COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID

MassHealth Section 1115 Demonstration Amendment Request

As Posted for Public Comment

October 11, 2024

Table of Contents

Introduction

Background

One Care is the Commonwealth's Medicare-Medicaid Plan (MMP) program currently operating under the authority of an 1115A Duals Demonstration as a Financial Alignment Initiative (FAI) capitated model. Full benefit dual eligible individuals (MassHealth members with Medicare Parts A and B and eligible for Part D) who have MassHealth Standard or CommonHealth, and who meet other One Care participation requirements (e.g., age 21-64 at the time of enrollment, no other source of insurance, etc.) may enroll in One Care plans. In addition, individuals may remain enrolled in One Care when they turn 65 as long as they continue to meet all other participation requirements, including continued eligibility for MassHealth Standard or CommonHealth. One Care offers a managed care enrollment option to these members to receive their MassHealth State Plan services, as well as diversionary behavioral health services, Medicare services, care coordination, and additional community-based services through a managed and integrated delivery system. As of February 2024, over 46,000 MassHealth members were enrolled in a One Care plan.

Senior Care Options (SCO) began as a demonstration in 2004, serving a diverse group of individuals ages 65 and older. SCO plans converted to Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) in 2006. EOHHS holds a Medicaid managed care organization contract with each SCO plan. SCO plans meet the highest level of integration available to D-SNPs, as Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) with exclusively aligned enrollment (i.e., members are enrolled with the same plan for their Medicaid and Medicare coverages). SCO is currently available to eligible MassHealth Standard members with or without Medicare. As of February 2024, SCO served over 78,000 members.

One Care and SCO each provide a comprehensive benefit package designed to address each enrollee's full range of health and functional needs. Coverage through One Care and SCO goes beyond standard Medicare and Medicaid benefits available through fee-for-service and other types of managed care plans. The One Care and SCO plans are accountable for delivering the full range of services with integrated care management and care coordination through Interdisciplinary Care Teams. One Care and SCO plans employ or contract with primary care providers to deliver team-based integrated primary and behavioral health care to enrollees, and direct care coordination across providers. Enrollee care teams, led by a primary care or behavioral health clinician and a care coordinator, arrange care and services across the continuum of services and supports. Within each model, plans have significant flexibility to innovate around care delivery, and to provide a range of community-based services that promote independent living and provide alternatives to high-cost inpatient and facility-based long term care services. The services received by enrollees are driven by their individually assessed needs and a care

plan tailored to their goals and preferences.

Summary of Request

In accordance with federal requirements, MassHealth is preparing to transition One Care from its current Duals Demonstration authority and structure to a FIDE SNP structure, which will provide coverage effective January 1, 2026. Consequently, EOHHS is conducting a procurement that will result in EOHHS entering into a State Medicaid Agency contract (SMAC) with successful One Care FIDE SNPs. In anticipation of this transition, EOHHS seeks to amend its Section 1115 Demonstration to authorize services and enrollment flexibilities for One Care that are currently authorized in Massachusetts' Duals Demonstration. This will allow Massachusetts to preserve the existing member experience and robust benefit package as One Care transitions to a FIDE SNP. EOHHS also seeks to extend these services and flexibilities to its SCO program to create alignment in the models of these two integrated care delivery systems. Specifically, through this amendment, EOHHS seeks authority to:

- Require One Care and SCO plans to cover certain expanded and additional services that enable members with disabilities and older adults to live successfully in the community;

- Implement certain enrollment flexibilities to ensure maximum possible alignment with Medicare enrollments and to prevent or minimize disruption of a member's managed care enrollment; and

- Permit eligible individuals with MassHealth CommonHealth to enroll in SCO when they otherwise meet SCO participation requirements.[1]

To align with the termination of the Commonwealth's Duals Demonstration and the transition of One Care to a FIDE-SNP model, as well as the procurement timeline for both One Care and SCO for 2026, EOHHS is seeking an effective date of January 1, 2026, for these amendments.

