancements to accept uploaded or emailed documents, as the majority of other state Medicaid programs and DTA do.*
- *Revise the online and paper application, member booklets and notices to clarify that no eligibility decision will be made for adults until income is verified and provide clearer information on acceptable documents (how many pay stubs, how recent, etc.).*

- *Monitor and report on timely processing measured from the date of an online or paper application submission to the date of the eligibility decision.*
- *If there is a delay upgrading the HIX to enable it to verify SSDI income with the Social Security Administration (SSA), retain provisional eligibility for adults with disabilities.*
- *Allow for a reasonable explanation of a discrepancy to be made online or by telephone.*

Thank you for the opportunity to offer these comments. We look forward to continuing working with EOHHS on the implementation of the state's 1115 Medicaid Waiver.

Sincerely,



Daniel J. McHale
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Massachusetts Health & Hospital Association

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June 12, 2017

By Email Only: kaela.konefal@state.ma.us
Kaela Konefal
EOHHS Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

RE: Comments for Demonstration Amendment/1115 Waiver Amendment Proposal

To Whom it May Concern:

We are grateful for the opportunity to share our opinion about the harm that would come to low-income people trying to prevent controllable chronic disease from escalating to serious disability or emergency, if they are cut off from access to preventive care for lack of subsidized transportation to it. Our perspective is based on extensive experience supporting people in just this circumstance to access transportation to preventive care and chronic disease care management services. MassHealth has to make tough choices in the context of scarcity, by necessity not by choice. In this instance a choice to reintroduce a barrier to preventive care is likely to increase rather than decrease total cost of care: those who are working and treading water just above the poverty line, may soon fall below the poverty line when a job is lost due to a flare-up of chronic disease that could have been managed through preventive treatment.

MLPB's mission is to equip healthcare and human services teams with upstream problem-solving strategies that address health-related social needs. Leveraging our public interest law expertise in these efforts, we advance health equity for individuals, families, and communities. We provide our services on a project-based, contract basis, meaning the bulk of our funding comes from healthcare and human services entities that understand and support our consumer-centered mission. Incubated in the pediatrics department of a large urban safety net hospital over twenty years ago, MLPB now provides a range of services to 25 health and human services entities in Massachusetts, Rhode Island, and several other states across the country. We provide services along the full spectrum of age and disease, including both pediatric and adult oncology programs.

A two-person family in Massachusetts is eligible for emergency assistance shelter if their income is $1,556.00 monthly. (**115%** of the Federal Poverty Level, or FPL) The same parent and child, managing life at **133%** of the FPL ($1,800.00), is not eligible for shelter and needs to afford the cost of living in Massachusetts with only an additional $244 in monthly income. Unsurprisingly, in the absence of deeply subsidized housing, such a family increasingly has to seek housing at the very bottom of the rental market, often doubling up households in "exurbs" far from public transportation. Under such conditions, there is a high risk of disrupting non-fungible clinical relationships (e.g. with a psychiatrist) or decreased engagement with a course of treatment that stands between the patient's functional management of a chronic illness versus deterioration of the functionality to a point of disability.

We serve socially isolated individuals whose health would be at risk were they to lose access to affordable transportation to care. We also serve families headed by parents bravely engaging with mental health treatment, vigilantly following prenatal care recommendations, doing their best to follow preventive cancer screening and early detection/treatment protocols, and sometimes making more than one of these commitments at a time.

Imagine families in these circumstances turning, for example, to Uber to continue in care for which they had relied on MassHealth transportation: a one-way "Uber Pool" fare from Taunton to Boston is $51.99. The fares are also high from areas where "Pooling" is infrequently available, as with Hancock, MA to Springfield, MA ($78.32), and Gardner, MA to Worcester, MA ($36.65).

While some non-emergency services can be found closer to Taunton, Hancock, and Gardner, Boston, Springfield and Worcester remain headquarters for particular kinds of care and are often where families that have moved to the exurbs or more rural locations still get care because of established relationships.

With such fares from an exurb or rural area in mind, a person trying to manage chronic disease that has not reached the threshold of disability or emergency, likely will be unable to afford continued preventive care engagement and predictably will either become disabled and eligible for transportation coverage because of the structural prevention barrier this change would represent, or would require emergency service entitling the patient to transportation, not to mention coverage for otherwise avoidable and expensive care.

For this reason, MassHealth will better advance its cost, quality, and healthy equity goals by continuing to assure transportation to medically necessary services, lack of access to which seriously threatens to stand between low-income patients at high risk for health disparities and their access to preventive and non-emergency care.

We close by thanking you for the work you are doing to blunt the impact of the proposed changes on those with foster care background and those seeking substance use treatment. The wisdom of protecting these vulnerable populations simply needs to be extended far more broadly to equally vulnerable low-income health disparities populations. In this regard as well as in opposition to terminating provisional eligibility, we endorse the comments submitted by the ACT!! Coalition.

Please feel free to outreach if it would help to discuss these concerns, and the experiences of our healthcare partners that inform them.

Respectfully submitted,

Samantha Morton, CEO JoHanna Flacks, Legal Director

CHCFC
Community Health Center of Franklin County

Hilltown Community Health Center
HCHC

Daniel Tsai, Assistant Secretary
Office of MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Mr. Tsai:

The Community Health Center of Franklin County (CHCFC) and Hilltown Community Health Center (HCHC) are concerned about the new changes to covered transportation services through MassHealth's Care Plus determination. Individuals making below $16,040 per year have a difficult time meeting their transportation needs, especially in the rural areas of Western Massachusetts. This proposed change adversely impacts areas not served and underserved by public transit, which include the rural communities we serve. These communities' lower health outcomes can be directly tied to a lack of communication and transportation infrastructure.

The mission of both of our organizations is to care for the health of the community's residents, which involves addressing their social determinants of health. Access to transportation is key determinant of patients' ability to access to the care they need, so our staff often help patients access MassHealth funded rides. Our community relies on PT1 requested rides for their health care needs. In addition, at CHCFC we offer a vehicle used exclusively for the farmworker population.

At all of our medical facilities, we see many patients who are in need of transportation to and from their medical visits. Our area does have Demand Response rides, but those rides are geared exclusively toward the disabled and elderly, neither population of which is on MassHealth Care Plus.

These are just two of many examples of the need that is met by the medical transportation benefit:

- One gentleman has trouble affording all the rides he needs to his various specialists. He is not determined disabled by Disability Evaluation Services or Social Security. He does have a little income to sustain himself, but is unable to afford the six rides he scheduled to specialists from his home in Bernardston, MA. These rides are necessary for him to receive the care he needs, which decreases his visits to the emergency room and thus decreases the cost of his care.
- Without transportation support from MassHealth, a stroke patient in her 50s has other serious co-occurring conditions. Since she lives in the Hilltowns, without MassHealth PT1 rides she could not reach her cardiologist, her neurologist, her primary care physician, CT scans, and MRIs. Due to transportation support she received she has significantly improved her health.

