The MassHealth Proposed Demonstration Extension 2022–2027:

Building on Success, Focusing on Equity

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I. INTRODUCTION

MassHealth is Massachusetts' combined Medicaid program and Children's Health Insurance Program (CHIP), providing coverage to more than one in four Massachusetts residents. Each state runs its own Medicaid program and those programs must meet certain federal standards unless the state obtains a "demonstration waiver" from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid. Demonstration waivers must be renewed (or "extended") periodically (typically every 5 years). Massachusetts administers much of MassHealth under a "demonstration waiver" (referred to in this report as the Demonstration), which it has extended several times since it was originally approved in 1995. On December 22, 2021, Massachusetts submitted to CMS a request to extend its demonstration once again.[1] The request unveiled Massachusetts' vision for MassHealth over the next five years, including many new initiatives. Health equity took center stage in the Demonstration request, informing the vision and new initiatives.

This report describes the proposed MassHealth Demonstration extension, what it means for MassHealth coverage moving forward, and implications for members, providers, and Massachusetts.

II. BACKGROUND

For many years, Massachusetts policymakers, consumer advocates, providers, and others have sought to undertake reforms and adopt innovations to make health care more accessible to all Massachusetts residents, and to motivate the continuing improvement of the quality of that care. An important tool in accomplishing those objectives is MassHealth. At its essence, MassHealth is a public health insurance program, providing needed care to Massachusetts residents who have low incomes. But Massachusetts has used MassHealth more ambitiously by taking advantage of opportunities in federal law—demonstration waivers—to try out program innovations that otherwise would not be permitted by federal Medicaid rules and guidelines. Through these waivers, Massachusetts has improved access to insurance coverage for adults with low incomes; it has also reformed the delivery system to better coordinate care and even attempted to address certain members' health-related social needs, such as housing and food insecurity.

Section 1115 of the Social Security Act allows states to request a waiver of certain sections of the federal Medicaid law in order to introduce an "experimental, pilot, or demonstration project which, in the judgment of the Secretary [of Health and Human Services], is likely to assist in promoting the objectives of" the Medicaid program. Through a series of initiatives authorized as a Section 1115 Demonstration, sometimes called "the MassHealth waiver," Massachusetts has used MassHealth as the engine for many important health care system reforms.

BRIEF HISTORY OF THE MASSHEALTH DEMONSTRATION

The original MassHealth Demonstration was approved in 1995 and went into effect on July 1, 1997. It has since been extended six times, often with major revisions to reflect new or expanded goals. The first iteration of the Demonstration focused on expanding eligibility to about 300,000 additional Massachusetts residents, introducing managed care to the MassHealth program, and instituting "supplemental payments" (payments to hospitals and health plans that treat large numbers of MassHealth members, and which are not payments for specific services) for the purpose of supporting "safety net" providers.

BUDGET NEUTRALITY

Federal support for state demonstrations is not a blank check. Approval depends on a state being able to show that its program will be "budget neutral" (meaning that the demonstration will not require more federal spending than what would be required without a demonstration). The budget neutrality methodology compares the projected "with waiver" spending with hypothetical spending in a "without waiver" program. For the current Demonstration extension request, Massachusetts estimates that projected with-waiver expenditures from State Fiscal Year (SFY) 2018 to 2027 will be approximately $75 billion less than projected expenditures in the absence of the Demonstration. A recently instituted change in CMS budget neutrality rules means that Massachusetts cannot count this entire amount as savings from the Demonstration. Still, Massachusetts projects that its budget neutrality "cushion" will be $12.6 billion for the period SFY 2018 through 2027.

The next significant revision of the Demonstration—in 2005, with an amendment in 2006—allowed lawmakers to use MassHealth as the vehicle for central features of the Commonwealth's 2006 health reform law. Supplemental payments were repurposed and combined with another source of payments to create the Safety Net Care Pool (SNCP) of funding for hospitals serving disproportionate shares of patients who were MassHealth members or had no health insurance. Some of the SNCP was used to support providers' delivery of uncompensated care (health care or services provided by hospitals or health care providers that don't get reimbursed) to uninsured patients. The SNCP also funded subsidies for the purchase of private health insurance by people with low and moderate incomes who did not qualify for MassHealth. This was the genesis of Commonwealth Care, a subsidized health plan now called ConnectorCare, and the Health Connector, the Commonwealth's health insurance marketplace. The 2006 Massachusetts reform, with the MassHealth Demonstration as a key part of its structure, was the model for the marketplace and subsidy structure enacted in the federal Affordable Care Act in 2010.

These earlier iterations of the Demonstration focused more effort on expanding coverage (though not to the exclusion of other goals). MassHealth now provides the foundation for coverage in the state with the nation's highest level of health insurance coverage: In 2019, 97.1 percent of the Massachusetts population had health insurance coverage, including 98.4 percent of its children.[2] More recent Demonstration renewals, beginning in 2011, began to reform delivery and payment systems, creating initiatives to promote better access to needed services, better coordination of those services, and improved quality and value of health care. In 2011, Massachusetts introduced Delivery System Transformation Initiatives (DSTI) to finance efforts to enhance patient access, improve quality of care, and expand use of alternative payment models in seven "safety net" hospitals serving high numbers of low-income and uninsured patients. Alternative payments are structured to motivate changes in the delivery of care by rewarding the quality of care and positive health outcomes, rather than simply paying a fee for every service that is delivered.

In 2015, MassHealth used the Demonstration to create a Public Hospital Transformation and Incentive Initiative (PHTII), which used funds that formerly were supplemental hospital payments to provide support and incentives to Cambridge Health Alliance (the Commonwealth's only non-state-owned public hospital) for primary care and behavioral health initiatives. Infrastructure and Capacity Building grants also offered support for similar reforms to hospitals and community health centers not eligible for DSTI. The SNCP and coverage expansions continued, and targeted new programs were added as well. These initiatives set the stage for the ambitious introduction of Accountable Care Organizations (ACO) and accompanying payment model demonstrations in the 2017 Demonstration.[3]

Figure 1 shows a timeline of the major reforms included in the MassHealth Demonstration over its history.

FIGURE 1. MAJOR MASSHEALTH REFORMS IMPLEMENTED THROUGH 1115 DEMONSTRATION WAIVERS, 1997–2017

Cycle	Year	Reforms
INITIAL DEMONSTRATION CYCLE	1997	Expanded eligibility by about 300,000 Introduced managed care Introduced supplemental payments
SECOND CYCLE	2002	Extended the same terms and conditions as the original five-year waiver
THIRD CYCLE	2005	Created Safety Net Care Pool Created Commonwealth Care 2006: Massachusetts Health Care Reform Bill (Chapter 58 of the Acts of 2006) enacted
FOURTH CYCLE	2008	Set savings targets
FIFTH CYCLE	2011	Created Delivery System Transformation Incentives (DSTI) 2014: Conformed with Affordable Care Act
SIXTH CYCLE	2015	Created Public Hospital Transformation and Incentive Initiative
SEVENTH CYCLE	2017–2022	Created Accountable Care Organizations, Community Partners, and the Flexible Services Program Expanded substance use disorder services

THE CURRENT DEMONSTRATION

The current Demonstration was approved on November 4, 2016. It began July 1, 2017, and was set to expire after five years (on June 30, 2022); CMS recently approved a temporary extension of the current waiver through September 30, 2022, to allow CMS and MassHealth time to finalize their negotiations over the proposed five-year Demonstration extension. The centerpiece of the current Demonstration is delivery system restructuring, including:

- **Accountable Care Organizations (ACO)**: Provider-led entities that enter into population-based payment models (contracts) with payers (in this case, the payer is MassHealth), where the ACO is held financially accountable for the cost and quality of care of its member population.
- **Community Partners (CP)**: Community-based organizations that work with ACOs and managed care organizations (MCO) to offer support services for members with extensive long-term services and supports[4] (LTSS) and/or behavioral health needs.
- **Delivery System Reform Incentive Payments (DSRIP)**: Time-limited funding to support the development of ACOs and CPs, Statewide Investments in workforce development, preparation for alternative payment models that reward quality and positive health outcomes, and improved care management, care coordination, and program navigation.
- **Flexible Services Program (FSP)**: A pilot initiative to offer services that address certain eligible members' health-related social needs, such as housing instability and food insecurity, which affect health. These services are not typically covered by MassHealth.[5]

The expansion of **substance use disorder (SUD) services** is another important feature of the current Demonstration.

These reforms have seen a measure of success in the first few years. According to an independent interim evaluation of the Demonstration, patients reported satisfaction with coverage, there were increasing rates of primary care visits and decreasing rates of low-value care, many ACOs, CPs, and FSPs reported positive outcomes, and costs largely stayed within range.[6] However, the evaluation notes opportunities for improvement, including:

- ACOs are not completing screenings of health-related social needs at expected rates.[7] These needs—housing, nutrition, transportation—are critical to members' health, for which ACOs are accountable.
- There are opportunities to improve collection of race, ethnicity, language, and disability data from MassHealth members to better understand how payment and delivery system reforms affect different groups.
- Methods of payment to ACOs, meant to incentivize attention to improved health outcomes by incorporating measures of value and risk, are not always reflected in how ACOs pay primary care practices.[8]

GOALS OF THE EXTENSION REQUEST

The current Demonstration will expire on September 30, 2022, and Massachusetts is working towards getting a new Demonstration agreement in place by then. As part of that process, Massachusetts submitted a Demonstration request to CMS on December 22, 2021. This request largely aims to continue and improve upon the programs and initiatives that are a part of the current Demonstration. It focuses on improving health outcomes and reducing health inequities, as articulated in these five stated goals:

1. Continue the path of restructuring and re-affirm accountable, value-based care [by] increasing expectations for how ACOs improve care, and refining the [ACO and CP] model[s].
2. Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and [continue to] move the delivery system away from siloed, fee-for-service health care.

3. Advance health equity, with a focus on initiatives addressing health-related social needs [social barriers to health such as housing instability and food insecurity] and specific disparities, including maternal health and health care for justice-involved individuals.

4. Sustainably support the Commonwealth's safety net [through] level, predictable funding for safety net providers.

5. Maintain near-universal coverage, [through] updates to eligibility policies to support coverage and equity.[9]

Along with requests to continue authorization of many services and supports from the current Demonstration, this extension proposal would restructure delivery of care and payment models to promote integrated and coordinated care across physical health, behavioral health, and LTSS. The following Sections III through VIII describe the details of the Demonstration request in these categories:

- Improving delivery system reforms
- Enhancing services and supports
- Updating eligibility policies
- Advancing health equity
- Investing in primary care and behavioral health
- Sustaining the Safety Net Care Pool

A discussion of the status and timeline for the Demonstration request and the implications of the request for various stakeholder groups follows.

III. IMPROVING DELIVERY SYSTEM REFORMS

To build on the progress made under the current Demonstration and make improvements where necessary, Massachusetts is asking for continued authority for ACOs, CPs, and the FSP. In response to challenges identified through the interim evaluation, Massachusetts is requesting some changes to these programs, described below. Furthermore, as $1.8 billion in DSRIP funding for MassHealth payment and delivery reforms comes to an end, MassHealth is incorporating what it has learned from the last few years about effective models of care and is requesting to transition approximately 80 percent of current DSRIP funding levels into sustainable base funding for primary care, health-related social needs, and care coordination (see Appendix).