Detailed Amendment Requests

I. Coverage of Expanded and Additional Services for Members Enrolled in One Care and SCO Plans

MassHealth is seeking expenditure authority to continue covering the additional community-based and flexible benefit services described in this section for MassHealth members enrolled in One Care, and, as applicable, to provide comparable services for

[1] As part of the Section 1115 Amendment Request submitted by EOHHS in October 2023, EOHHS requested that CommonHealth members' ability to enroll in One Care be preserved; this request remains pending with CMS.

MassHealth members enrolled in SCO.

The additional community-based services currently provided in One Care were initially developed using utilization history for the 21-64 age group from several of Massachusetts' Home and Community-based Services (1915(c) Waivers. Including certain HCBS Waiver-like services in One Care's benefit package created access to independent living and community tenure supports for younger MassHealth adults with disabilities. The set of additional community-based services are similar to many of those available to older adults through the Frail Elder Waiver, SCO, and the state's Home Care Program, improving equity in access for disabled members under age 65 with their elder peers. The services are currently authorized for One Care members through the Commonwealth's Duals Demonstration.

In addition to preserving access to these benefits for One Care enrollees once the Duals Demonstration sunsets, MassHealth also seeks to align benefits between its One Care and SCO programs, where appropriate. Most of the One Care additional community-based services are similar to (or the same as) services available to SCO enrollees as articulated in the Frail Elder Waiver (1915(a)/(c)) for individuals age 60+. Where the scope of some of these services in One Care is broader, MassHealth seeks to apply the same benefit rules to the corresponding services in SCO to simplify program administration and align benefits across populations.

These services are provided to individuals to address needs identified in their functional and comprehensive person-centered assessments. Enrollees work with their One Care or SCO care coordinator to build an individualized care plan based on the needs identified in their assessment. Services facilitate or assist the member to live successfully and independently in the community. Individuals must have one or more disabilities to meet One Care participation requirements. SCO enrollees, whether or not they are enrolled in the Frail Elder Waiver, must have a need for such supports to maintain their independence or remain in the community. Individuals enrolled in SCO may also have originally qualified for Medicare due to a disability. MassHealth may establish specific clinical eligibility criteria for the services. Massachusetts requests that certain of these services be covered as Health-Related Social Needs (HRSN) services. Massachusetts requests that the remaining services be covered as a new set of Independent Community Living Services, outside of the HRSN framework.

A. Health Related Social Needs (HRSN)

1. Background

Massachusetts requests to add the following services to its existing HRSN authority. These services will be available to One Care and SCO enrollees who are assessed to need these services when the services address one or more identified needs in the enrollee's care plan.

a. **Environmental and Home Accessibility Adaptations** – Environmental and physical adaptations that remove or reduce physical barriers to independent living and community tenure.

1) **Environmental Accessibility Adaptations** – Adaptations and modifications to remove or reduce physical barriers to an enrollee's community-based activities, including in an enrollee's place of residence, work, school, transit, or other regularly visited locations.

2) **Home Accessibility Modifications** – Physical adaptations to an enrollee's residence that are necessary to ensure the health, welfare, and safety of an enrollee or that enable the enrollee to function with greater independence in the home. Home modifications, adaptations, and remediation services such as accessibility ramps, handrails, grab bars; mold/pest remediation; adaptations to improve accessibility of functional areas and facilities (e.g. bathroom, kitchen, and laundry facilities, etc.), infrastructure repairs, improvements, and specialized systems (e.g. electric, plumbing, ventilation systems, etc.) necessary for medical equipment, supplies, or to support related adaptations required by the enrollee.

b. **Respite** - Services provided to an enrollee to support their caregiver (e.g., family member, friend, etc.); such services may be provided to relieve informal caregivers from the daily stresses and demands of caring for an enrollee in order to strengthen or support the informal support system. Respite may include short-term room and board.