This change will disproportionately impact residents of the rural communities we serve in Franklin, Hampshire, and Hampden counties. Thank you for your consideration of our concerns. Please feel free to contact us if you have any questions.

Sincerely,

Ed Sayer, CEO
Community Health Center of Franklin County

Eliza B. Lake, CEO
Hilltown Community Health Center

health law advocates
Lawyers Fighting for Health Care Justice

HLA

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June 12, 2017

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

Submitted by email to kaela.konefal@state.ma.us

Re: Request to Amend the MassHealth 1115 Demonstration and Related State Plan Amendments

Dear Assistant Secretary Tsai,

Health Law Advocates (HLA) respectfully submits the following comments to the Massachusetts Executive Office of Health and Human Services regarding the proposed changes to the MassHealth 1115 Demonstration Waiver and related State Plan Amendments.

HLA is a non-profit, public interest law firm that provides free legal assistance to low-income Massachusetts residents who face barriers to accessing health care and coverage. HLA endorses and enthusiastically supports the comments submitted by the ACT!! Coalition regarding the proposed Waiver amendments. We submit these comments to share several stories of HLA clients that counsel caution as MassHealth pursues these changes. Specifically, we address the elimination of coverage for non-emergency medical transportation in the Care Plus program and the proposed changes to MassHealth provisional eligibility.

Non-Emergency Medical Transportation

HLA is concerned that the effort to remove non-emergency medical transportation (NEMT) from the benefit package would unduly penalize a vulnerable, Medicaid-eligible population in an attempt to "align" coverage with commercial insurance. In HLA's experience, Care Plus beneficiaries who qualify for help with NEMT constitute a distinct population that tend to have more demanding health needs and less access to resources than the commercially-insured population. At the same time, this population also has less access to modes of transport, particularly in more rural areas of the Commonwealth. We acknowledge that before implementation of the Affordable Act, many of these members had coverage under Commonwealth Care (CommCare), which did not cover NEMT. Nonetheless, at that time, many of these same members were unable to access necessary care due to transportation barriers.

The termination of NEMT services would be most detrimental to Care Plus members who do not live in the Boston area. Public transportation is spotty outside of Metro-Boston and non-existent in some rural parts of the state. Coverage for NEMT provides critical access, especially for people with chronic illnesses or disabilities for whom non-emergency medical appointments are unreachable without transportation assistance. Without NEMT, many will forgo or delay care until they experience a health crisis. The stories of two HLA clients[1] illustrate the obstacles to care that Care Plus members may experience if NEMT is removed as a benefit:

- A.P. is a fifty-one-year-old Care Plus member with bipolar disorder and other intellectual and emotional impairments who lives in Worcester County. MassHealth had denied her disability determination, so Care Plus was the best coverage available to her. A.P.'s primary care provider (PCP) prescribed medically necessary cognitive behavioral therapy and her in-network provider was located in Boston. Without NEMT provided by MassHealth, A.P. would not have the ability or means to access this medically necessary treatment, which is essential to managing her diagnoses. While we admire MassHealth's commitment to maintain NEMT for substance use disorder (SUD) services, many Care Plus members such as A.P. rely on NEMT to access non-SUD-related mental and behavioral health services. Without NEMT coverage, many of these members will be unable to reach the services that keep them stable and healthy.

- D.F. is a disabled, adult with a low income who has access to private health insurance. Although she has coverage for necessary medical care, she lives in an area of the state without comprehensive public transportation. She contacted HLA when the charity transportation provider in her community ceased their services due to funding cuts. D.F. had no other viable or available option for transportation. If the charity transportation provider had not come back online some months later, D.F.'s health and well-being would have been severely compromised because she was unable to access her regularly scheduled medical appointments during the gap. Although D.F. had income that was too high to qualify for Medicaid, her case represents the access barriers that exist for vulnerable people with private insurance who do not benefit from Medicaid protections, including coverage of NEMT.

Provisional Eligibility

HLA recognizes the importance of system integrity and emphatically agrees that MassHealth benefits should not be available to individuals who are ineligible. However, we believe that provisional eligibility has been a crucial protection for eligible members while the state has addressed multiple errors in technology and eligibility processing systems. We urge MassHealth to devote special attention to these persistent problems during and after the transition away from provisional eligibility for members without an income match.

HLA is concerned about the ability of the HIX and MA 21 computer systems to handle in a timely manner the increased workload and documentation. Under the current systems, we have clients who are eligible for MassHealth, but who have been unable to access benefits because of paperwork processing delays, misplaced documentation by MassHealth workers, delayed notices, and unclear noticing due to confusing language or multiple conflicting notices that members receive at the same time. Churn is a persistent problem in the current system and we

[1] Client's names and some personal information were changed to protect confidentiality.

fear that more eligible members will be unable to access benefits if eligibility processing systems are not updated to handle increased volume. One concrete enhancement that would help to address these issues is creation of an online portal where documents could be uploaded at the time of application.

Additionally, many MassHealth members have non-traditional or unreliable income that can cause mismatch between reported income and state data sources. For example, many of HLA's MassHealth-eligible clients engage in seasonal work. A Department of Revenue (DOR) income match made during a busy season would render a substantially different result than an income match made during an off-season. The systems must account for these income fluctuations in a timely and accurate way, which we do not see happening now.

Currently HLA has several clients who have been unable to verify their incomes because of a glitch in how income is calculated. These are families where one spouse is non-working and the families submitted joint tax returns as proof of income, thinking this would be sufficient. It is not until after submitting this documentation that MassHealth informs the family that the non-working spouse must submit an affidavit attesting that they have no income. During this time, the family either remains without coverage or they may churn off MassHealth.

Stories of two HLA clients demonstrate how eligibility processing problems cause undue coverage gaps for people who are technically eligible for MassHealth:

- D.R. is a head-of-household who submitted all required paperwork to MassHealth in a timely manner and even called customer service to confirm that the documents were received. Initially, a MassHealth representative informed D.R. that everything was in order. Nonetheless, multiple processing problems, including an incorrect address in the system and delayed communication about the types of income the family had reported, caused a significant gap in coverage. D.R. and his family members incurred unaffordable medical bills and a tax penalty for non-coverage despite being eligible for MassHealth during the entire time-period.

- Variable income has caused R.T. and his family to fluctuate between eligibility for MassHealth and Connector Care. Recently, to his great surprise, R.T.'s Connector Care plan informed him they were terminating his coverage. Eventually, he received notice from MassHealth about his eligibility and he submitted – on two separate occasions – what he believed were correct documents for income verification purposes. After the first time, a MassHealth representative initially said that his documentation had been lost, and then informed him that his non-working spouse had to provide a letter stating she had no income (though he had submitted their joint tax return). While R.T. was compiling these documents, MassHealth terminated coverage for the entire family, including his children (whose MassHealth coverage had previously been stable and maintained). R.T. sent in the documentation a second time, including the affidavit from his spouse. Soon thereafter, he received a notice that his MassHealth terminated his benefits due to his non-response. HLA is still working to resolve the coverage issues, which have caused disruptions in care for the entire family, including a child with mental and behavioral health care needs.