UPDATES TO THE ACCOUNTABLE CARE ORGANIZATION PROGRAM

CURRENT STRUCTURE OF THE ACO PROGRAM

When the ACO program began in 2018, three models of ACO were available. The models vary in their management of clinical and financial responsibilities, in the networks of doctors and other health care providers they include, in how MassHealth pays them, and in their relationships to MCOs. MCOs perform financial and administrative functions usually associated with an insurer, such as assembling a network, and authorizing and paying for services. The three ACO models were:

- **Accountable Care Partnership Plans** (also known as "Model A ACOs"), provider-led entities that partner with MCOs. Partnership Plans receive a set monthly payment per member from MassHealth and operate a provider network. As of June 2021, there were about 660,000 members in 13 Model A ACOs.

- **Primary Care ACOs** ("Model B ACOs"), provider-led entities that are paid for provided services and held accountable by MassHealth for the cost of care provided through a calculation of shared savings and shared losses against a benchmark spending target. As of June 2021, there were about 450,000 members in three Model B ACOs.

- **MCO-Administered ACOs** ("Model C ACOs"), provider-led organizations that contract with MCOs and are held accountable for the cost of care provided through shared savings and shared losses similar to Model B ACOs. As of June 2021, there were about 11,000 members in one Model C ACO.

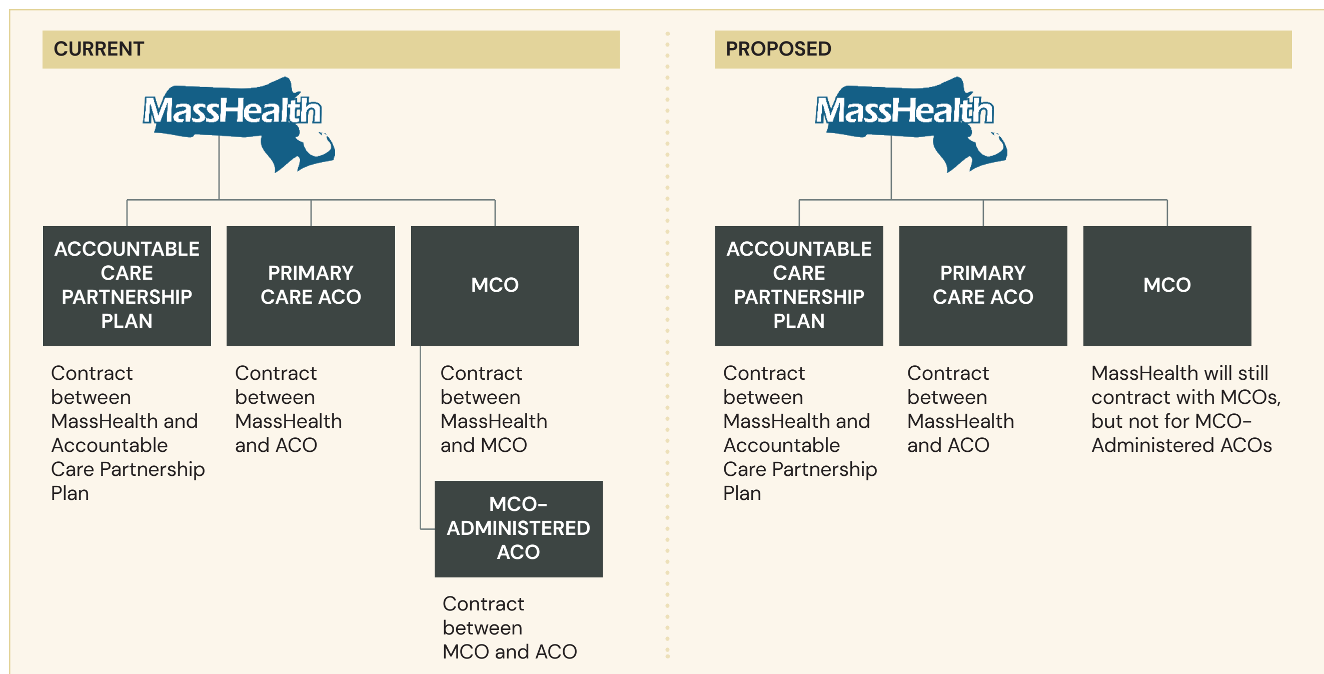
For more information on MassHealth's ACO models, see the Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation's "What to Know About ACOs: MassHealth Accountable Care Organizations."

PROPOSED CHANGES TO THE ACO PROGRAM

In the Demonstration request, MassHealth proposes continuing the current ACO contracts until the following changes to the ACO program are implemented in 2023:

Continue two of the three ACO models. Model C was adopted by only one organization. Citing operational challenges and lack of interest, MassHealth will discontinue Model C ACOs, effective in 2023. MassHealth members will still be able to choose to enroll in one of two MCOs rather than in an ACO (see Figure 2). Boston Medical Center [BMC] HealthNet MCO and Tufts Health Together MCO are the two current MCOs MassHealth members can enroll in; their contracts with MassHealth expire in December 2022. Members will also still have the option to choose not to be in an ACO and to remain instead in the Primary Care Clinician (PCC) Plan, receiving care from a primary care provider not affiliated with an ACO.

FIGURE 2. PROPOSED CHANGES TO THE ACO PROGRAM IN THE 2022 MASSHEALTH DEMONSTRATION REQUEST



Continue and enhance the ACO program. MassHealth has issued a procurement in 2022 to contract with current and new organizations that meet the requirements for a Model A or Model B ACO, beginning in 2023. In that procurement, MassHealth intends to introduce some changes to the ACO model, including:

- New opportunities for ACOs to pay primary care practices using payment models that reward value (described in Section VII below).
- Enhanced requirements for ACOs for population health, care coordination, network access, and cost growth, as well as increased focus on children and families.

- Payment incentives for ACOs that reward improvements in health equity (described in Section VI below).

UPDATES TO THE COMMUNITY PARTNERS PROGRAM

CURRENT STRUCTURE OF THE CP PROGRAM

MassHealth introduced CPs in 2018, to provide extra care coordination and management to members with heightened needs. There are two types of CPs, Behavioral Health (BH) CPs and Long-Term Services and Supports (LTSS) CPs. The two types of CPs support different populations:

- BH CPs support members age 21 and older with a serious mental illness or SUD and who use a high level of health care services, members between ages 18–20 with an SUD and who use a high level of health care services, and children and adolescents (less than 21 years of age) with serious emotional disturbance.
- LTSS CPs support members age 3 and older with a complex LTSS need (which may derive from having physical disabilities, acquired or traumatic brain injury, intellectual or development disabilities, and others, as defined by the state).

The two types of CPs have somewhat different responsibilities (see Figure 3). Currently, ACOs are required to enter into agreements with CPs to provide services and supports to members with significant BH and/or LTSS needs. MassHealth then pays CPs a monthly fee per member.

FIGURE 3. CURRENT COMMUNITY PARTNER RESPONSIBILITIES[10]

BH CPs are responsible for **comprehensive care coordination and care management**, which includes:	LTSS CPs are responsible for **LTSS care coordination**, which includes:
• Outreach and engagement	• Outreach and engagement
• Support for transitions of care	• Support for transitions of care
• Health and wellness coaching	• Health and wellness coaching
• Comprehensive needs assessment and ongoing person-centered treatment planning	• Care planning including providing informed choice of services and providers
• Care team formation and operation, as well as care coordination and care management across services including medical, BH, LTSS, and other state agency services	• Care team participation
• Medication reconciliation support	• LTSS care coordination, including social services and services provided by other state agencies
• Connection to social services and community resources	• Connection to social services and community resources

There are 18 BH CPs and nine LTSS CPs, with total monthly enrollment averaging 42,000 members. CPs are paid entirely with DSRIP funds, which will expire at the end of the current Demonstration period. The CP program has had some success, including patient satisfaction, bolstering of community-based organizations, and early positive outcomes.[11] There also have been some challenges for CPs in engaging members.[12]

PROPOSED CHANGES TO THE CP PROGRAM

In the Demonstration request, Massachusetts asks for continued authorization for the current CP program until the state has selected the new CP vendors and operations with them have begun in 2023. The request describes planned changes to the CP program in 2023:

Change the funding flow. MassHealth will continue to select CPs using a public procurement process and will still require ACOs to partner with CPs. However, the funding flow will change. Because DSRIP funds, the current CP funding source, will soon expire, Massachusetts plans to require ACOs and MCOs to pay CPs directly, using

administrative payments that MassHealth pays ACOs and MCOs. Unlike DSRIP, these administrative payments are built into MassHealth payment rates to the ACOs and MCOs and are not time limited.

Increase requirements for BH CPs. Some changes to the existing model may include:

- Requiring BH CPs to have formalized processes for communication and referral with the Community Behavioral Health Center (CBHC) in each of their service areas, if the BH CP is not a CBHC itself. CBHCs are a new type of MassHealth provider and a key component of Massachusetts' Roadmap for Behavioral Health Reform, a series of initiatives intended to create a comprehensive, effective outpatient behavioral health delivery system in the Commonwealth.
- BH CPs will take on some accountability for a subset of ACO quality measures.

More detail on requirements for BH CPs will be outlined in the procurement that MassHealth plans for 2022.

Increase requirements for LTSS CPs. Some changes to the existing model may include:

- LTSS CPs will be newly accountable for outreach, engagement, assessment, and care planning (aligning them with requirements for BH CPs).
- LTSS CPs will take on a new role as the "lead responsible entity" and care coordination home for enrolled members, rather than ACOs.
- There will be substantially higher requirements for clinical staffing (aligning with BH CPs).
- LTSS CPs will take on some accountability for a subset of ACO quality measures.

More detail on requirements for LTSS CPs will be outlined in the procurement MassHealth plans for 2022.

UPDATES TO THE FLEXIBLE SERVICES PROGRAM

Because the Flexible Services Program (FSP) started halfway into the current Demonstration cycle, Massachusetts is requesting that its authority to operate this program continue largely the same, with some small changes to eligibility and services offered (described below in Section IV, and including expanding eligibility for flexible services for postpartum individuals, extending nutrition services to the household, and including limited child care). Because DSRIP, which currently funds the FSP, is ending, MassHealth is requesting federal FSP funding under its own funding stream.

STATEWIDE INVESTMENTS

Statewide Investments under the current Demonstration were financed using DSRIP funds, and financially supported state-level innovations, such as workforce development and technical assistance initiatives, in support of the implementation of the ACO, CP, and FSP programs. With the new Demonstration request and discontinued DSRIP funding, it appears that most Statewide Investment programs are ending, though some may continue using other funding streams (see Appendix). One Statewide Investment for which Massachusetts requests continued federal 1115 Demonstration funds is the student loan repayment program discussed below in Section VII.

IV. ENHANCING SERVICES AND SUPPORTS

With this Demonstration request, Massachusetts is asking for expanded services and supports to meet specific member needs, including expanded offerings from the FSP, expanded BH services, and new care coordination programs.