2. Request

Massachusetts requests to add the services described above to the HRSN services in the Demonstration for One Care and SCO enrollees who are assessed to need these services by their care manager. The services will be part of the enrollee's individual plan of care.

B. Independent Community Living Services

1. Background

Massachusetts requests expenditure authority to add the following services to its Demonstration as new Independent Community Living Services. These services will be available to One Care and SCO enrollees who are assessed to need these services when the services address one or more identified needs in the enrollee's care plan.

a. **Assistive/Adaptive Technology (AT)** – Devices, equipment, accessories, products, and/or methods, whether acquired commercially off the shelf, modified, or customized, that are used to increase, maintain, or improve the functional capabilities, mobility, communication, and overall independence of individuals with disabilities. Coverage includes any changes and modifications to improve or prolong the effective functioning of, or to add

functionality to such devices/items; repairs of such devices or items; and training for enrollees or individuals supporting them in usage.

b. **Home Care Services** - Services provided within the enrollee's home or in the community to support the enrollee's independent living in the community and maintaining community tenure including:

    1) **Household Support:** Assistance with or performance of general household tasks when the enrollee needs them and/or when the person who is regularly responsible for the activities, (such as a family caregiver, friend, or other informal support) is absent, unavailable, or unable to manage the tasks. Household support includes:

        a) **Chore** – Services needed to maintain the home in a clean, sanitary, and safe environment, including minor home repairs, maintenance, and heavy household chores.

        b) **Grocery Shopping and Home Delivery** – Menu planning, ordering, obtaining, and storing groceries; does not include the cost of the food.

        c) **Home-delivered Meals** – Delivered meals for enrollees who need assistance with preparing meals due to functional limitations and/or health conditions. Home-delivered meals support access to a well-balanced diet and meet their individual dietary and nutritional needs, which may be arranged in addition to or instead of a support worker preparing meals in the enrollee's home. Delivered meals shall be appropriate to support medically indicated diets.

        d) **Laundry** – Pick-up, washing, drying, folding, wrapping, and returning laundry as applicable.

    2) **Enrollee Support**: Providing a worker or support person, including Adult Companion, Home Health Aide, Homemaker, or Supportive Home Care Aide, to provide a range of personal support and assistance, and/or companionship to the enrollee. Enrollee support includes:

        a) **Adult Companion** – Non-medical care, supervision, and socialization provided to an adult with functional limitations in accordance with the enrollee's care plan.

        b) **Home Health Aide** – Support activities for enrollees without a skilled nursing need or an ongoing therapy need, when indicated in the enrollee's care plan, including both hands-on assistance and cueing/supervision.

c) **Homemaker** – Performance of other light and routine household tasks for the purpose of maintaining a household (e.g. cooking, cleaning, laundry, medication pick-up and similar errands, changing bedding, etc.).

d) **Supportive Home Care Aide** – For individuals with emotional and/or behavioral challenges, or who have Alzheimer's Disease or Dementia, a Supportive Home Care Aide provides personal care and/or homemaking services, as well as emotional support, socialization, and escort services.

3) **Community Skills Training:** A variety of activities to help the enrollee acquire, retain, or improve their skills related to personal finance, health, shopping, use of community resources, community safety, independence, and other social and adaptive skills to live in the community.

c. **Peer Supports:** Services provided by an individual with a disability with lived experience that support and empower an individual with a disability to navigate everyday barriers and challenges related to their disability in choosing to live independently at home or in the community. These peer supports are available from an independent living perspective.

d. **Personal Assistance Services**

1) **Cueing and Monitoring** – A prompt or direction to assist an individual who needs assistance that is not physical in nature in performing activities they are physically capable of performing, but unable to independently initiate.