In summary, we urge MassHealth to address the persistent computer system and document processing deficits before implementing changes to the provisional eligibility system.

Thank you for the opportunity to comment on MassHealth's proposed 1115 Waiver Amendment. If you have any questions, please do not hesitate to contact Michelle Virshup at (617) 275-2845 or mvirshup@hla-inc.org.

Sincerely,

Michelle Virshup
Staff Attorney

Andrew P. Cohen
Staff Attorney

Konefal, Kaela (EHS)

From: Imran Cronk <icronk@gmail.com>
Sent: Monday, June 12, 2017 5:07 PM
To: Konefal, Kaela (EHS)
Subject: Comments for Demonstration Amendment

Dear Ms. Konefal,

I'm writing on behalf of Ride Health, an organization that assists patients who face transportation barriers to care, to urge you to not include the waiver of the requirement for NEMT as part of the Medicaid plan for the Commonwealth. Investments in medical transportation yield dramatic savings for state programs, as evidenced by Florida's experience wherein (according to an evaluation from Florida State University) the state saved $11.08 for every dollar invested in medical transportation assistance due to avoided hospitalizations.

Thank you for the opportunity to comment. We hope that the Commonwealth chooses to preserve access to NEMT for all Medicaid beneficiaries.

Best wishes,
-Imran Cronk

--
Imran Cronk

Co-Founder, Ride Health
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NPAF National Patient Advocate Foundation

The Patient's Voice | since 1996

June 12, 2017

Kaela Konefal
EOHHS Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Kaela.konefal@state.ma.us

Re: Comments for Demonstration Amendment

As a national non-profit organization representing patients nationwide, we write you today to urge you not to waive the requirement for non-emergency medical transportation (NEMT) as part of the Medicaid plan within Massachusetts.

The National Patient Advocate Foundation (NPAF) represents the voices of millions of adults, children, and families coping with chronic, life-threatening and disabling diseases nationwide. Our sister organization, Patient Advocate Foundation (PAF), provides direct case management and other services to nearly 100,000 patients and caregivers each year, improving their quality of life by reducing their financial and other distressing burdens. NPAF's policy agenda is inspired by PAF's work and grounded in evidence collected through qualitative and quantitative data, which enables thoughtful development of person-centered policies to optimize outcomes and experiences for all patients. Since 2007, PAF has provided personalized case management services to over 2,000 Massachusetts patients.

Lower-income patients comprise the majority of the patients we serve, and it is on their needs that we urge you to focus. In particular, PAF case management data indicates – as it has almost every year—that the inability to afford transportation expenses is one of the most common concerns of our patients. In fact, this need is so great that PAF has devoted specific funds devoted to providing transportation relief for patients with certain cancers.

We have conducted surveys of our patients, and they align closely with what other experts have to say: transportation access is an indicator of health. Poor transportation access contributes to missed appointments and even delayed medication. The burden of getting transportation to health care increases with distance—and at PAF, almost 44% of patients traveled more than 20 miles to a provider in 2015—and is also greater for those who ride with a family member, friend or a volunteer driver, despite the NEMT requirement that these options be used before the benefit is available. The lack of access to affordable and accessible transportation greatly contributes to health disparities by isolating

low-income patients from health care facilities and forcing families to spend a large percentage of their budgets on travel, at the expense of other needs, including health care.

Incredibly, this is a problem with accessible solutions. The average financial need for patients with transportation issues was about $19.63 per way. For this cost, patients can see a doctor, get the treatment they need and ultimately have a better quality of life—all at a comparatively low cost to the system.

Massachusetts has led the nation in providing comprehensive health benefits to its citizens. Waiving the NEMT benefit for the Medicaid population will inevitably drive up health costs for the system, as patients can no longer make the wellness visits and other, more crucial appointments they need to maintain their health.

We welcome the opportunity to discuss this issue with you further. If you have any questions, please contact Melissa Williams at Melissa.Williams@npaf.org.

Best regards,

Melissa L. Williams, MPH
Manager of Healthcare Policy and Advocacy
National Patient Advocate Foundation

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Comments for Demonstration Amendment submitted by email to kaela.konefal@state.ma.us

Dear Ms. Konefal,

These comments are submitted by the undersigned legal services organizations on behalf of our clients who rely on MassHealth and the Health Safety Net for access to health care. We appreciate the opportunity to make these comments expressing our strong objections to the proposed amendments pertaining to Nonemergency Medical Transportation and Provisional Income Eligibility for Adults. We support the third amendment to continue coverage for former foster care children.

Non-emergency medical transportation for CarePlus members is a low cost high value benefit for a small population for whom transportation is a barrier to care

MassHealth proposes to eliminate non-emergency medical transportation (NEMT) for adults in the CarePlus program except for travel to substance use disorder services.

There is no financial rationale for reducing NEMT benefits

There are over 300,000 adults enrolled in CarePlus, however, MassHealth estimates that only about 13,000 of them now use NEMT for other than SUD services. As this number suggests, access to NEMT is already very limited. The costs of services in CarePlus are reimbursed at an enhanced matching rate (89.6% in 2018). Thus, for every dollar less in CarePlus benefits, the state will save only ten cents. We have not seen any estimate of total cost savings from eliminating NEMT but given the low utilization and high federal matching rate, it cannot be large given the value of the benefit.

Non-emergency medical transportation is a high value benefit

The Medicaid program has required coverage of NEMT for a reason, studies have shown that it improves health outcomes and in some cases reduces costs. In 2006, the National Academy of Sciences released a report called a "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation."[i] The study looked at 12 specific preventive services and chronic conditions and found the costs of transportation for the target population resulted in reduced health care spending in four conditions, was highly effective in improving morbidity and mortality for six conditions, and moderately effective in the remaining two. We have not been able to obtain more detailed information on the CarePlus members now using NEMT. However, a doctor must request prior authorization for a patient to obtain a NEMT in the form of a ride to obtain a

covered service either because no public transportation is available or because the patient cannot use public transportation for medical reasons. The few patients who use NEMT are likely to be just like those in the target population of the study for whom NEMT is most cost effective.

Transportation is a greater access barrier for low-income Medicaid beneficiaries than for the commercially insured

The state's rationale for eliminating NEMT is to better align CarePlus with commercial insurance. However, transportation is a greater access barrier for low income Medicaid beneficiaries than for the commercially insured. Only six-tenths of one percent of those with private insurance reported that transportation was a barrier to accessing timely primary care treatment, while seven percent of Medicaid beneficiaries did so.[ii] Approximately 25 percent of lower-income patients have missed or rescheduled their appointments due to lack of transportation. [iii] Because of statistics like these, a January 2016 report by the United States Government Accountability Office concluded that the NEMT benefit "can be an important safety net for enrollees as research has identified the lack of transportation as affecting Medicaid enrollees' access to services."[iv]It is ironic that just at the time that the Medicaid agency is attempting to address the role of social determinants of health through its delivery system reforms, it is proposing to eliminate NEMT.