EXPANDED OFFERINGS FROM THE FLEXIBLE SERVICES PROGRAM

CURRENT FSP STRUCTURE

In 2020, MassHealth started the FSP, which provides housing and nutrition supports to certain members identified by ACOs. While these services address important social drivers of health, they are not usually allowed as part of a Medicaid benefit. Flexible services were added to the Demonstration in the current extension to provide ACOs with tools to address social and environmental factors, which—along with health behaviors such as diet, smoking, and exercise—are the primary drivers of members' health, more so than medical care.[13]

Flexible services are not an entitlement, meaning members with a need do not automatically receive them simply by being enrolled in MassHealth, as is the case with most MassHealth benefits. Members must meet broader eligibility criteria (enrollment in an ACO and having specified health needs and social risk factors), then must be selected by an ACO to receive flexible services. Flexible services include help with first month's rent, help with a security deposit, other help maintaining housing, meal delivery, and food benefit assistance.[14]

PROPOSED CHANGES TO FSP

In the Demonstration request, Massachusetts asks CMS for permission to extend the FSP. There are promising early results for this program: ACOs found improvements in diabetes management, reductions in emergency department visits, and reductions in total cost of care associated with their FSPs.[15] Given the program's delayed start—flexible services have been offered for just two years—Massachusetts asserts that more time is needed to measure their contribution to meeting MassHealth's goals. Massachusetts also asks to make certain changes to the FSP.

- One change would expand the number of individuals who meet the eligibility criteria based on postpartum status, allowing individuals to be eligible for the program for a longer time after the birth of a child.
- Another change would extend nutritional supports to a member's entire household, not just the individual member. This change acknowledges the communal aspect of food assistance. While children can and do qualify for flexible services, this improvement would help more children because all members of a household will benefit when one member qualifies for assistance.
- A third change would expand flexible services to include intermittent child care while members are engaging with the FSP. For example, a member attending a Section 8 housing voucher information session, a flexible service, could receive child care to make attendance possible.

Massachusetts is also proposing continued funding for infrastructure, capacity building, and technical assistance for Social Service Organizations (SSOs) who participate or wish to participate in the FSP.

EXPANDED BEHAVIORAL HEALTH SERVICES AND SUPPORTS

CURRENT DIVERSIONARY BH SERVICE OFFERINGS

Massachusetts has included "diversionary behavioral health services" in the Demonstration for years. These services are designed to help individuals at risk of needing inpatient mental health or SUD treatment receive services in more community-based settings instead. Examples of diversionary services include community crisis stabilization, intensive day

treatment programs for mental health and addiction, the Community Support Program (CSP), and others. CSP provides a navigator to assist an individual with outreach and supportive services, including:

- Providing service coordination
- Assisting with obtaining public benefits, housing, and health care
- Developing a plan in the event of a psychiatric or SUD crisis
- Fostering empowerment and recovery

Massachusetts currently offers CSP as a diversionary service to members with BH needs and a specialized form of CSP for chronically homeless individuals called CSP for Chronically Homeless Individuals (CSP-CHI).

In June 2021, in a proposed amendment to the current Demonstration, Massachusetts requested authorization for a CSP program to support people who are justice involved. This would enable the state to expand the community portion of the Behavioral Health Supports for Justice-Involved Individuals (BH-JI) program, in which health care navigators engage with individuals prior to release from incarceration, post-incarceration, on parole, and on probation and assist them with accessing BH services and community supports. This request is awaiting approval from CMS.

PROPOSED CHANGES TO DIVERSIONARY BH SERVICE OFFERINGS

In this Demonstration request, Massachusetts is asking (1) to extend eligibility for diversionary BH services to more members and (2) to add new specialized services.

Extending eligibility for diversionary BH services. The diversionary BH services authorized through the current Demonstration are available only to people enrolled in managed care—an ACO, MCO, or the PCC Plan.[16] In this Demonstration request, Massachusetts asks to extend those services to individuals who are not in managed care. Most MassHealth members are in managed care, except certain members who have another source of primary insurance, such as Medicare or a commercial health plan, and use MassHealth for secondary coverage.

Adding specialized diversionary BH services. In this Demonstration request, Massachusetts seeks authorization for two additional forms of CSP:

1. CSP for Homeless Individuals (CSP-HI), for those members experiencing homelessness who do not meet the narrow definition of "chronically homeless" for the existing CSP-CHI and are high utilizers of MassHealth services; and

2. CSP Tenancy Preservation Program (CSP-TPP), for individuals facing risk of eviction as a result of behavior related to a disability.

Along with other diversionary BH services, MassHealth is asking that CSP-HI and CSP-TPP be offered to all qualifying members, whether or not they are enrolled in managed care. The proposed new variations of CSP again directly acknowledge MassHealth's interest in stable housing for its members as an important driver of their health.

FIGURE 4. SUMMARY OF REQUESTS TO EXPAND MASSHEALTH DIVERSIONARY BEHAVIORAL HEALTH SERVICES

<table>
<tr><th>DIVERSIONARY BEHAVIORAL HEALTH SERVICE</th><th>DESCRIPTION</th><th>DEMONSTRATION REQUEST</th></tr>
<tr><td colspan="3">EXISTING PROGRAMS</td></tr>
<tr><td>Program of Assertive Community Treatment</td><td>Ongoing community-based treatment, rehabilitation, and support services for adults with mental illness.</td><td rowspan="6">Expand to individuals who are not in managed care.</td></tr>
<tr><td>Community Crisis Stabilization</td><td>24-hour addiction treatment.</td></tr>
<tr><td>Acute Treatment Services for Substance Abuse</td><td>24-hour addiction treatment.</td></tr>
<tr><td>Clinical Support Services for Substance Abuse</td><td>24-hour short-term, intensive addiction treatment as an alternative to hospitalization.</td></tr>
<tr><td>Community Support Program (CSP)</td><td>Outreach, supportive services, and other services delivered by community-based team of paraprofessionals for members with mental health needs and/or SUD.</td></tr>
<tr><td>CSP for Chronically Homeless Individuals (CSP-CHI)</td><td>CSP provided to individuals experiencing chronic homelessness (narrower definition).</td></tr>
<tr><td colspan="3">FUTURE PROGRAMS</td></tr>
<tr><td>CSP for Justice Involved Individuals (part of BH-JI) (June 2021 Amendment Request)</td><td>CSP provided to individuals who are on parole, probation, or have experienced incarceration within one year.</td><td rowspan="3">Add service to the Demonstration.[17]
Provide to all qualifying members, whether or not they are enrolled in managed care.</td></tr>
<tr><td>CSP for Homeless Individuals (CSP-HI)</td><td>CSP provided to individuals experiencing homelessness and are high utilizers of MassHealth services.</td></tr>
<tr><td>CSP Tenancy Preservation Program (CSP-TPP)</td><td>CSP provided to individuals facing risk of eviction as a result of behavior related to a disability.</td></tr>
</table>

STREAMLINED CARE COORDINATION FRAMEWORK WITH NEW CARE COORDINATION PROGRAMS

Massachusetts has made progress in the last decade recognizing areas where MassHealth members need care coordination and care management, and has built programs to address those needs. At times, however, it has been difficult for members to navigate their sometimes complex care coordination options. In the Demonstration request, Massachusetts notes that "… the current landscape of care coordination programs is varied and often confusing for members and providers, and it is not always clear which provider or team is the lead coordinator for a given member."[18] ACOs, MCOs, CPs, and specialized providers all have some responsibility for care coordination, and efforts can overlap.

In the Demonstration request, Massachusetts reviews its landscape of care coordination and proposes a holistic, streamlined framework for providing care coordination. This framework has three tiers of care coordination and includes continuation of programs (including CP, with a new structure described in Section III, above) as well as new features (e.g., new CSP programs, described above, and enhanced requirements for ACOs to provide baseline care coordination).

FIGURE 5. NEW FRAMEWORK FOR CARE COORDINATION

TYPE OF CARE COORDINATION	DESCRIPTION	EXAMPLES OF WHO WILL PROVIDE CARE COORDINATION
Baseline	Care coordination for all MassHealth members. Baseline care coordination will include "foundational supports such as an assigned primary care clinician, care needs screenings and referrals, and assistance with transitions of care."	• Primary Care Providers
Enhanced	Enhanced level of care coordination for members experiencing high and rising risk, including comprehensive assessment, multi-disciplinary team, and assistance with transitions of care and access to social services.	• Community Partners • ACOs and MCOs • MassHealth CARES for Kids providers and Children's Behavioral Health Initiative (CBHI) Intensive Care Coordination providers
Specialized	Episodic care coordination for specific circumstances, including working with individuals who are experiencing homelessness.	• Community Support Program (CSP) providers, including CSP-CHI, CSP-JI, CSP-TPP, and CSP-HI • Recovery Support Navigators

MassHealth will require ACOs and MCOs to ensure that members "have a clearly identified, single lead entity to serve as their 'care coordination home'" to help members and providers better understand care coordination resources available to them.[19]

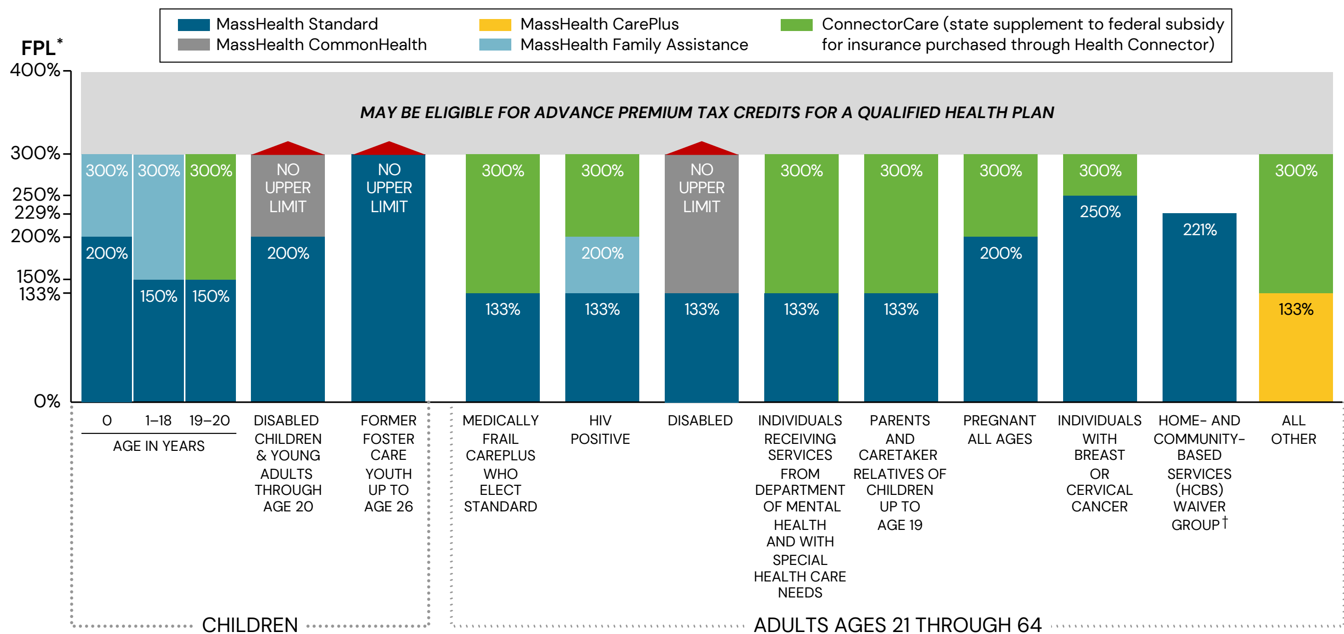
CONTINUED AUTHORITY FOR EXPANDED BENEFITS

In the Demonstration request, Massachusetts requests authority to continue offering enhanced benefits already in the current Demonstration. These include SUD benefits; premium assistance for members with access to other sources of insurance; Medicare cost-sharing (premiums, deductibles, and copayments) assistance for certain members eligible for both MassHealth[20] and Medicare; and ConnectorCare, which provides enhanced premium and cost-sharing subsidies to individuals with low- and moderate-incomes who purchase coverage through the Massachusetts Health Connector.