2) **Agency Model –** Personal care services purchased from an agency, rather than through the enrollee as employer model.

e. **Structured and Supportive Day Services** - onsite structured day activity and support in a provider-operated group setting in the community. Services focus on the enrollee's strengths and abilities while maintaining the enrollee's connection to the community and helping them to retain their daily skills. Such Day Services are beyond the scope of Adult Day Health or Day Habilitation described in the State Plan but may reinforce some aspects of other covered services by allowing individuals to continue to strengthen skills necessary for greater independence, productivity, and community inclusion. Such day services are individually designed around consumer choice and preferences with a focus on improvement or maintenance of the person's skills and their ability to live as independently as possible in the community.

f. **Transportation (Non-medical)** - services within the community, beyond the scope of Medically Necessary Non-Emergency Medical Transport (NEMT) services described in the State plan. Non-medical transportation services

shall be simply and flexibly accessible to the enrollee, and shall be provided, in accordance with the enrollee's care plan, to enable the enrollee to access community services, activities, and resources, and to reduce isolation, in order to foster the enrollee's independence and support integration and full participation in their community.

2. Request

Massachusetts requests expenditure authority to add the services described above to its Demonstration for One Care and SCO enrollees who are assessed to need these services by their care manager. The services will be part of the enrollee's individual plan of care.

C. Flexible Benefits[2]

1. Background

Flexible Benefits are currently offered by One Care plans to promote independent living or recovery, positively impact outcomes, or address access or other barriers to achieving goals in the enrollee's care plan. They are specified in the enrollee's care plan and individualized as appropriate to address the enrollee's needs. One Care plans are required to authorize service requests for Flexible Benefits in the enrollee's individualized care plan that promote independent living or recovery, positively impact member outcomes, or address barriers to achieving goals in the enrollee's care plan.

Massachusetts is requesting authority to require One Care and SCO plans to cover these services as additional benefits under 42 CFR 438.3(e)(1)(i).

Flexible Benefits act as a mechanism for a One Care plan or SCO plan to provide a support that the plan is unable to operationalize through covered services, including items or services other than, or beyond the amount, duration, and scope of One Care plan or SCO plan covered services.

Flexible Benefits meet one or more of the following criteria:

- **Facilitates a Care Plan Goal** – the requested service or item supports progress toward an enrollee's goal in their care plan or addresses a barrier to an enrollee goal (e.g. for a member who needs to start using an adjustable bed to support self-transfers to their wheelchair, but does not want to sleep separately from their partner, providing a commercially available queen size adjustable bed – instead of a smaller hospital bed –

[2] Flexible Benefits for One Care and SCO enrollees are distinct from the Commonwealth's legacy Flexible Services Program that was authorized under the state's Delivery System Reform Incentive Payment (DSRIP) program.

would better meet the member's functional and accessibility needs while also addressing their individual goals and preferences);

- **Advances Enrollee Independent Living, Health, or Quality Outcomes –** the requested service or item promotes, contributes to, or mitigates a barrier to the member's health, wellness, independence, recovery, or functioning, it improves the quality or effectiveness of other services, or it improves enrollee health or quality outcomes (e.g., a member with low vision moved into an unfamiliar neighborhood and has been challenged in finding an accessible route to nearby shops. The member could order necessary food and supplies to be delivered or mailed, but really wants to learn their way around the neighborhood so they can be more self-reliant and active. A sighted guide accompanies the member on daily errands and outings during their first few weeks in the new neighborhood to help identify routes to the member's new regular destinations);

- **Reduces/Avoids Social Isolation** – Facilitates enrollee's connection to, and ability to participate in, their community(ies), including when the enrollee's health or functioning interferes with their preferred or prior mode of participation (e.g., a sculptor can no longer practice their art due to progressive muscle weakness and has developed anxiety and depression due to this loss. A membership and regular transportation to an art museum could reduce the sculptor's anxiety and depression and reconnect them with the art community);

- **Conserves Enrollee's Capacity** – Maintains, protects, improves, or extends enrollee's overall capacity and/or functioning (e.g., such as by enabling enrollee to allocate energy consistent with their goals and priorities by facilitating an alternate approach or providing coverage for an energy intensive task);

- **Cost Effective** – Avoids or reduces costs that would likewise otherwise be incurred under covered services (e.g., instead of bags covered through DME that frequently get caught and rip, a durable backpack for a wheelchair user's IV equipment).