There is little doubt that CMS will approve this change if the state moves ahead with its plans to ask for it. The new HHS Secretary and CMS administrator have called the ACA's Medicaid expansion "a clear departure" from the mission of Medicaid, and invited states to dismantle it. We will be deeply disappointed if Massachusetts accepts that invitation.

Eliminating Provisional Income Eligibility for Adults in MassHealth and the Health Safety Net Will Exacerbate Already Unacceptable Delays

MassHealth is also proposing to change the current practice of providing coverage during a temporary period pending receipt of paper documentation of income with respect to adults (with a few exceptions). This change is not limited to the adults in CarePlus but extends to low income parents and adults with disabilities in MassHealth Standard, CommonHealth and Limited and to the Health Safety Net. While we have very limited information about who will be affected by this proposal, we were told that about 140,000 adults were provisionally eligible based on income last year, about 25 percent (35,000) were ultimately not found eligible, and that the state expects to save about $31 million in state dollars based on this change.

While the 75% of income eligible adults will eventually have retroactive coverage, many will have been unable to access any but emergency room care during the retroactive period. The retroactive period will also be fee for service, delaying enrollment into managed care. This shift from managed care in primary care settings to fee for service for the emergency room undermines the whole thrust of delivery system reform.

The great strength of the current system is that eligible applicants can obtain a real time determination for MassHealth and the Health Safety Net and obtain immediate access to care if needed. It aligns with the real time eligibility determination available in the Connector for ConnectorCare and private insurance. If MassHealth operations are experiencing prolonged

delays in call wait times or in paper processing, those delays do not result in access to care delays for eligible applicants.[v] Massachusetts was not alone in welcoming real time determinations; it is one of nine state Medicaid programs that do not require pre-eligibility income verification.[vi]

It is understandable that the state seeks to save money by eliminating the payment of benefits to individuals who are not eligible; we share with you an interest in achieving more accurate program determinations. However, ending provisional income eligibility comes at the cost of delaying eligibility determinations and access to care for a far greater number of eligible individuals. Further, the change will increase the volume of calls to MassHealth and the volume of paper submitted to MassHealth for processing which will delay all customer-facing operations.

We are also concerned with the anticipated timing for this change in October 2017. This will be just the time that health care providers, enrollment assisters and Navigators will be preparing for the massive shift of MassHealth members into new types of managed care, and for the Connector's next open enrollment period. Returning to a more labor intensive process for new applicants with more calls to MassHealth needed and more documents to be gathered and submitted at application or soon after could not come at a more challenging time for everyone.

Eliminating Provisional Income Eligibility Exacerbates All the "Pain Points" in the Current Eligibility and Enrollment System

Prior to January 2014, MassHealth required income to be verified prior to determining eligibility for most adults. Returning to this practice presents new challenges because of changes in the law and the limited capacity of the new HIX-hCentive eligibility system compared to MA-21 and to most other states' Medicaid programs. We urge MassHealth to increase staffing and upgrade technology to assure timely determinations and access to care in medically urgent situations before it goes forward with this proposal.

Prior to 2014, Massachusetts required proof of income to be submitted as part of a complete application. Medicaid law is now explicit that proof of income cannot be required until a state has first checked electronic data sources.[vii] Prior to 2014, most paper applications were processed within a few weeks of submission. Currently the state is taking the full 45 day time frame for an eligibility determination. Prior to 2014, applications submitted by Virtual Gateway providers had a 3-day window to fax proof of income and a "wet" signature to the Central Processing Unit for a timely decision without issuance of a request for information. Currently, assisters report that it is taking several months for proofs to be processed. Further, prior to 2014, assisters (Virtual Gateway providers) could use My Account Page to see requests for information, deadlines and the dates that MassHealth received documents and processed documents. We are told the new assister portal and on-line accounts do not include this information. See Table 1 for an example of the timely processing challenges without provisional income eligibility.

Long Call Wait Times

Data released by MassHealth for the period from May 2015 to May 2016 show large fluctuations in call wait times and call abandonment rates at the MassHealth Enrollment Centers and the Customer Service Center. While we are told average call wait times are currently 15 minutes, in almost any customer service setting 15 minutes is not an acceptable time to be on hold. Further, we still hear of callers waiting 30 minutes or more on hold. Other limitations of the current telephone system include hours of operation limited to weekday work hours during which MassHealth applicants who are employed may be unable to call, and an automated attendant in English with only a Spanish language option making telephone service difficult to access for individual who speak other languages. Further, because there are only four MassHealth Enrollment Centers with walk-in service, and none located in the population centers of Boston or Worcester, most applicants rely on the telephone system to communicate with MassHealth.

Responding to a request for information often requires one or more calls to MassHealth to understand what proof is required. This is true when notices are not clear, when a person who reads a language other than English or Spanish receives a request for information, or when an applicant is unable to read or has cognitive limitations understanding written material. With provisional eligibility, individuals have coverage while they try to get through to MassHealth. Without provisional eligibility, long call wait times will add delay to eligibility determination and access to care.

Further, eliminating provisional eligibility can be expected to increase call volume. With access to care now tied to document processing, MassHealth can expect more calls about whether proof was received, whether proof has been processed, and requests for expedited processing in urgent care situations. Even after a determination, there are likely to be increased calls relating to retroactive coverage issues: the retroactive date is not correct, providers are billing patients for services provided during the retroactive period, or providers are refusing to reimburse out of pocket costs incurred during the retroactive period.

We strongly urge MassHealth to improve telephone access prior to any change in provisional income eligibility by:

- staffing-up to meet greater volume of calls including expediting medically urgent cases
- improving telephone access when people call to have a notice translated
- providing clearer information about what to submit in notices, member books, and assister training, and
- improving the capacity of HIX-hCentive to display notices, deadline dates and the status of document submissions.

Lengthy Document Processing Times

It is disappointing to see MassHealth proposing to return to a more paper-driven eligibility system instead of focusing on continuing to improve the current HIX system including by extending data matching to more sources, such as unemployment insurance. As we noted above, HIX-hCentive doesn't have the capacity of the legacy Virtual Gateway My Account Page to

display document-related information to on-line users much less to take advantage of newer technologies to submit documents electronically.

MassHealth already handles a massive quantity of paper. Currently, only a delay in processing a paper application or a delay in processing documents needed to reinstate eligibility after a termination will delay an eligibility determination. However, without provisional income eligibility, all applicants whose income is not verified electronically will need to have at least their income documents processed before they can obtain coverage. Paper applicants, of course, must additionally have had their application processed. Again, we do not have current information on MassHealth processing times, but it appears application forms are being processed within 45 days but other documents may take 30-60 days to process. See Table 1 for examples of the problems created by these time frames.

As with call volume, eliminating provisional income eligibility is likely to increase the volume of documents that must be processed. On the one hand, individuals required to submit documents may be more likely to do so if they have immediate care needs. On the other hand, with this change there is likely to be more documentation submitted than is needed. Paper applications continue to make up a significant portion of all applications submitted to MassHealth, and paper applicants have no way to know whether their income will be electronically verified. Many paper applicants who would not otherwise need to submit proof of income may do so to avoid a potential delay in obtaining a determination. If most paper applications are submitted with proof of income it will significantly increase paper volume.