V. UPDATING ELIGIBILITY POLICIES

Earlier eligibility expansions under the Demonstration brought MassHealth coverage to hundreds of thousands of Massachusetts residents who otherwise would be uninsured because they did not have access to or could not afford private health insurance. Figure 6 shows the current MassHealth income cutoffs for different population groups. Eligibility gaps remain, however. With this Demonstration request, Massachusetts is asking for some updates to eligibility policies to support coverage for people with disabilities, pregnant people and children, people experiencing homelessness, and individuals experiencing incarceration, while maintaining existing eligibility criteria for all other members. These updates do not affect the income cutoffs illustrated in Figure 6; instead, they improve coverage by addressing other eligibility constraints, described in Figure 7.

FIGURE 6. ELIGIBILITY FOR MASSHEALTH FOR INDIVIDUALS UNDER AGE 65



*FPL = income as percent of federal poverty level; in 2021, 100 percent FPL for an individual was $12,880 annually.

†Eligibility for all Home- and Community-Based Waivers except one (the waiver for Young Children with Autism) is based on 300 percent of the Supplemental Security Income (SSI) Federal Benefit Rate (FBR). FBR is a metric used by the Social Security Administration and tied to the consumer price index. In 2021, 300 percent SSI FBR for an individual was $28,590 annually (222 percent FPL for an individual).

NOTES: MassHealth eligibility includes nuances not included in this chart; MassHealth staff can help determine eligibility. Additional information can be found at https://www.mass.gov/service-details/masshealth-coverage-types-for-individuals-and-families-including-people-with.

MassHealth Limited, not shown in this chart, provides emergency health services to people who, under federal law, have an immigration status that keeps them from receiving more services. Income eligibility for this population is similar to MassHealth Standard: 200 percent FPL for pregnant women and children up to age 1; 150 percent FPL for children ages 1–20 years; 133 percent FPL for adults 21–64. Sources: 130 C.M.R. §505; 130 C.M.R. §519; MassHealth (2019) Member Booklet for Health and Dental Coverage and Help Paying Costs.

FIGURE 7. SUMMARY OF ELIGIBILITY UPDATES IN DEMONSTRATION REQUEST

CHARACTERISTIC OF MASSHEALTH MEMBER	CURRENT ELIGIBILITY CONSTRAINT	CHANGE REQUESTED
Adults with disabilities, age 21–64, enrolled in CommonHealth	One-time deductible required if working less than full-time.	Eliminate the deductible.
Adults with disabilities, age 65 and older, enrolled in CommonHealth	Member must work at least 40 hours per month to maintain eligibility.	Work not required if member has been enrolled in CommonHealth for 10 years or longer.
Pregnant people and children up to age 19	Eligibility begins as of date of application; federal requirement for "retroactive eligibility" to three months prior to application is waived.	End waiver of retroactive eligibility for this group; eligibility retroactive to three months prior to application.
People experiencing homelessness	Standard eligibility determination and redetermination rules apply, often resulting in loss of eligibility due to frequent change of address, failure to respond to communications, etc.	Eligibility continues for 24 months regardless of changes in circumstances.
People experiencing incarceration	Eligibility is suspended (with narrow exceptions) while incarcerated; standard eligibility determination and redetermination rules apply after release.	Youth in care or custody of Department of Youth Services receive full, uninterrupted MassHealth coverage; adults with chronic conditions, mental health conditions, and SUD receive coverage for last 30 days in correctional setting; all receive 12 months of continuous eligibility post-release.

STREAMLINED ELIGIBILITY FOR PEOPLE WITH DISABILITIES

CURRENT COMMONHEALTH COVERAGE

MassHealth CommonHealth coverage offers people with disabilities one of the most expansive options in the country to access Medicaid benefits. In many other states, when a person with disabilities is employed and reaches a certain income level, they can lose Medicaid coverage, which includes access to the long-term services and supports necessary for that person to work (employer-sponsored insurance does not usually cover those services).

CommonHealth allows Massachusetts residents with disabilities to "buy in" to MassHealth, continuing coverage even while working and earning income.[21] In fact, there is no income limit to CommonHealth enrollment; it is available to all people with disabilities, and those with higher incomes paying a premium on a sliding scale. In addition to the sliding scale premiums, adults who are not working full-time must also pay a one-time deductible for disabled adults who are not working full-time. This deductible requires people to show proof of medical expenses at a certain level for six months before becoming eligible for CommonHealth.[22] While the program was initially designed for people under the age of 65, as part of the last Demonstration extension request, MassHealth expanded coverage for CommonHealth for people with disabilities who continue working past age 65.

PROPOSED COMMONHEALTH COVERAGE CHANGES

In the current Demonstration request, Massachusetts asks for authorization to allow members over the age of 65 who have been enrolled in CommonHealth for ten years or longer and who stop working (because they wish to retire, or for other reasons) to continue to receive MassHealth benefits through the CommonHealth program. The goal of this policy change is to ensure continuity of care for individuals with disabilities as they approach retirement.

Massachusetts is also asking permission to eliminate CommonHealth's one-time deductible for adults with disabilities who are not working full-time. Eliminating this requirement would allow people with disabilities to maintain Medicaid coverage as they enter the workforce gradually, even if they do not meet the hourly work requirements currently in place.

EXPANDED RETROACTIVE ELIGIBILITY FOR PREGNANT INDIVIDUALS AND CHILDREN

CURRENT STATE OF RETROACTIVE ELIGIBILITY IN MASSHEALTH

Federal law requires states to extend most Medicaid coverage backwards in time, to three months prior to the application date.[23] This is a crucial tool in addressing medical debt, supporting safety net hospitals (by paying recent hospital bills), and improving health care; expensive health crises do not wait for application paperwork. Because the American health care system is largely based on employer-sponsored insurance, catastrophic events that could land a person in the hospital or nursing facility could also end a person's employment and health coverage, during a time when a person is least able to fill out a Medicaid application.[24] During the COVID-19 pandemic, when individuals may get very sick very quickly, there is a heightened need for retroactive coverage.[25]

MassHealth has long had a waiver to allow it not to comply with this retroactive eligibility requirement, meaning that most MassHealth enrollees are *not* entitled to coverage for the three months prior to a Medicaid application.[26]

PROPOSED EXPANSION OF RETROACTIVE ELIGIBILITY IN MASSACHUSETTS

In this Demonstration request, Massachusetts announced that it will eliminate the current waiver from retroactive eligibility for pregnant people and children, thus restoring retroactive eligibility for these groups to three months prior to the application date. In other words, MassHealth announced that it is extending eligibility for three months prior to the date of application for pregnant people and children.

ENSURING CONTINUITY OF COVERAGE FOR PEOPLE EXPERIENCING HOMELESSNESS

CURRENT MASSHEALTH RENEWAL PROCESSES

Like all states, Massachusetts received enhanced federal Medicaid funding under the Families First Coronavirus Response Act, the first major federal stimulus package passed by Congress in 2020.[27] As a condition of receiving these funds, Massachusetts is required to maintain continuous Medicaid coverage for those who were enrolled at the start of the federal COVID-19 public health emergency and for anyone who becomes eligible during the emergency. When the public health emergency expires, MassHealth will return to its standard renewal process, in which it redetermines the eligibility of each member every 12 months. The first stage is to redetermine member income eligibility through automated means, based on available income data sources. If a member's income cannot be verified or if the member does not appear income-eligible based on these data sources, MassHealth sends a renewal form to be completed, with a request for documentation. If the member does not return the documentation within a specified time, eligibility is terminated. In addition to the annual redetermination process, members are expected to notify MassHealth of any changes to their income no later than 10 days from the date of the change, so that their eligibility can be redetermined.

PROPOSED RENEWAL PROCESSES FOR PEOPLE EXPERIENCING HOMELESSNESS

Massachusetts asks CMS to provide up to 24 months of continuous eligibility for individuals experiencing homelessness, even after the public health emergency ends. Continuous eligibility means that once someone has established their eligibility, they would remain enrolled in MassHealth for 24 months regardless of changes in their circumstances. People with unstable housing are at risk of losing eligibility because a frequently changing address affects their ability to receive and respond to communications necessary to maintain MassHealth coverage. According to the Demonstration extension request, about 15 percent of MassHealth members experiencing homelessness lose their coverage due to missing paperwork.[28]

ENSURING COVERAGE FOR INDIVIDUALS EXPERIENCING INCARCERATION AS THEY TRANSITION BACK INTO THE COMMUNITY

CURRENT ELIGIBILITY POLICIES FOR PEOPLE EXPERIENCING INCARCERATION

Medicaid has included an "inmate exclusion policy" since the federal government created the program in 1965. Individuals who are incarcerated in jails and prisons have their Medicaid coverage terminated or suspended, even if their incarceration only lasts for a few days and they are otherwise eligible.[29] This break in coverage can impede communication between community and correctional health care providers and make it difficult to re-activate coverage quickly once an individual is released. This can be particularly disruptive for people with chronic diseases, those with mental health disorders, and those with SUDs.

Massachusetts has implemented several policies to ease the effects of the inmate exclusion policy, including a policy to suspend (rather than terminate) MassHealth coverage during incarceration, so it is easier to reinstate coverage when people leave incarceration and re-enter the community. MassHealth also supports the BH-JI program, which provides assistance before and after release by connecting people to BH services and other supports.

PROPOSED ELIGIBILITY CHANGES FOR PEOPLE EXPERIENCING INCARCERATION

In the Demonstration request, Massachusetts makes two proposals to ensure coverage for individuals who have experienced incarceration.

Coverage during incarceration. First, Massachusetts asks CMS to extend MassHealth coverage to individuals who are incarcerated. Specifically, people in county and state correctional facilities who meet MassHealth eligibility requirements and who have a chronic physical condition, mental health condition, or SUD would be covered by MassHealth and able to receive MassHealth-covered services within 30 days of their release. These clinical requirements would likely include

most incarcerated and detained individuals. The proposed change would be even more extensive for those engaged in the juvenile justice system: Massachusetts is requesting authorization to provide services to eligible youth committed to the care and custody of the Department of Youth Services (DYS) for the duration of their custody.