2. Request

EOHHS seeks authority to require One Care and SCO plans to provide Flexible Benefits as additional benefits under 42 CFR 438.3(e)(1)(i). Plans would be required to identify and report funding used for Flexible Benefits in their financial reporting; Flexible Benefit spending could be counted as service expenditures in the calculation of plan Medicaid Medical Loss Ratios (MLRs) but would not be included when determining capitation rates for plans. Expenditures for Flexible Benefits are expected to be de minimis (likely less than 0.5% of capitation) and, in accordance with 42 CFR 438.3(e)(1)(i), such expenditures would be excluded from rate-setting.

II. Enrollment Flexibilities for Integrated Care Programs

A. Medicaid Monthly Enrollments and Aligned Coverage

1. Background

Massachusetts has structured its One Care and SCO programs to achieve the highest possible level of Medicare-Medicaid integration, including by requiring plans to operate as FIDE SNPs and requiring exclusively aligned enrollment for dual eligible individuals for both One Care and SCO.

MassHealth members must have full Medicare and Medicaid coverage as a participation requirement for One Care. While a small percentage of SCO enrollees are Medicaid-only members, most SCO enrollees are also full-benefit dual eligibles. Aligning the timing of Medicare and Medicaid enrollments and disenrollments helps achieve this integration goal. Where Medicare enrollments are always monthly, Medicaid enrollments for One Care and SCO must also continue to be monthly. Specifically:

a. Enrollment in a One Care plan or a SCO plan will be monthly, with changes, including enrollment and disenrollment, effective on the first day of a calendar month.

b. When a One Care or SCO enrollee loses Medicaid eligibility, plan enrollment continues through the end of the calendar month in which the enrollee's last eligible day occurs, except when extended to align Medicaid with Medicare enrollments and coverage as described below.

c. Capitation payments are for monthly periods of enrollment. MassHealth may pay monthly capitation for One Care plan and SCO plan enrollees with one or more eligible days within the calendar month.

Medicare regulations at 42 CFR 422.52(d) permit Medicare Advantage Special Needs Plans to maintain enrollees' eligibility for their Medicare plan when the individual no longer meets Medicaid eligibility criteria but can reasonably be expected to meet the criteria again within a certain time period (not less than 30 days but not to exceed 6 months). D-SNPs must provide such enrollees with at least 30 days advance notice prior to disenrollment from their Medicare plan (see Medicare Managed Care Manual, Chapter 2, Section 50.2.5). In practice, this means that Medicare coverage through the D-SNP will nearly always continue for at least the next calendar month. Plans receive Medicare Part A/B and Part D capitation payments from CMS for enrollees' Medicare coverage during such periods.

As part of the FAI Duals Demonstrations, CMS allowed Medicare-Medicaid Plans (MMPs) to match this Medicare rule with aligned Medicaid enrollment and coverage[3]. Under Massachusetts' Duals Demonstration, One Care aligns

[3] Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (version effective 10/12/2023), Section 40.2.3.2 "Optional Period of Deemed Continued Eligibility Due to Loss of Medicaid Eligibility for MMP Enrollees. Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (rev. 10122023) (cms.gov)

Medicare and Medicaid enrollment and coverage, permitting individuals to remain enrolled in their One Care plan for their Medicaid coverage for the duration of their Medicare enrollment. One Care plans are required to assist enrollees who lose Medicaid eligibility for a potentially resolvable reason (such as unreturned paperwork) with restoring their Medicaid eligibility. If Medicaid eligibility is restored, MassHealth retroactively pays Medicaid capitation to the plan for any month during which the member was enrolled and had at least one Medicaid eligible day.