Further, if individuals are not eligible until proof is processed, in addition to added calls checking on the status of proof, there are likely to be multiple submissions of the same proof. This can be expected if applicants cannot easily confirm document receipt and resend documents or if workers enter the self-reported income into the system and trigger an RFI before the accompanying proof of income is entered.

In addition, for individuals needing immediate access to care, MassHealth should expect that hospitals will make greater use of hospital presumptive eligibility and both hospitals and health centers may make greater use of HSN presumptive determinations. This increases the workload for hospitals and health centers and MassHealth workers who must process the presumptive eligibility information in addition to later processing a full application.

Further, the exchange of documents between applicants and MassHealth can be problematic. Currently, homeless individuals can access care right away based on an on-line application or as soon as a paper application is processed. Even if it is difficult for homeless individuals to reliably receive requests for information or gather documents, they have coverage and 90 days to submit required documents. Without provisional income eligibility, they may easily slip through the cracks. For this reason, we are urging MassHealth to add the homeless to those adults who can still obtain provisional income eligibility.

There are still only limited ways of getting documents to MassHealth. MassHealth has only four walk-in centers statewide and none in Boston or Worcester. MassHealth has not upgraded its technology to enable people to upload documents to their on-line accounts like the majority of

state Medicaid programs[viii] or to photograph and submit documents via a smartphone application like DTA Connect www.mass.gov/DTAConnect

Federal regulations allow states to accept a reasonable explanation for a discrepancy in addition to other methods of verification such as documentation. Most state Medicaid take advantage of this option which can avoid needless documentation.[ix]

We strongly urge MassHealth to retain provisional income eligibility for homeless adults and to improve the procedure for processing documents before ending provisional income eligibility for other adults. Such improvements include:

- For on-line applicants, setting up a dedicated fax line or other method to expedite processing proof of income like the current ID-proofing fax line or the earlier 3 day period to fax proofs (& wet signatures) to the CPU for Virtual Gateway applications
- Staffing up to allow for a 2-3 week time frame for processing documents
- Coordinating with the Connector to allow MassHealth applicants to submit documents at Connector walk-in sites
- Upgrading HIX to accept uploaded documents or emailed documents as the majority of other state Medicaid programs and DTA do
- Revising the paper application, RFI for income for adults, member books and notices to be clear that no eligibility decision will be made for adults until income is verified and provide clearer information on acceptable documents
- Retaining provisional income eligibility for adults with disabilities until HIX can electronically verify Social Security Disability Income
- Allowing for a reasonable explanation of a discrepancy to be made on-line or by telephone as the majority of other states do
- And, most importantly, monitoring and reporting on timely processing measured from the date of submission of an application on-line or on paper to the date of the eligibility decision.

Provisional Income Eligibility Should be Retained for the Health Safety Net

The proposed 1115 amendment does not address changes to the Health Safety Net (HSN), but it is our understanding that MassHealth also plans to eliminate provisional income eligibility for adults in the HSN. We strongly object to delaying access to care through the Health Safety Net. Whatever cost savings rationale applies to MassHealth does not apply to the HSN. The Health Safety Net is primarily funded by hospitals and surcharge payers not through state appropriations. The state contribution is likely to be no more than $15 million from the Commonwealth Care Trust Fund in 2018 whether or not there are reduced claims for HSN services. When there is a shortfall, it is borne entirely by the hospitals.

Further, HSN claims were significantly reduced just last year when income eligibility levels for full free care were reduced by 50% of the poverty level and for partial free care by 100% of the poverty level and when retroactive eligibility was reduced from 6 months to 10 days. The HSN does not provide insurance coverage but it does provide important access to care to the uninsured and underinsured and financial support for acute hospitals and community health centers. It is most needed to fill gaps in care such as delays in MassHealth eligibility determinations.

Further, it will only increase administrative burdens to require hospitals to use Hospital Presumptive Eligibility for patients with immediate care needs and for hospitals and health centers to use HSN Presumptive Determinations. Hospital PE and HSN PD do address urgent care situations but double the administrative burdens on providers and MassHealth. Another concern is individuals with time-limited HSN from the date of application, like ConnectorCare beneficiaries. They may be enrolled in ConnectorCare coverage (which will still use provisional eligibility for income) before they even obtain an HSN eligibility determination for a time-limited period that has now elapsed.

For the reasons set forth above, we urge MassHealth to reconsider its plans to eliminate NEMT for adults in CarePlus and provisional income eligibility. If MassHealth goes forward with the provisional eligibility change, systems should be in place to address the expected increase in call volume and in document processing, and no changes should be made for homeless adults or to the Health Safety Net.

Yours truly,

Victoria Pulos, Health Law Attorney
Massachusetts Law Reform Institute

Nancy Lorenz, Senior Attorney
Greater Boston Legal Services

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Mental Health Legal Advisors Committee

Jay McManus, Executive Director
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Ethan Horowitz, Managing Director
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Table 1: Comparison of time from application to eligibility determination with and without provisional income eligibility			
	Current (with PE)	**Proposed (without PE)**	**Key Variables**
Feb. 1 Fax paper application; Mar 1 worker enters info into system (assuming 30 day processing time for applications)	**Application pending**	**Application pending**	**How long from receipt of document to data entry?**
OR Feb. 1 On-line or telephone application	**Provisionally eligible On-line applicant can obtain care**	**Application pending**	
Mar 5 (paper) Feb 5 (on-line) Applicant receives notice & RFI (assuming 4 day for mail)	**Provisionally eligible (Paper) applicant can obtain care**	**Application pending**	**How long to receive mail?**
Mar 5-April 5 (paper) Feb 5-Mar 5 (online) Applicant calling with questions about info needed, applicant gathering docs, applicant submits docs by Fax (assuming 30 days to understand request, gather & submit proof)		**Application pending**	**How long to reach MassHealth to understand request, how long to gather & submit info? Need to call for translation if primary language not English or Spanish**
April 5 (online) May 5 (paper) Worker enters info into system and final notice received by applicant (assuming 30 days processing time for proofs)		**Applicant can obtain care April 5 (on-line) or May 5 (paper)**	**How long from time of document submission for MassHealth to enter info in system? Lost documents? 2d RFI if more proof needed?**
Time from application submission to eligibility decision (assuming 30 days processing for all docs)	**Same day (on-line) 32 days (paper)**	**63 days (on-line) 93 days (paper)**	**45 day legal deadline for eligibility determination from date of application submission**
Time from application submission to eligibility decision (assuming 60 days processing time for proofs)	**Same day (on-line) 32 days (paper)**	**93 days (on-line) 123 days (paper)**	

[i] P. Hughes-Cromwick and R. Wallace, et al., Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation, Transit Cooperative Research Program (Oct. 2005), Retrieved from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

[ii] P. Cheung, J. Wiler, and et. al., National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries, Annals of Emergency Medicine (July 2012), Retrieved from http://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext

[iii] S. Syed, B. Gerber, and L Sharp, Traveling Towards Disease: Transportation Barriers to Health Care Access, Journal of Community Health (Oct. 2013). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215

[iv] U.S. Government Accountability Office, Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage (Jan 2016). Retrieved from http://www.gao.gov/assets/680/674674.pdf

[v] Data released by MassHealth for the period from May 2015 to May 2016 show large fluctuations in call wait times and call abandonment rates at the MassHealth Enrollment Centers and the Customer Service Center. While we have not been able to obtain more recent information, it appears that the system is once more experiencing wait times of 30 minutes or more.