This request follows a trend, with a handful of states asking for extension of Medicaid for incarcerated individuals. Congress is also considering legislation that would soften the inmate exclusion in federal law.[30] Massachusetts asserts that this updated eligibility policy would "improve health care outcomes for newly released MassHealth members by increasing continuity of care, improving transitions from correctional facilities and juvenile justice facilities."[31]

Continuous coverage for one year following release from incarceration. In the Demonstration request, Massachusetts also requests authority to maintain MassHealth eligibility continuously for one year following release from incarceration or DYS custody, "to reduce administrative eligibility churn during the post-release period when the risk of adverse health outcomes is particularly high."[32]

VI. ADVANCING HEALTH EQUITY

"Advancing health equity," a fundamental challenge to the health care system that has vexed health care providers and policymakers for decades, is one of the five goals Massachusetts has set for MassHealth to achieve in this Demonstration extension. Simply stated, access to health care services and health status in general varies across groups with certain characteristics, including race, ethnicity, disability status, gender, gender identity, and sexual orientation.[33] There are multiple sources of these inequities. Some originate in the health care system itself, including discrimination, implicit bias, and cultural misunderstanding. Certain communities also mistrust the medical care system because of historical or current experiences of discrimination. Other health inequities are created by social and economic injustices, such as inequitable access to housing stability and quality, nutritious food, healthy environments, educational and employment opportunities, and more.

THE CURRENT MASSHEALTH APPROACH TO EQUITY

The current structure of the MassHealth program has addressed health equity through coverage, benefits, and attention to health-related social needs.

Coverage. Lack of health insurance is a significant barrier to care for people with low incomes, who are disproportionately people of color. While access to health coverage alone will not solve entrenched health inequities, it is an essential step toward equitable health care access. MassHealth is a key source of health coverage for populations that face significant health inequities. While the majority of MassHealth members are White, there is significant racial diversity. Four in 10 self-report a race/ethnicity other than White, and Hispanic and Black members make up 30 percent of the total MassHealth population.[34] The state also recently announced that it would take up the option under the American Rescue Plan Act (ARPA) to extend postpartum coverage from 60 days to 12 months[35] to address challenges to maternal health, particularly maternal mortality, which disproportionately affects people of color. This benefit would extend to new birthing parents regardless of their immigration status, so that people who would otherwise not qualify for Medicaid can access postpartum care.

Benefits. MassHealth has many benefits and programs targeted to better meet the needs of specific populations that have experienced health inequities. For example, the One Care program is designed to better meet the needs of people with disabilities who are under age 65 by offering coordinated, comprehensive medical care and LTSS through specialized health plans. MassHealth's BH-JI program addresses health inequities by connecting people reentering the community following incarceration with needed BH services.[36] Because people of color are disproportionately incarcerated,[37] these services have the potential to reduce health inequities.

Attention to health-related social needs. The current Demonstration addresses equity through its attention to health-related social needs. The FSP acknowledges housing instability and food insecurity as significant determinants of health and as circumstances that disproportionately affect people of color.[38]

MassHealth also accounts for health-related social needs in its payment policies. Payments to ACOs and MCOs are "risk adjusted," not only for the health and disability status of their member populations, as is typically done, but also for social drivers of health such as housing deficits and neighborhood-level stressors. These risk adjustments mean that ACOs and MCOs receive higher payments to care for people with more significant health-related social needs.[39] And the ACO quality score includes a measure focused on the annual health-related social needs screening, meaning that how well an ACO performs on this measure may ultimately impact its compensation.

ELEMENTS OF THE DEMONSTRATION REQUEST THAT ADDRESS EQUITY

This Demonstration extension makes equity a specific goal for the first time in the history of the state's Demonstration requests. To advance health equity, the proposal builds on current program elements and adds new ones. Notably, the Demonstration proposal includes as aims of its equity initiatives the reduction in disparities by race, ethnicity, language, disability status, sexual orientation, and gender identity.[40]

Several key equity-related elements of the proposal addressing health-related social needs, services for people who are justice-involved, and improvements to maternal and child health were introduced in earlier sections of this report. In addition, Massachusetts proposes introducing financial incentives to address structural racism and reduce disparities.

HEALTH-RELATED SOCIAL NEEDS

The proposed Demonstration would expand services for health-related social needs, including the improvements to the FSP covered in Section IV (expanding nutritional supports, child care, and postpartum care). The Demonstration request also includes enhancements to several programs aimed at addressing housing. Housing instability is a major factor associated with negative health outcomes, including maternal depressive symptoms, nutritional deficits, psychological distress, and infectious disease.[41] Elements of the Demonstration request related to homelessness include:

- Offering 24 months of continuous eligibility to individuals experiencing homelessness
- Expanding CSP and CSP-CHI to MassHealth members not enrolled in managed care (described in Section IV)
- Adding CSP for individuals meeting a broader definition of homelessness (described in Section IV)
- Adding CSP for individuals facing eviction due to behavior related to a disability (described in Section IV)

SERVICES FOR INDIVIDUALS WHO ARE JUSTICE-INVOLVED

As described in Section V, Massachusetts is requesting authority to extend MassHealth coverage to certain individuals who are incarcerated and provide continuous coverage for 12 months following release. Improving access to coverage and quality of care for individuals with experience in the criminal justice system is an equity issue. Massachusetts has one of the lowest incarceration rates in the nation, but one of the highest in the world.[42] Black and Hispanic individuals are disproportionately affected by this system. For example, when adjusting for the severity of the charged crimes and other factors, Black and Hispanic individuals receive disproportionately higher sentences in Massachusetts[43] and make up a disproportionate share of the prison population.[44] Allowing MassHealth coverage during incarceration for certain members would increase the resources available to support individuals' health care needs in correctional facilities, and maintaining their coverage for 12 months post-release would improve continuity of care during the early months of this transition, with the potential to reduce health inequities based on race and ethnicity.

A FOCUS ON IMPROVING MATERNAL AND CHILD HEALTH

The state's Demonstration request includes a focus on maternal and child health. This focus directly addresses the Demonstration's goal of advancing health equity because maternal and child health is an area of significant racial inequities in Massachusetts. Though Massachusetts has one of the lowest infant mortality rates in the nation for Black infants, it also has one of the largest *differences* in infant mortality between Black and White infants.[45] Elements of the Demonstration request that reflect a focus on improving maternal and child health outcomes include:

- Extending MassHealth eligibility for three months prior to the application date for pregnant people and children (see Section V)
- Attention to pediatric needs in a new primary care payment model (see Section VII), and enhanced care coordination expectations for a subset of children with rising or moderate medical complexity, including attention to coordinating with schools and early childhood providers (see Section IV)
- New requirements that flexible service programs will be tailored to better recognize and serve the needs of children and families, including expanding nutritional services to the whole household (see Section IV)

Beyond the Demonstration request, Massachusetts has other plans to bolster coverage for maternal and child health, including:[46]

- Expansion of MassHealth postpartum coverage eligibility from 60-days postpartum to 12 months[47]
- Addition of doula services to the MassHealth benefit
- A new targeted case management benefit, MassHealth Coordinating Aligned, Relationship-Centered, Enhanced Support (CARES) for Kids, for the highest risk children with medical complexities to provide comprehensive, high-touch care coordination for children and their families. MassHealth CARES for Kids providers will serve as lead entities to coordinate prompt and individualized care across the health, educational, state agency, and social service systems.
- New requirements for ACOs and MCOs to offer enhanced care coordination for members with high-risk pregnancies
- Coverage for preventive BH services to youth who screen positive for BH symptoms and would benefit from preventive interventions[48]
- Partnership with Massachusetts Child Psychiatry Access Project to create a program through which mobile crisis clinicians can consult with autism experts while working with youth and young adults with Autism Spectrum Disorder or Intellectual Disability who are having a BH crisis

HEALTH EQUITY INCENTIVE PAYMENTS

In addition to these programmatic elements, Massachusetts proposes introducing financial incentives for hospitals and ACOs to reduce health inequities.[49] The details of the payments are under discussion among the ACOs, hospitals, and MassHealth. Under the proposal, ACOs would be eligible for health equity incentives totaling 1–2 percent of the capitation rate (for Partnership Plan ACOs) or the total cost of care benchmark (for Primary Care ACOs). The proposal also includes $350 million annually for incentive payments to hospitals participating in ACOs and, separately, $90 million available annually for Cambridge Health Alliance (CHA), the Commonwealth's only non-state-owned public hospital. The CHA incentive replaces the Public Hospital Transformation and Incentive Initiative (PHTII) pool, a component of the SNCP in the current Demonstration. This arrangement recognizes CHA's critical role in providing targeted services to a very high percentage of Medicaid and uninsured patients. The incentive program for CHA will parallel the one designed for other hospitals and will ensure accountability for serving its unique population, while helping to sustain its services for the Commonwealth's MassHealth and uninsured populations.[50]

There are three components of the health equity incentive payment program for ACOs and hospitals:

1. **Collect social risk factor data**. A performance-based incentive requires complete and accurate data to gauge achievement. Currently, data that facilitate the measurement of health inequities across various groups are incomplete and inconsistent. MassHealth will offer incentives for ACOs and hospitals to collect data on the social risk factors of their members and patients. Social risk factors include socioeconomic position, race, ethnicity, gender, gender identity, sexual orientation, social relationships, and residential and community context.[51] As a fundamental element of measuring and then reducing health inequities, MassHealth plans to set ambitious targets for data completeness and incentivize ACOs and hospitals to meet them.

2. **Identify and monitor inequities**. The second component of the incentives program is to encourage ACOs and hospitals to use their data to stratify the reporting of their quality performance by social risk factors in order to identify the presence of inequities. MassHealth will prioritize quality measures that are "disparities-sensitive" for stratified reporting. Disparities-sensitive quality measures are those likely to be able to detect disparities when they occur. Some examples in the national literature of disparities-sensitive measures are influenza immunization and effective care coordination for children.[52] MassHealth will require stratification on selected disparities-sensitive measures for selected social risk factors in the first year of the Demonstration and add to the list in subsequent years. Incentive payments will be offered to ACOs and hospitals that meet reporting targets.

3. **Reduce identified inequities**. The goal of improving data collection and reporting is, ultimately, to reduce inequities, which is the third component of the payment incentive. MassHealth will prioritize the identified health inequities and select target metrics to incentivize hospitals and ACOs to reduce specific inequities between a socially at-risk population and a reference population. MassHealth will choose target metrics based on the stratified reporting described above and criteria including the scope of the inequity, evidence of a strong relationship between the risk factor and health outcomes, and a basis for and technical feasibility of an intervention.[53] There will be targets based on system-wide inequities and a smaller number based on inequities identified in an individual ACO's or hospital's reporting.

Each of these components provides a foundation for the next: Initiatives to reduce inequities requires stratified reporting, which, in turn, requires complete data on social risk factors. While the incentives are not sequential—incentives for stratified reporting, for example, begin in Year 1 of the Demonstration, while work to improve data collection is ongoing—there clearly is a relationship from one component of this initiative to the next.