EOHHS seeks to allow One Care and SCO enrollees whose Medicaid eligibility is downgraded or closed for a potentially resolvable reason to remain enrolled in their One Care or SCO plan, which will align their Medicaid coverage with their Medicare enrollment and coverage through the D-SNP. Aligning Medicare and Medicaid coverage and enrollments minimizes disruptions in coverage and enrollment and supports continuity and enrollee access to care.

2. Request

Massachusetts seeks expenditure authority to make capitation payments to One Care and SCO plans during partial eligibility months as follows:

a. **Capitation Payments for Months with Partial Eligibility** – For individuals enrolled in a One Care or SCO plan who lose Medicaid eligibility during the month, EOHHS seeks expenditure authority to pay the One Care or SCO plan for the full month and for such individuals to remain enrolled in their One Care or SCO plan for Medicaid coverage for the full calendar month.

b. **Retroactive Capitation Payments for Months with Partial Eligibility** – For One Care and SCO plan enrollees who remain enrolled in the D-SNP for their Medicare coverage during a loss of Medicaid eligibility, EOHHS seeks expenditure authority to make retroactive capitation payments to the One Care or SCO plan for any month during which the individual restored their Medicaid eligibility and had at least one Medicaid eligible day.

B. Allow CommonHealth Members to Enroll in SCO

1. Background

Through the 1115 Demonstration, MassHealth CommonHealth provides coverage to adults with disabilities at higher income and asset levels than available through MassHealth Standard. In addition, adults aged 65 and over who do not meet MassHealth Standard requirements may enroll in CommonHealth when they have disabilities that would meet the federal definition of “permanent and total disability” if they were under age 65. Individuals in MassHealth CommonHealth receive the same benefits as those available under MassHealth Standard.

Both MassHealth Standard and MassHealth CommonHealth members are eligible to enroll in a One Care plan, and this same Standard and

CommonHealth eligibility has extended to One Care enrollees who remain enrolled in One Care after they turn age 65. Currently, only MassHealth Standard members are eligible for SCO.

In 2022, EOHHS expanded eligibility for MassHealth CommonHealth to allow individuals who have had CommonHealth coverage for at least 10 years to keep that coverage after age 65, regardless of employment status. MassHealth expects a growing number of individuals ages 65+ will enroll in CommonHealth as they age.

In fall 2023, EOHHS proposed amendments to the Demonstration that would further codify the option for CommonHealth members to enroll in One Care as it moves forward with its transition to a D-SNP model. EOHHS now seeks to amend the Demonstration to make SCO a delivery system option for MassHealth CommonHealth members ages 65+.

2. Request

EOHHS requests an amendment to its Demonstration Special Terms and Conditions to specify that MassHealth CommonHealth members ages 65 and older may elect SCO as their delivery system for their Medicaid coverage. EOHHS believes this will not require any changes to existing 1115 waiver or expenditure authorities. We request this option be effective January 1, 2026.

Summary of Waiver and Expenditure Authorities Requested

The table below lists the waivers and expenditure authorities the Commonwealth is seeking to support the policies described above.

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
I.A. Add Environmental and Home Accessibility Adaptations and Respite as Health Related Social Needs (HRSN)	Add Environmental and Home Accessibility Adaptations and Respite as Health-Related Social Needs services under existing expenditure authority 22 and STC 15, including all related waivers applicable to HRSN services in the current demonstration	
I.B. Add Independent Community Living Services as New Covered Services for	Expenditure Authority for the provision of Independent Community Living services in One	

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
One Care and SCO	Care and SCO	
I.C. Require coverage of Flexible Benefits in One Care and SCO	Authority to vary from 42 CFR 438.3(e)(1)(i) in that the provision of Flexible Benefits will be required of One Care and SCO plans	42 CFR 438.3(e)(1)(i)
II.A. Medicaid Monthly Enrollment and Aligned Coverage	Expenditure authority to make monthly capitation payments for enrollees with 1 or more eligible days during a month they are enrolled in a One Care or SCO plan Authority to limit enrollments to and disenrollments from One Care and SCO to monthly segments	
II.B. Allow CommonHealth Members to Enroll in SCO	Clarify delivery system enrollment options for CommonHealth Adults in the STCs under existing expenditure authority #1 for expenditures for CommonHealth Adults	