[vi] The other eight states are: CO, CT, DE, HI, MT, NH, OK and WA. Kaiser Commission on Medicaid and the Uninsured, Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost-Sharing Policies in January 2016, Table 10.

[vii] "An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949 or § 435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j) with information provided by or on behalf of the individual." 42 CFR §435.952(c).

[viii] Kaiser Commission on Medicaid and the Uninsured, Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in January 2017, Table 9, "Functions of Online Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January 2017," and Table 10, "Features of Online Medicaid Accounts, January 2017."

[ix] 42 CFR 435.952. 30 of 51 states and DC., Kaiser Commission on Medicaid and the Uninsured, Medicaid and CHIP Eligibility, Enrollment, Renewal and Cost-Sharing Policies in January 2016, Table 10.

mca Marlene Connor Associates LLC

June 12, 2017

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Re: Comments for Demonstration Amendment

I am writing to you today to urge you to not include the waiver of the requirement for NEMT transportation as part of the Medicaid plan for the Commonwealth. I am a public transportation planning consultant in Holyoke with over 20 years of experience working with federal, state and local agencies on a number of public transportation system projects – urban, suburban and rural. Previously I was the CEO of Pioneer Valley Transit Authority in Springfield for seven years and still maintain my connection to the Regional Transit Authorities in Massachusetts as a member of the MARTA Board.

One of the core beliefs I have developed and promoted based on my experiences is that public transportation needs to be viewed as one system, with a family of services to best use resources and serve customers. To promote that belief, I have actively participated in programs and projects such as FTA's United We Ride program and supported the creation of the Coordinating Council on Access and Mobility. The CCAM, which is chaired by DOT, and includes representation from a number of federal agencies and Departments was created by President Bush 2003. Most recently it was reconvened as part of the FAST Act and as required by that legislation, create a strategic plan, develop a cost allocation process between agencies and protocols to share resources/vehicles, and share rides between the agencies and programs. This process is currently underway and in fact a webinar with participating agencies was held last week to gather input nationally.

Historically over 80 federal agencies have been identified having some form of public transportation programs or services, with many of those operating independently. The United We ride process sought to identify opportunities for coordination and collaboration that could improve efficiencies and effectiveness. The largest of the non-FTA programs is Medicaid NEMT, which surpasses the size of many FTA programs.

The family of services concept is based on the logic that by combining all these programs into one system that the sum of these components can act to make the system work as effectively as possible. Conversely, if one transportation program is withdrawn from that system, then all other programs are

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adversely affected. It would be similar to taking one layer from a cake. That layer would be fine, but the rest of the cake would crumble.

This is what will happen if this NEMT waiver is granted. CMS will create its own fiefdom for transportation and have the ability to operate independently from all other federal agencies and departments. Clearly not offering these services or running your own program based on your goals only has the potential to decrease costs for your program. However, not only is the coordinated benefit lost for other programs, but the potential for increases in other program costs are likely. For example, if a client is dually eligible for both ADA paratransit and NEMT transportation and NEMT is not available, the costs will shift solely to ADA, increasing the cost of that program.

Since the CCAM is responsible for developing a strategic plan the CCAM should study the impacts of potential NEMT transportation waivers and report back to Congress before moving forward with a self-centered concept that excludes other federal partners. CMS should suggest the waivers be evaluated as part of the CCAM process to allow for full vetting and input by other CCAM partners since they all will be impacted.

Very Truly Yours,

Marlene Connor
Principal
Marlene Connor Associates

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ACT!! AFFORDABLE CARE TODAY

June 12, 2017

Kaela Konefal
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Boston, MA 02108

Submitted by email to kaela.konefal@state.ma.us

Re: Request to Amend the MassHealth 1115 Demonstration and Related State Plan Amendments

Dear Ms. Konefal,

On behalf of the ACT!! Coalition, thank you for the opportunity to submit comments on MassHealth's proposed 1115 Medicaid Waiver Amendment. We understand the current budget constraints and the potential impact of pending federal policies on the MassHealth program, and we stand ready to work with you to ensure that not one Massachusetts resident loses health coverage. We do, however, have concerns with two changes proposed in the 1115 Waiver Amendment – cuts to non-emergency medical transportation services for MassHealth CarePlus members and elimination of provisional eligibility for most adult applicants – which represent steps backwards in access to care for low-income Massachusetts residents.

Non-Emergency Medical Transportation

Adults who are eligible for Medicaid under the Affordable Care Act (ACA)'s expansion must receive a benefit package that includes non-emergency medical transportation (NEMT).[1] Through the 1115 Waiver Amendment, MassHealth proposes to waive NEMT benefits for MassHealth CarePlus enrollees, except for transportation to substance use disorder (SUD) services. The ACT!! Coalition opposes this proposed change, and strongly urges MassHealth to reconsider eliminating NEMT for travel to most services for MassHealth CarePlus members.

Transportation Barriers Lead to Delayed or Missed Care for Consumers

Low-income consumers, such as those enrolled in MassHealth CarePlus, may not have access to reliable and affordable transportation, impacting their ability to access health care services. This issue may be particularly acute in areas of the state that do not have reliable or affordable public transportation systems, such as Western Massachusetts and Cape Cod and the Islands.

A number of studies suggest that transportation barriers often lead to delayed or missed care for patients. Estimates show that nearly 3.6 million people nationally miss or delay medical care each year because they lack available or affordable transportation.[2] Approximately 25 percent of lower-income

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[1] 42 C.F.R. § 440.390.

[2] P. Hughes-Cromwick and R. Wallace, *et al.*, *Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation,* Transit Cooperative Research Program (Oct. 2005), Retrieved from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

patients have missed or rescheduled their appointments due to lack of transportation[3] and Medicaid enrollees are disproportionately impacted by transportation barriers. Only six-tenths of one percent of those with private insurance reported that transportation was a barrier to accessing timely primary care treatment, while seven percent of Medicaid beneficiaries did so.[4] Because of statistics like these, a January 2016 report by the United States Government Accountability Office concluded that the NEMT benefit "can be an important safety net for enrollees as research has identified the lack of transportation as affecting Medicaid enrollees' access to services."[5]

We have heard stories about how transportation barriers impact consumers' ability to receive the care the care need, and how beneficial the NEMT benefit is for the CarePlus population. For example:

- People with diabetes need access to regular preventive care. Missing or delaying appointments due to transportation barriers could cause their condition to become more serious and more costly.
- People who have cancer may need chemotherapy or radiation up to five times a week, meaning regular, accessible transportation is crucial to their successful treatment, especially if they are immunocompromised. One cancer treatment provider received 3 requests this past week alone for NEMT:
    - A 27 year old man with Metastatic Melanoma needs radiation treatment 5 days a week.
    - A man in his 40s with a recent diagnosis of late stage lung cancer is unemployed and living with his elderly, frail mother who is unable to drive him to radiation appointments. His mother is finding it financially difficult to help her son by paying for taxis 5 days a week. The PT-1 has helped to alleviate both the transportation issue to much needed medical appointments and the financial burden to the patient's mother.
    - A 64 year old woman with gallbladder cancer has had many difficult months of chemotherapy. Access to NEMT is helping her get to these medical appointments as her family members are unable to drive her to all of her treatments due to work and schedule conflicts.