VII. INVESTING IN PRIMARY CARE AND BEHAVIORAL HEALTH

One of the Commonwealth's goals in the Demonstration extension request is to make significant investments in primary care and BH. To that end, MassHealth requests authority to transition primary care payment in ACOs away from the fee-for-service model and towards a payment model that offers more flexibility and helps support enhanced care delivery expectations (such as BH integration). Additionally, among the DSRIP-funded Statewide Investments under the current Demonstration were initiatives to support building, training, and diversifying the primary care and BH workforce. While DSRIP funding is ending, Massachusetts intends to continue this workforce focus in the new Demonstration, most prominently in a set of loan repayment and professional training programs. This section focuses on these key components; however, there are many ways in which the Demonstration is focusing on primary care and BH that are captured in other sections of this brief (such as, for example, the expansion of Diversionary Behavioral Health Services summarized in Figure 4).

PRIMARY CARE SUB-CAPITATION

CURRENT PRIMARY CARE PAYMENT MODEL

In current Model A and Model B ACO contracts, Massachusetts requires ACOs to "develop, implement, and maintain value-based payments for participating PCPs [primary care providers]."[54] Value-based payments, also called alternative payment models, reward quality of care and positive health outcomes, rather than simply paying a fee for every service that is delivered. Despite the contractual requirement, PCPs within ACOs are still primarily reimbursed fee-for-service.[55]

PROPOSED PRIMARY CARE PAYMENT MODEL

In the Demonstration request, Massachusetts proposes a new program to pay ACO-affiliated primary care practices with a sub-capitation payment—a fixed monthly amount per member (adjusted for characteristics such as age and health risks)——regardless of the health care services the member uses in that month. MassHealth would continue to pay Model A ACOs a set monthly payment per member—a capitation payment—and would direct Model A ACOs to make sub-capitation payments to their participating PCPs, essentially a portion of the ACO's capitation fee, in line with MassHealth's prescribed model. For Model B ACOs, MassHealth would make capitation payments for certain primary care services to the ACO, which will then be required to make sub-capitation payments to their participating PCPs, in line with MassHealth's prescribed model.

To be eligible for sub-capitation payments, primary care practices would need to offer certain clinical features, including:

- Integration of BH care
- Care coordination
- Screening and appropriate referral for oral health, BH, and health-related social needs
- Services tailored to the needs of children and families
- Culturally and linguistically appropriate care
- Same-day urgent care capacity and video telehealth capability

"Higher tier practices"[56] would receive higher capitation payments and have additional responsibilities, including:

- Meeting certain heightened staffing requirements to address the clinical features listed above (for example, using community health workers for care navigation and to address health-related social needs)
- Employing certain persons with appropriate training and expertise for pediatric patients and their families/caregivers
- Offering enhanced evening and weekend availability
- Offering expanded telehealth capabilities and developing capacity for e-consults

PRIMARY CARE WORKFORCE INVESTMENTS

MassHealth proposes three workforce initiatives focused on primary care. Two are student loan forgiveness programs:

- Repayment of student loan obligations up to $100,000 for PCPs, in exchange for a four-year commitment to working in community-based settings that serve a significant number of MassHealth members.
- Repayment up to $50,000 per clinician for advanced practice registered nurses, pediatric clinical nurse specialists, nurse practitioners, and physician's assistants who make a similar four-year commitment.

The programs are projected to engage 60 new providers per year for four years and would prioritize clinicians with cultural and linguistic competence in the communities they would serve.[57]

The third primary care workforce initiative is a family nurse practitioner (FNP) residency grant program for community health centers. The grants would fund 10 residency slots per year for four years and, as with the loan repayment programs, would prioritize programs that target FNP applicants with cultural and linguistic competence and that serve a diverse MassHealth population.[58]

BEHAVIORAL HEALTH WORKFORCE INVESTMENTS

Although Massachusetts was among the first states to require coverage of BH services, this care is not always easily accessible because of a shortage of BH providers. A 2019 BCBSMA Foundation report highlights how workforce shortages across the BH sector create significant access challenges for most residents.[59] And in 2020, during the COVID-19 pandemic, the number of people reporting mental health challenges increased by 11 percent from the previous year, according to the Department of Public Health's COVID-19 Community Impact Survey.[60] This increase has further exposed the BH care shortage in the state. According to a recent survey commissioned by the BCBSMA Foundation, more than 1 in 3 adults report needing BH care for themselves or a family member during the first year of the pandemic and among those who report needing BH care, 26 percent did not receive any BH care.[61]

A 2017 report on the outpatient mental health system in Massachusetts found that reimbursement rates for mental health services are not enough to reliably retain providers.[62] Stakeholders overwhelmingly report that reimbursement rates in most cases do not cover the actual cost of providing services, creating a difficult situation for providers. Mental health advocates and representatives from associations of safety net organizations report that reimbursement rates for outpatient mental health services under MassHealth are lower than those for commercial insurance.[63] There is evidence that incentivizing BH providers through loan forgiveness can help alleviate financial strain and increase retention rates.[64]

PROPOSED PROGRAMS TO BOOST THE BH WORKFORCE

The Demonstration request proposes two additional student loan repayment programs with the aim of increasing retention rates among BH providers, particularly those of diverse backgrounds. This aligns with the goals of the Commonwealth's *Roadmap for Behavioral Health Reform* to recruit and retain a diverse and culturally competent workforce and improve access to high quality BH care.

- The first program would offer up to $50,000 in loan obligation repayment for licensed BH clinicians or Masters-prepared clinicians who intend to obtain licensure within one year of the award. As with the primary care loan forgiveness program, recipients would be obligated to work for at least four years in a community-based setting that serves a significant number of MassHealth members.
- The second program would repay up to $300,000 per clinician for psychiatrists or nurse practitioners with prescribing privileges who make a four-year commitment to maintaining a patient panel, or working at an organization with a panel, that is at least 40 percent MassHealth or uninsured members.[65]

VIII. SUSTAINING THE SAFETY NET CARE POOL

Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. "Disproportionate share" refers to the portion of patients who are enrolled in Medicaid or have no health insurance; hospitals with a high proportion (as defined by the state) of these patients are deemed "DSH hospitals" and receive additional payments. The federal share of these payments is limited by an annual DSH allotment. In Massachusetts, the DSH allotment is incorporated into a pool of funds that is a feature of the MassHealth Demonstration, called the Safety Net Care Pool (SNCP).

The SNCP became part of the Demonstration in 2005. It is a key source of funding for DSH hospitals and other facilities that treat populations with limited access to care, for delivery system innovations in those facilities, and for subsidies to

people purchasing insurance through the Health Connector. In 2016, MassHealth restructured the SNCP to align with the introduction of ACOs and CPs, while continuing to provide sustaining funds for Massachusetts safety net providers. In this Demonstration period, the proposed SNCP design reaffirms the state's commitment to these providers, while adding new quality, population health, and health equity standards.

SAFETY NET CARE POOL COMPONENTS

In this Demonstration request, Massachusetts retains the structure of the SNCP it established in the current extension, with three main funding streams. The requested authorization totals $5.6 billion over five years (see Figure 8).

FIGURE 8. SNCP COMPONENTS, SFY 2023–2027 ($M)

Disproportionate Share Hospital Pool	$3,741
Uncompensated Care Pool	$500
ConnectorCare subsidies	$1,400
Total	**$5,641**

The total amount requested for the SNCP is less than the $8 billion in the current Demonstration, largely as a result of the discontinuation of DSRIP ($1.8 billion in the current Demonstration) and PHTII ($850 million). The total request for the remaining components of the DSH Pool is about $250 million lower than in the current Demonstration, with some components reduced and others increased. The request for authorization of ConnectorCare subsidies is $175 million higher than in the current Demonstration.

1. DISPROPORTIONATE SHARE HOSPITAL POOL

The largest component of the SNCP is the DSH Pool, which provides support to hospitals serving high numbers of patients who have low incomes, are MassHealth members, or are under- or uninsured. Other than DSRIP and PHTII, the subcomponents of the DSH Pool carry over from the current Demonstration. These subcomponents include:

- Funding for the Health Safety Net (HSN), which pays hospitals and community health centers for care provided to people with low incomes and inadequate or no insurance ($1.2 billion over five years, compared with $1.5 billion originally allocated in the current Demonstration)[66]
- A Public Service Hospital payment to Boston Medical Center, for services to patients eligible for HSN ($100 million, the same as in the current Demonstration)[67]
- Payments for uncompensated care to non-acute hospitals operated by the Department of Mental Health ($616 million) and Department of Public Health ($200 million); in aggregate, this is about $548 million less than the amount originally allocated in the current Demonstration
- Payments to Institutions for Mental Disease (hospitals or nursing facilities) for otherwise unreimbursed BH care provided to MassHealth members age 21–64 ($150 million, compared with $160 million originally allocated in the current Demonstration)[68]
- Safety Net Provider Payments ($1.5 billion, a substantial increase from the $883 million in the current Demonstration)

Safety net providers are defined for this purpose as hospitals that have a "patient mix" of 20 percent or more MassHealth members or patients without insurance combined with no more than 50 percent of patients with commercial insurance. Because patients without insurance often cannot pay for their care and MassHealth typically has lower reimbursement rates for hospital services than commercial insurance, these hospitals receive less revenue per patient (often much less) than hospitals with more commercially insured patients. The SNCP payments are intended to shore up safety net providers' operational sustainability. The "patient mix" criteria for a hospital to qualify for Safety Net Provider Payments in the request are no different from the current Demonstration, but there are now 23 hospitals that meet the criteria, up from 14 in the current Demonstration, with a corresponding increase in the requested amount to be authorized for these payments.

In addition to the "patient mix" criteria, the safety net providers must demonstrate meaningful participation in MassHealth's ACO program. Accordingly, a portion of each year's funds will be withheld, with hospitals having the opportunity to earn back the withholdings based on their performance on ACO quality measures.

Two current pieces of the DSH Pool are not part of the SNCP in the extension request. As explained in Section III, the DSRIP program was intended to be time-limited, lasting only the five years of the current Demonstration, and in 2020, CMS made it clear that there is no possibility of a DSRIP extension.[69] DSRIP was the funding source that launched the CP program and the FSP, two of the key innovations of the current Demonstration. In the extension request, CPs would be paid directly by ACOs and MCOs out of administrative funds, and flexible services would have a separate funding stream. PHTII, a time-limited incentive payment targeted to Cambridge Health Alliance, is also no longer part of the SNCP. As described in the discussion of health inequities in Section VI, PHTII is replaced in the Demonstration request by the "Non-state–owned Public Hospital Health Equity Incentives" payment, a potential payment to Cambridge Health Alliance of $90 million per year.