Budget Neutrality

Budget neutrality prior to amendment

The Commonwealth's projected budget neutrality cushion as of the quarterly report for the quarter ending June 2022 is approximately $28.2 billion total, of which $6.2 billion is attributable to the SFY 2018-2022 waiver period [4,5]. This estimate incorporates projected expenditures and member months through SFY 2022 as reported through the quarter ending June 30, 2022. This budget neutrality calculation reflects significant realized and anticipated savings.

Effect of amendment

As reflected in the accompanying budget neutrality workbook, this amendment results in $41.6 million in costs to the MassHealth program and expenditures under the demonstration. For the calculation of the budget neutrality impact, the expenditures for the proposed amendments will decrease the budget neutrality cushion by $18.6M. The proposed amendments to add environmental and home accessibility adaptations and respite as health-related social needs, and to allow CommonHealth members to enroll in SCO will fall under hypothetical MEGs will have no impact on the budget neutrality cushion. Overall, after integrating the proposed amendments, the Commonwealth and the federal government would continue to realize savings on the demonstration.

The attached budget neutrality workbook contains a data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. This analysis includes current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, by eligibility group.

[4] The budget neutrality cushion as of the quarterly report for the quarter ending September 30, 2020, includes member month and actual expenditure data as reported in the CMS-64 report for the corresponding time period. Safety Net Care Pool spending included in the calculation reflects figures as reported in the budget neutrality agreement approved by CMS on November 4, 2016.

[5] Note, CMS introduced a savings phase-out methodology to the Budget Neutrality calculation so that the Commonwealth may only carry forward 25% of selected population-based savings each year between SFY18-22.

Evaluation

The currently approved demonstration seeks to advance five goals; the Commonwealth proposes to update Goal 1 to incorporate the goals of the requests related to One Care and SCO:

- Goal 1: Continue the path of restructuring and reaffirm accountable, value-based care, including:
    - Increasing expectations for how ACOs improve care and trend management, and refining the model; and
    - Improving integration, supporting independent living, and preserving community tenure through comprehensive, person-centered models of care and benefits in One Care and SCO.
- Goal 2: Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and move the delivery system away from siloed, fee-for-service health care;
- Goal 3: Continue to improve access to and quality and equity of care, with a focus on initiatives addressing health-related social needs and specific improvement areas relating to health quality and equity, including maternal health and health care for justice-involved individuals who are in the community;
- Goal 4: Support the Commonwealth's safety net, including ongoing, predictable funding for safety net providers, with a continued linkage to accountable care; and
- Goal 5: Maintain near-universal coverage including updates to eligibility policies to support coverage and equity.

The general impact of the amendment on the evaluation of the waiver is described below:

- Amendment request #I.A (Expanded Health Related Social Needs (HRSN)) seeks to advance Goal #3 by expanding the availability of certain HRSN services to One Care and SCO enrollees (to the extent such services vary from Frail Elder Waiver services).
- Amendment request #I.B (Independent Community Living Services) seeks to advance Goal #1 by preserving authority for One Care

members – and adding authority for SCO members (to the extent such services vary from Frail Elder Waiver services) – to access services that support independent living and preserve community tenure through person-centered benefits.

- Amendment request #I.C (Flexible Benefits) seeks to advance Goal #1 by providing access for One Care and SCO members to services that support independent living and preserve community tenure through the implementation of person-centered care plans.

- Amendment request #II.A (Medicaid Monthly Enrollment and Aligned Coverage) seeks to advance Goals #1 and #5 by improving integration of Medicare and Medicaid services through aligned enrollment periods and maintaining access Medicaid coverage for vulnerable populations.