In addition, while we appreciate that the MassHealth CarePlus program will continue to cover transportation for SUD services, many people who struggle with SUD also have co-occurring mental health disorders, and require mental health services to move forward in their recovery. These mental health services may be provided separately from the SUD services, and lack of transportation would impose a barrier to recovery.

While there are no comprehensive national or state-level data about Medicaid member use of NEMT, one company that provides Medicaid NEMT services in 32 states (not including Massachusetts) reported that the most frequently cited reasons for using NEMT are accessing behavioral health services (including mental health and substance abuse treatment), dialysis, preventive services (including doctor visits), specialist visits, physical therapy/rehabilitation, and adult day health care services.[6] Data from

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[3] S. Syed, B. Gerber, and L Sharp*Traveling Towards Disease: Transportation Barriers to Health Care Access*, Journal of Community Health (Oct. 2013). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215.

[4] P. Cheung, J. Wiler, and et. al., *National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries,* Annals of Emergency Medicine (July 2012), Retrieved from http://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext.

[5] U.S. Government Accountability Office, *Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage* (Jan 2016). Retrieved from http://www.gao.gov/assets/680/674674.pdf.

[6] Kaiser Commission on Medicaid and the Uninsured, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, February 24, 2016. Retrieved from http://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/.

other states that have implemented NEMT for expansion populations show that enrollees are utilizing the benefit in increasing numbers to access vital services. In New Jersey and Nevada, use of the benefit has grown over time as enrollees learn about the benefit and gain a better understanding of how to use Medicaid. Additionally, expansion populations are more likely to use the benefit to access cost-effective preventive services than traditional Medicaid populations.[7] According to MassHealth, approximately 13,000 MassHealth CarePlus members utilized NEMT for travel to non-SUD services last year.[8]

Providing Non-Emergency Medical Transportation is Cost-Effective

In addition to helping consumers access the health care services they need, providing NEMT benefits is cost-effective. A study of NEMT and health care access found that NEMT benefits are cost-effective or cost-saving for all 12 medical conditions analyzed, such as prenatal care, asthma, heart disease and diabetes.[9] Additionally, evidence shows that adults who lack transportation to medical care are more likely to have chronic health conditions.[10] Without adequate transportation, these conditions are likely to go unmanaged and eventually lead to costly emergency care and treatment that could have been prevented. While NEMT makes up less than one percent of total national Medicaid expenditures, emergency room visits result in 15 times the cost of routine transportation.[11] Another estimate calculates $11 saved for up to each dollar spent on NEMT if one percent of total medical trips resulted in avoiding an emergency room visit.[12]

In addition, it is worth noting that Massachusetts currently receives 86% in federal reimbursement for MassHealth CarePlus spending. There is no financial benefit to forfeiting that much federal revenue for this needed benefit to keep people from seeking care through acute settings like the ED, including calling an ambulance.

As one hospital social worker in the Berkshires put it: *I have worked in various settings as a social worker for over 30 years, both medical and mental health, as well as inpatient and outpatient. I can tell you that people will find a way to get treatment and without a PT-1, they will call 911 and/or arrive at the emergency room for care. The state will not, in my opinion, save money by eliminating non-emergency medical transportation. Eventually it will cost the state more by an increase in emergency transportation, as well as an increase in acute care for those who go without primary care and other specialty services to treat chronic health problems.*

Moving forward with the elimination of NEMT would not only have negative impacts for MassHealth CarePlus enrollees, but would also set an undesirable precedent for cuts to this critically important

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[7] M. Musumeci and R. Rudowitz, *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers*, The Henry J Kaiser Family Foundation, (February 2016). Retrieved from http://kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/view/footnotes/#footnote-177328-18.

[8] We received these numbers during a FY2018 budget debrief phone call on January 27, 2017.

[9] P. Hughes-Cromwick and R. Wallace, *et al.*, *Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation,* Transit Cooperative Research Program (Oct. 2005), Retrieved from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

[10] R Wallace, P. Hughes-Cromwick, et al, *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, Transportation Research Record: Journal of the Transportation Research Board (Dec 2004) retrieved from http://www.researchgate.net/publication/39967547.

[11] Community Transportation Association. Medicaid NEMT Saves Lives and Money. Retrieved from http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf.

[12] J. Cronin, *Florida Transportation Disadvantaged Programs Return on Investment Study*, Florida State University and Marking Institute.(2008) Retrieved from http://tmi.cob.fsu.edu/roi_final_report_0308.pdf.

service in other states. We urge MassHealth to reconsider its proposal and maintain full NEMT benefits in the MassHealth CarePlus program.

Provisional Eligibility

Current policy and practice enables MassHealth to make real-time eligibility determinations based on self-declared income. When income cannot be verified electronically, applicants are provided with 90 days of provisional eligibility, during which time they are required to verify the self-declared income.

Through this 1115 Waiver Amendment, MassHealth proposes to discontinue its authority to provide 90 days of provisional MassHealth eligibility for adults ages 21 and older when income is unverified, except for the following populations:

- pregnant women with attested MAGI income at or below 200% FPL;
- adults 21 through 64 years old who are HIV positive and have income at or below 200% FPL; and
- adults 21 through 64 with breast or cervical cancer and have income at or below 250% FPL.

We appreciate these exemptions, and that children and youth under age 21 will also continue to be eligible for provisional coverage. We further suggest that homeless adults ages 21 through 64 who check the "No home address" box on the application and have attested MAGI income at or below 133% FPL continue to receive provisional eligibility.

We understand that MassHealth's intent is to enhance program integrity – preventing ineligible people from enrolling in MassHealth. We acknowledge the importance of program integrity in ensuring that only those who are truly eligible for MassHealth are enrolled in the program. However, the ACT!! Coalition opposes the elimination of provisional eligibility, as it will bring the Commonwealth several steps backwards in ensuring timely access to care for adult MassHealth and Health Safety Net (HSN) applicants. Applicants' eligibility determinations especially should not delayed due to factors beyond their control.

Under the 1115 Waiver Amendment proposal, affected adults will not receive an eligibility determination until they have submitted proof of income and the proof is manually processed by MassHealth. ACT!! Coalition member organizations, several of which employ staff who provide application and enrollment assistance, have regularly discussed with MassHealth concerns about delays in processing applications and verifications, long call wait times, processing errors, and other issues that we fear will be exacerbated with this policy change. In addition, use of both hospital-determined and HSN presumptive eligibility may increase with the removal of provisional eligibility, thereby increasing the workload of community health center and hospital-based enrollment assisters and MassHealth workers alike.