2. UNCOMPENSATED CARE POOL

Massachusetts proposes to maintain the structure of the two other components of the SNCP (the Uncompensated Care Pool and ConnectorCare subsidies). The Uncompensated Care (UC) Pool reimburses hospitals and community health centers for care provided only to people without health insurance, and can be accessed when the DSH Pool has been exhausted. The proposal requests continuing the level of $100 million per year for the UC Pool, but also states that "funding levels of individual initiatives are subject to change based on ongoing negotiations between the Commonwealth and CMS."[70]

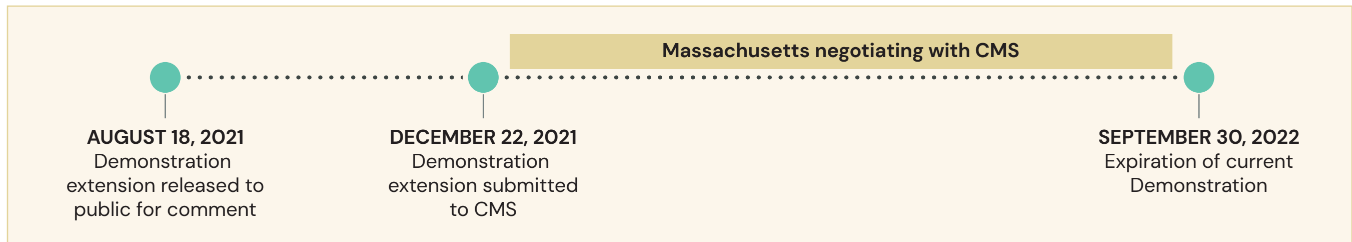
3. CONNECTORCARE SUBSIDIES

The Health Connector is the Commonwealth's marketplace for individuals and small businesses to purchase health insurance. Under the Affordable Care Act (ACA), some purchasers are eligible for federal subsidies of their premiums.[71] Massachusetts offers an additional state subsidy for premiums and cost sharing to purchasers who are at or below 300 percent of the federal poverty level (FPL), through a program called ConnectorCare, a remnant of the state coverage expansions that preceded the ACA. These state subsidy payments receive federal matching funds through the Demonstration. ConnectorCare continues as part of the SNCP in the extension request.

IX. STATUS OF THE DEMONSTRATION EXTENSION REQUEST

After releasing the Demonstration extension request for public comment in August 2021, Massachusetts submitted the request to CMS on December 22, 2021. Massachusetts is currently in negotiation with CMS regarding whether the federal government will approve, partially approve, or deny the request (see Figure 9).

FIGURE 9. TIMELINE OF DEMONSTRATION SUBMISSION AND APPROVAL



CMS is expected to approve or partially approve the MassHealth Demonstration extension request, which will be announced with an approval letter. When the approval letter becomes public, it will be accompanied by a long document setting out the details of the Demonstration, known as the "Special Terms and Conditions," or STCs.[72]

Even after approval, negotiations with CMS about certain details of the Demonstration could be ongoing. For example, though the last Demonstration was approved effective July 1, 2017, the details of the FSP weren't finalized until 2018 and the program did not launch until January 2020.[73] Some items with details that might take time to finalize include: (1) Expansion of eligibility to certain individuals experiencing incarceration; and (2) Primary care sub-capitation (because of the complexity of this kind of model). The public can expect to see these details as they are finalized, as protocols attached to the STCs.[74]

X. IMPLICATIONS

IMPLICATIONS FOR HEALTH EQUITY

With its new request, MassHealth has included advancing health equity as an explicit goal for the first time in the 20-plus years of the Demonstration. While health inequities—in access and outcomes—have been apparent for a long time, they were brought into bold relief by the disparate impacts of the COVID-19 pandemic. Government and health care leaders seized an opportunity to elevate health equity as a policy issue. A Health Equity Task Force, created by an act of the Legislature, issued its final report and recommendations in July 2021. In addition to strengthening public health infrastructure, diversifying the health care workforce, investing in community health centers and safety net providers, and expanding coverage to all immigrant children, among other policy recommendations, the Health Equity Task Force also envisioned a cabinet-level Executive Office of Equity and a Secretary of Equity to help lift up equity within state government.[75] Federal actions to address the impacts of the pandemic, including ARPA, also acknowledge the importance of reducing inequities.[76] Attention to equity is high, as are the stakes: Many residents of Massachusetts are looking for results in correcting the impacts of structural racism and other types of discrimination; health inequity is one of the most prominent.

By establishing a health equity goal and weaving that focus throughout the Demonstration proposal, MassHealth can be an engine for moving the system towards greater equity, as it was (and still is) for health care coverage. The Demonstration's focus on social drivers of health—particularly housing stability and food security—is important because these (and other) social factors often have a greater influence on the health of populations than health care services.[77] The continuation and expansion of the FSP, which provides nutritional and housing supports, is therefore very significant.

Whether and how flexible services—and other Demonstration provisions such as the extension of postpartum coverage, services for people who are justice-involved, and others—reduce inequities needs to be measured, which is another important feature of the Demonstration request. ACOs and hospitals will be partners with MassHealth in achieving the equity goal. The request would tie incentive payments to improved collection of social risk factor data, to development and monitoring of disparity-sensitive measures, and ultimately, to the reduction of inequities. MassHealth has announced with this proposal that equity is an element of health system performance and part of what ACOs are accountable for. To be successful, standards for data collection and reporting will need to be among the details of the plan. This is new ground and will be important to follow as the details of how these data will be collected and how the payment incentives will be administered are rolled out.

IMPLICATIONS FOR MASSHEALTH MEMBERS

This Demonstration request includes proposed expansions of eligibility and services that have the potential to include more individuals in MassHealth coverage and more opportunities to access key BH and care coordination services and supports. Of note, if the request for waiving the inmate exclusion policy is approved, Massachusetts would be among a handful of states extending, for the first time in the history of Medicaid, coverage to some individuals experiencing incarceration. Expanded coverage and services for individuals who are incarcerated, postpartum individuals, and individuals facing health conditions related to unstable housing and food insecurity offer a targeted approach to addressing key areas of health inequity in the Commonwealth.

When MassHealth ACOs were introduced in 2018, they offered promise for improved care management and integration, while introducing risks that payment reform may negatively affect the patient experience. Early evaluation results show that MassHealth ACOs may be delivering on the promise, with members reporting (on average) positive experiences as ACO members. Continued vigilance is called for as these programs evolve, to ensure that new models of coordination enhance access and health care quality.

IMPLICATIONS FOR ACCOUNTABLE CARE ORGANIZATIONS

Four years ago, Massachusetts launched an ambitious delivery system reform project, with the launch of the ACO program at the center. As discussed above, early results on member satisfaction, quality, and cost metrics are promising. As a result, Massachusetts plans to continue its ACO program for the next five years. The current ACO contracts will be extended until some time in 2023 when the state has selected a new slate of ACOs (which will include many of the current ACOs), resulting in new ACO contracts, with new requirements.

ACOs that wish to contract with MassHealth will face different options and requirements. The Model C ACO program (where an ACO contracts with an MCO in a shared savings/shared losses relationship) will no longer be available. ACOs will be asked to operate new models of care, including new approaches to care coordination, new approaches to paying CPs, and operating a primary care sub-capitation program. These changes will require effort and infrastructure to build the required administrative process.

As DSRIP ends, Massachusetts intends to move 80 percent of the $1.8 billion in DSRIP funds into ongoing programs. DSRIP funding has been declining since it started in 2017, so this may not represent a stark reduction in funds for ACOs. But there may be some adjustments that ACOs will have to make to line up funding and new administrative functions. Health equity incentive funds for ACOs will be available, with a required additional focus on health equity.

IMPLICATIONS FOR PRIMARY CARE PROVIDERS

Primary care providers are a key part of the ACO infrastructure. Moving forward, a proposed new payment method (sub-capitation) will change the way they are paid by ACOs. There remain some open questions about the model, especially for smaller practices. Due to natural variation, quality and cost metrics can "bounce" around a lot. At the same time, practices that focus on at-risk populations (e.g., high numbers of limited-English-proficient patients requiring interpretation) may be penalized if cost/quality metrics do not adequately take those factors into account. Further details regarding guardrails,

opt-out options, and intersections with the Division of Insurance (which regulates providers taking on risk) will assist in understanding the further implications of this proposal.

IMPLICATIONS FOR BEHAVIORAL HEALTH PROVIDERS

Beyond the Demonstration request, Massachusetts is redesigning its BH system, across all payers; these changes include a crisis response call/text option, expanded access to treatment, more BH services available in primary care offices, and community-based alternatives to the emergency department for BH crises.[78] Massachusetts' Demonstration request asks for several items that need CMS approval to implement the state's broader BH redesign, including workforce initiatives such as student loan repayment (described in Section VII) and expanded access to diversionary BH services (described in Section IV). For BH providers, additional covered services and workforce initiatives may mean better care for their clients, more payment for services they deliver, and debt relief that could increase the viability of remaining in practice.

IMPLICATIONS FOR COMMUNITY PARTNERS

In the rollout of MassHealth delivery system reforms, the CP program was successful in reaching populations historically not fully engaged in the health care system, but many CPs and ACOs also struggled with the complexity and rigidity of the program design.[79] MassHealth has already made changes to the structure of the CP program in response to these concerns, including increases to the CP payment rate.

Looking ahead, DSRIP, which has been the sole source of funding for CPs, is coming to an end. Massachusetts plans to transition funding for CPs to be part of the ACO payment, with ACOs paying CPs directly for services. Alongside this change, Massachusetts plans to give CPs more responsibility in the care planning process (this change will be especially significant for LTSS CPs). In addition, BH CPs will be required to either be designated as a CBHC, a new type of entity that will deliver behavioral health care for MassHealth members and other Massachusetts residents, or to have formalized processes for communication and referral with the CBHC in each of their service areas.

These changes mean that CPs will have many new processes, activities, and partnerships to build over the coming months and years. They have already shown success in the implementation of reforms, engaging members who might otherwise have been unable to access care coordination and management.[80]

IMPLICATIONS FOR COMMUNITY-BASED SOCIAL SERVICE ORGANIZATIONS

When the FSP started in 2020, there was hope that ACOs would partner with social service agencies to provide housing and nutrition supports, bolstering social service organizations (SSOs) that have been at this work for decades. This hope has been borne out, with 33 social service providers in partnerships with ACOs to run FSPs. In an analysis of the rollout of the ACO program, organizations noted a desire for more structure in the FSP and better approaches to affordable housing.[81] Another analysis found a strong need for resources and technical assistance to improve data-sharing systems, to allow ACOs and SSOs to exchange referrals and other necessary information for serving members.[82] If the requests to extend the FSP and to continue funding for infrastructure, capacity building, and technical assistance for SSOs are approved, relationships between ACOs and SSOs will have the chance to grow stronger over the course of the next five years to meet these challenges.

IMPLICATIONS FOR MASSHEALTH AND MASSACHUSETTS

By refining the delivery reform models, and encouraged by interim evaluation findings, Massachusetts is signaling its commitment to moving ahead with its transformation of the MassHealth delivery system, and to accountable, value-based care.[83] These innovations mirror similar trends in the broader health care system. The elevation of health equity as an explicit goal of the Demonstration is a notable new feature of MassHealth policy and, because MassHealth is an important engine of state health policy overall, the structure, process, and outcomes of the proposed financial incentives to improve equity has the potential to influence payers and providers beyond MassHealth.