- Amendment request #II.B (Allow CommonHealth Members to Enroll in SCO) seeks to advance Goals #1 and #2 by creating access for CommonHealth members to elect SCO as an alternative to MassHealth FFS for their Medicaid coverage.

Public Process

The public process for submitting this amendment conforms with the requirements of STC 15, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements as outlined in the Commonwealth's approved State Plan. In addition, the Commonwealth has implemented certain of the transparency and public notice requirements outlined in 42 CFR § 431.408, although the regulations are not specifically applicable to demonstration amendments. The Commonwealth is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Notice

The Commonwealth released the amendment for public comment starting on October 11, 2024. The public notice, the Amendment Request, which included the Budget Neutrality Impact section, and a Fact Sheet (including the instructions for submitting comments) were posted on the MassHealth website https://www.mass.gov/info-details/1115-masshealth-demonstration-waiver, and the public notice with a link to the MassHealth website was also published in the Boston Globe, Worcester Telegram & Gazette and the Springfield Republican on October 11, 2024.

Tribal Consultation

MassHealth provided a summary of the Amendment through an email to all Tribal leaders or their designees and additional Tribal health contacts on October 11, 2024. The summary included links to the documents and instructions for providing comment.

Public Meeting

The Commonwealth will host a virtual listening session to seek input regarding the amendment. The session will include a presentation on the proposed changes and an opportunity for public testimony. The listening session will be held October 23, 2024 from 11 a.m. to 12 p.m. at One Ashburton Place, 2nd Floor, Boston, MA 02108 and will be available at this link and phone number Join from PC, Mac, Linux, iOS or Android: https://umassmed.zoom.us/j/94314751050?pwd=POwYqn6KhxtxIBcZYpxZYNVtN1YQJp.1

Password: 462264

Or iPhone one-tap (US Toll): +13017158592,94314751050# or +13052241968,94314751050#

Or Telephone:

Dial:

+1 301 715 8592 (US Toll)

+1 305 224 1968 (US Toll)

+1 309 205 3325 (US Toll)

+1 312 626 6799 (US Toll)

+1 646 876 9923 (US Toll)

+1 646 931 3860 (US Toll)

+1 669 900 6833 (US Toll)

+1 689 278 1000 (US Toll)

+1 719 359 4580 (US Toll)

+1 253 205 0468 (US Toll)

+1 253 215 8782 (US Toll)

+1 346 248 7799 (US Toll)

+1 360 209 5623 (US Toll)

+1 386 347 5053 (US Toll)

+1 507 473 4847 (US Toll)

+1 564 217 2000 (US Toll)

+1 669 444 9171 (US Toll)

Meeting ID: 943 1475 1050

Password: 462264

International numbers available: https://umassmed.zoom.us/u/ac6igBTuVH

Reasonable Accommodation: If you require an ADA accommodation for either the in-person or virtual option, please contact 1115WaiverComments@mass.gov.

.

Conclusion

The proposed flexibilities described in the demonstration amendment request build on lessons learned from the Commonwealth's Duals Demonstration and SCO, the current FIDE SNP program to provide integrated, comprehensive care. These requests, as well as the pending request submitted in October 2023 to preserve CommonHealth Members' Ability to Enroll in One Care, seek to preserve access to independent living and person-centered individualized supports, and to improve and simplify member access to care. These flexibilities will allow Massachusetts to preserve certain benefits that have been available to MassHealth members through the Duals Demonstration, and to avoid removing benefits and access that our members with disabilities and older adults have had for over a decade. Finally, the flexibility will also allow the state to maintain alignment with the Medicare coverage available to our members through One Care and SCO, upon the expiration of the Duals Demonstration.

The Commonwealth appreciates this opportunity to amend our 1115 demonstration and to continue to work with CMS to improve health care quality and outcomes, as well as independent living, for the people of the Commonwealth.

State Contact

Mike Levine
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place,
Boston, MA 02108
617-573-1770