We have received feedback from several enrollment assisters about how the proposed elimination of provisional eligibility will negatively impact low-income consumers:

- Most individuals seek out assistance with applying for coverage when they learn that existing coverage has already been terminated, most often when they are in need of medical services. Having access to provisional coverage allows our consumers to get immediate access to medications necessary to ward off a medical crisis, allows them to see their primary care doctor instead of utilizing high cost emergency room care in non-emergent situations, and allows them to continue current treatment even in the event of loss of other coverage.
- I recently worked with an individual whose spouse is currently receiving extensive medical treatment. In an effort to be closer to home and better care for her needs, this individual made a very difficult decision to leave his job, which provided him and his wife with health insurance,

to take another job which will offer health insurance only after 90 days. He was only able to do this because in the interim, she would have access to the care she needs through the Health Safety Net. At the time of the application, a request for information due to a decrease in income was issued. Without provisional coverage, his wife would have had to suspend treatment and would not have been able to pay for medications needed to prevent a potential hospitalization.

- People with hard-to-determine income, such as freelance workers and artists, often experience problems and delays getting appropriate health coverage. This problem was somewhat mitigated with the introduction of provisional eligibility in 2014, and will return with the elimination of provisional coverage.
- As assisters, we often see those applying when they are in great need of services. Having a portal to access instant decisions has been highly beneficial to patients and providers. A patient that is seen in the ER and is able to get on MassHealth right away can go home and take a prescription for his/her condition. Without immediate access to prescription drug coverage, the person would likely return to the ER, the most costly care setting. The goal should be for people to get primary care, not services through the ER.

We ask MassHealth to have the following processes in place before making any changes to provisional eligiblity:

- Give higher priority to HIX enhancements to accept uploaded or emailed documents, as the majority of other state Medicaid programs and DTA do. Currently 33 other states allow Medicaid applicants to scan and upload documents, 29 of which allow upload of verification documents.[13] We appreciate that MassHealth is moving forward on this recommendation.
- Set up a dedicated fax line or other method to expedite processing of proof of income, similar to the identify-proofing fax line or the earlier 3-day period to fax verifications to the Central Processing Unit (CPU) for Virtual Gateway applications.
- Retain the 2-3 week timeframe for processing paper applications, as occurred prior to the Health Insurance Exchange (HIX) system, and engage sufficient staff to meet it.
- Expand staffing to meet greater call volume and larger volume of requests for expedited processing.
- Improve telephone access when people call to have a notice translated by adding more language options and other effective processes.
- Coordinate with the Health Connector to allow MassHealth applicants to submit documents at Health Connector walk-in sites.
- Revise the online and paper application, member booklets and notices to clarify that no eligibility decision will be made for adults until income is verified and provide clearer information on acceptable documents (how many pay stubs, how recent, etc.).
- Monitor and report on timely processing measured from the date of an online or paper application submission to the date of the eligibility decision.
- Maintain provisional eligibility for adults with disabilities until there are no longer delays and other problems in verifying SSDI income with the Social Security Administration (SSA).

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[13] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in January 2017: Findings from a 50-State Survey*. Table 9, "Functions of Online Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January 2017," and Table 10, "Features of Online Medicaid Accounts, January 2017." Retrieved from http://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-findings-from-a-50-state-survey/.

- Allow for a reasonable explanation of a discrepancy to be made online or by telephone as 30 other states and Washington D.C. do.[14]

We would appreciate the opportunity to further discuss these recommendations to ensure adult MassHealth and HSN applicants are able to receive timely eligibility determinations and access to needed services.

MassHealth Coverage for Former Foster Youth

We applaud MassHealth for continuing to cover up to age 26 both former foster youth who have "aged out" of Massachusetts Department of Children and Families (DCF) services as well as those who currently reside in Massachusetts but who lived in a different state as of age 18 or when they "aged out" of foster care. This important ACA provision ensures parity of coverage options between former foster youth and young adults who receive coverage through their parent(s) up to age 26.

The ACT!! Coalition further requests that MassHealth consider policies and procedures that make it easier for former foster youth to maintain coverage, such as automatic re-enrollment until age 26, as recommended in pending state legislation (House Bill 607 and Senate Bill 33, *An Act Ensuring Continuous Healthcare Coverage for Youth Who Have Aged Out of the Department of Children and Families*).

Thank you again for the opportunity to comment on MassHealth's proposed 1115 Waiver Amendment. We look forward to our work together to protect the gains we have made in the Commonwealth and further strengthen health coverage for low-income Massachusetts residents. Should you have any questions, please contact me at (617) 275-2977 or scurry@hcfama.org. Thank you for your time and consideration.

Sincerely,

Suzanne Curry
Associate Director, Policy and Government Relations, Health Care For All
Director, ACT!! Coalition

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[14] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey*. Table 10, "Income Verificatio Procedures Used by Medicaid Agencies at Application, January 2016." Retrieved from http://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey/.

ACT!! Coalition Member Organizations

AARP Massachusetts
Action for Boston Community Development, Inc.
AIDS Action Committee
American Cancer Society Cancer Action Network
American Heart Association / American Stroke Association
Association for Behavioral Healthcare
Boston Center for Independent Living
Boston Children's Hospital
Boston Medical Center
Boston Public Health Commission
Cambridge Health Alliance
Children's Health Access Coalition
Coalition for Social Justice
Committee of Interns and Residents/SEIU Healthcare
Community Catalyst
Community Servings
Disability Policy Consortium
Episcopal City Mission
Families USA
Greater Boston Interfaith Organization
Greater Boston Legal Services
Health Care For All
Healthcare for Artists
Health Law Advocates
Home Care Alliance of Massachusetts
Joint Committee for Children's Health Care in Everett
JRI Health
Massachusetts Academy of Family Physicians
Massachusetts Association of Community Health Workers
Massachusetts Association of Behavioral Health Systems
Massachusetts Breast Cancer Coalition
Massachusetts Building Trades Council
Massachusetts Business Leaders for Quality, Affordable Health Care
Massachusetts Chapter of the American Academy of Pediatrics
Massachusetts College of Emergency Physicians
Massachusetts Communities Action Network
Massachusetts Council of Community Hospitals
Massachusetts Immigrant and Refugee Advocacy (MIRA) Coalition
Massachusetts Health Council
Massachusetts Health & Hospital Association
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Medical Society
Massachusetts Organization for Addiction Recovery
Massachusetts NOW
Massachusetts Public Health Association
NARAL Pro-Choice Massachusetts
National Association of Social Workers – Massachusetts Chapter
Neighbor to Neighbor Massachusetts
Partners HealthCare
Public Policy Institute
32BJ SEIU New England 615
1199 SEIU United Healthcare Workers East
Tobacco Free Mass
Treatment Access Expansion Project
UMass Memorial Health Care