XI. CONCLUSION

Throughout the last few decades, Massachusetts has established a tradition of pushing the limits of what a health care system could look like in the United States, particularly in the area of expanded coverage for its residents. Over the past several years, MassHealth leapt into accountable care, with high hopes and a commitment to CMS to improve care and mitigate costs. The Demonstration's interim evaluation shows positive results—including high patient satisfaction, increasing rates of primary care visits, and decreasing rates of low-value care, as well as costs that are largely staying within range. It also points to opportunities for continued improvement, including to strengthen collection of data to better understand health inequities and to ensure that the incentives built into the value-based payment model extend from ACOs and MCOs to their primary care provider networks.

Looking ahead, Massachusetts aims to build on the foundation of expanded access and accountable care and to explicitly address and improve health equity. Using the MassHealth Demonstration as its vehicle, Massachusetts intends to improve MassHealth eligibility and services for populations that experience health inequities, make adjustments to some of the core features of the Demonstration (ACOs, CPs, and FSPs) in response to opportunities for improvement identified in the interim evaluation, introduce new accountability for ACOs and hospitals to address health equity, and support continued investment in primary care and BH. The next few months will reveal the detailed contours of these changes.

APPENDIX: FUTURE PLANS FOR DSRIP PROGRAMS

DSRIP ELEMENT	FUNDING (2017–2022)	DESCRIPTION	ANTICIPATED CHANGES (2022 AND BEYOND)
Support for ACOs	$1,065,000,000	In addition to MassHealth payments for services, DSRIP funding provided ACOs with funding for: • Startup/ongoing—primary care investment • Startup/ongoing: discretionary • Flexible services • DSTI Glide Path	Massachusetts is asking for continued authority to continue the Flexible Services Program. Massachusetts indicates that it will continue funding for 80 percent of DSRIP, including through increased non-medical administration rates in support of primary care sub-capitation, ACO care management/coordination programs, flexible services funding, and health equity activities.[84]
Support for CPs and Community Service Agencies (CSAs)	$546,000,000	DSRIP is the sole MassHealth funding source for CPs.	Massachusetts requests that CP funding be continued through 2022. After 2022, Massachusetts plans to pay for CP services through an administrative rate paid from MassHealth to ACOs/MCOs. ACOs/MCOs will be required to contract with CPs. Massachusetts indicates that it will continue funding for 80 percent of DSRIP, though specifics are not addressed.[85]
Statewide Investments	$114,800,000	DSRIP is the sole MassHealth funding source for Statewide Investments. Statewide Investments include funding for: • Student loan repayment for behavioral health and primary care providers • Primary care integration • Primary care residency training for PCPs and nurse practitioners • Workforce development • Technical assistance for ACOs, CPs, and CSAs • Alternative Payment Methods Preparation Fund • Enhanced diversionary behavioral health activities • Improved accessibility for people with disabilities or for whom English is not a primary language	MassHealth is asking for authority to continue student loan repayment for primary care providers and certain behavioral health professionals. The request indicates that Massachusetts plans to continue the majority of DSRIP activities, but specifics are not addressed.[86]
State operations and implementation	$73,000,000		Massachusetts indicates that it will continue funding for 80 percent of DSRIP, though specifics are not addressed.[87]

ENDNOTES

1 Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS), Office of Medicaid, "Section 1115 Demonstration Project Extension Request," submitted December 22, 2021, accessed at https://www.mass.gov/doc/1115-waiver-extension-request/download.

2 Massachusetts Center for Health Insurance and Analysis, "Findings from the 2019 Massachusetts Health Insurance Survey" (April 2020), available at https://www.chiamass.gov/assets/docs/r/survey/mhis-2019/2019-MHIS-Report.pdf.

3 Further detail about the history of the MassHealth Demonstration is available in two previous publications: Seifert, R., Grenier, M., & Sullivan, J., "The MassHealth Waiver Extension for State Fiscal Years 2015–2019: Foundation for Coverage, Engine for Innovation." Blue Cross Blue Shield of Massachusetts Foundation (February 2015); Gershon, R., Grenier, M., & Seifert, R., "The MassHealth Waiver 2016–2022: Delivering Reform." Blue Cross Blue Shield of Massachusetts Foundation (January 2017).

4 Long-term services and supports (LTSS) encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities. They include home health services, personal care, adult day health care, and nursing facility stays.

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7 Draft Independent Evaluation Interim Report p. 23.

8 Demonstration Request, p. 18.

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10 "MassHealth Community Partners Program: Information for Providers," accessed at https://www.mass.gov/guides/masshealth-community-partners-cp-program-information-for-providers#-objectives-.

11 EOHHS, "Massachusetts Delivery System Restructuring: 2019 Update Report," slides 39–47.

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13 Artiga, S., & Hinton, E., "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity," Kaiser Family Foundation (May 10, 2018), accessed at https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

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15 Demonstration Request, pp. 55–56.

16 The Primary Care Clinician Plan is a plan in which MassHealth members are enrolled with a Primary Care Clinician, seek referrals to see specialists, and receive behavioral health from MassHealth's behavioral health vendor.

17 CSP-JI authority was requested earlier, as part of a June 2021 MassHealth Demonstration amendment request.

18 Demonstration Request, p. 28.

19 Demonstration Request, p. 29.

20 Individuals may only be eligible for Medicare cost-sharing assistance through MassHealth, not the full range of MassHealth services.

21 130 CMR, §505.004; 130 CMR, §519.012.

22 Not all individuals are currently subject to the one-time deductible in order to access CommonHealth. Because eligibility is complicated, it is recommended to talk to a MassHealth representative or health care navigator when trying to determine MassHealth eligibility.

23 42 CFR 935. States are required to extend Medicaid eligibility retroactively if a person received a Medicaid-covered service during that time and would have been eligible for Medicaid if an application had been submitted.

24 Shafer, P., Huberfeld, N., & Golberstein, E., "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible for Coronavirus Treatment Costs," <footnoteital>Health Affairs Forefront, Health Affairs</> (May 8, 2020), accessed at https://www.healthaffairs.org/do/10.1377/hblog20200506.111318/full/.

25 Ibid.

26 MassHealth members do have access to provisional coverage, where they can state without documentation that they meet application requirements and receive temporary coverage. Provisional eligibility has been narrowed in recent years.

27 Families First Coronavirus Response Act, Public Law 116–127, §6008(b)(3), available at https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf.

28 Demonstration Request, p. 75.

29 Social Security Amendment of 1965, Pub. Law 89–97 (July 30, 1965). There is an exception to the Medicaid inmate exclusion when individuals are hospitalized outside of the correctional setting. See CMS State Medicaid Director Letter #16-007 RE: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities (April 28, 2016), accessed at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf.

30 Other states have asked for Medicaid to take effect for the last 30–90 days of incarceration (California, New York, Utah, and Vermont); only during the public health emergency (Illinois); or only for SUD benefits (Kentucky). As of this writing, none of these requests have yet been approved.

31 Demonstration Request, p. 68.

32 Ibid.

33 See, for example, Massachusetts Department of Public Health, "COVID-19 Community Impact Survey (finding disparities in access to health care and basic needs in Massachusetts)," accessed at https://www.mass.gov/info-details/covid-19-community-impact-survey.

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35 Letter to CMS, Jan 22 2022, accessed at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-postpartum-req-withdrawal-ltr-01202022.pdf

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39 Gershon, Grenier, & Seifert, "The MassHealth Waiver 2016–2022."

40 Demonstration Request, p. 20.

41 See, for example, Taylor, L., "Housing and Health: An Overview of the Literature," <footnoteital>Health Policy Brief, Health Affairs</> (June 7, 2018), accessed at https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/.

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46 Demonstration Request, pp. 20, 46, and 47.

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51 Demonstration Request, p. 51.

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53 Demonstration Request, p. 53.

54 Primary Care ACO Contract, Section 2.2.A.2, accessed at https://www.mass.gov/lists/primary-care-aco-pcaco-contracts (Third amended and restated Primary Care ACO Contract); ACPP Contract, Section 2.7.C.1.b, accessed at https://www.mass.gov/lists/accountable-care-partnership-plan-acpp-contracts#3rd-amended-and-restated-(a&r)-acpp-contract-%E2%80%93-base-contract-shared-by-all-acpps-3rd-a&r-acpp-contract-and-appendices-shared-by-all-acpps- (Third amended and restated base ACPP Contract).

55 Demonstration Request, p. 18: "Primary care providers within ACOs are still primarily reimbursed fee-for-service, incentivizing volume rather than driving health systems and providers further towards value."

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63 Ibid.

64 Covino, N. A., "Developing the Behavioral Health Workforce: Lessons from the States," <footnoteital>Administration and Policy in Mental Health and Mental Health Services Research, 46</>(6) (August 2019), pp. 689–695, accessed at https://doi.org/10.1007/s10488-019-00963-w.

65 Demonstration Request, p. 47.

66 According to Administration officials, MassHealth did not spend the full amount allocated to HSN in the current demonstration, which is the reason for the discrepancy between the amount allocated in the proposed extension and the amount allocated in the current demonstration. There were similar circumstances with the payments for uncompensated care to non-acute hospitals and payments to Institutions for Mental Disease.

67 While not a public hospital, Boston Medical Center services a very high proportion of patients covered by MassHealth or who have no insurance, many of whom have complex medical and social needs. CMS has recognized BMC's special status with the designation as a Public Service Hospital since the SNCP was created.

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71 Typically, individuals with incomes up to 400 percent of the FPL are eligible for federal subsidies. Currently, under the American Rescue Plan Act, federal subsidies have been temporarily extended to include individuals with incomes above 400 percent of the FPL.

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79 Blue Cross Blue Shield of Massachusetts Foundation, "The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success" (May 2021), accessed at https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2021-05/ACO_Qual-Assess_FullReport_Final_0.pdf.

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81 Blue Cross Blue Shield of Massachusetts Foundation, "The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success" (May 2021).

82 Mullarkey, C., Ear, S., Ribble, M., & Sheff, A., "LIFT OFF: Partnerships to Address Health-Related Social Needs," available at https://36eh4c5otxj1b3ekp2bd3fk1-wpengine.netdna-ssl.com/wp-content/uploads/2021/12/Lift-Off_Partnerships-to-Address-Health-Related-Social-Needs-Y3-Report-11.23.21.pdf.

83 Governor Charles D. Baker, letter transmitting Demonstration request to HHS Secretary Xavier Becerra, (December 22, 2021).

84 "Time-limited DSRIP funding was critical to the start-up and early success of the ACO and CP programs. With DSRIP ending, high-impact DSRIP-funded activities would transition to become core elements of the MassHealth program. MassHealth aims to transition approximately 80 percent of current DSRIP funding into sustainable base funding for primary care, health-related social needs, and care coordination (e.g., supports for members with disabilities, embedded Community Health Workers and peers in primary care practices, the CP program)." Demonstration Request, p. 6.
"Moving forward, MassHealth seeks to transition ~80 percent of annual DSRIP funding to base program funding to sustainably support successful programs built under DSRIP that will continue to provide high-quality primary care, care management, and Flexible Services within the ACO program. MassHealth will continue to refine these programs, and these targeted investments will be standardized and more streamlined for ACOs and providers to administer." Demonstration Request, p. 18.

85 See above note.

86 See above note.

87 See quotes above.

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