

# A Focus on Health Care:

## Five Key Priorities for the Next Administration

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manatt

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## **ABOUT BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION**

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## TABLE OF CONTENTS

Introduction .....	1
Health Care Priorities for a New Administration and Legislative Leaders.....	2
1. Addressing Systemic Racism and Inequities in Health.....	2
2. Ensuring Consumer Health Care Affordability .....	6
3. Confronting the Mental Health Crisis for Children and Youth .....	10
4. Improving Access to Long-Term Services and Supports, Including Long-Term Care .....	14
5. Mitigating Critical Health Care Workforce Shortages .....	18
Conclusion .....	23
Appendix I. Methodology .....	24
Appendix II. Additional Health Equity Resources.....	25
Appendix III. Additional Consumer Affordability Resources .....	26
Appendix IV. Additional Mental Health for Children Resources.....	27
Appendix V. Additional LTSS Resources.....	28
Appendix VI. Workforce Development Organizing Framework.....	29
Appendix VII. Additional Workforce Resources.....	30
Endnotes .....	31

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## INTRODUCTION

Massachusetts' historical achievements in bold and innovative health care policy, including its state-based near universal health insurance coverage and health care cost containment laws, have positioned the state as a national leader in transforming health care coverage, access, affordability, and quality.<sup>1</sup> Massachusetts has one of the nation's highest rates of health insurance coverage,<sup>2</sup> the first health insurance exchange or marketplace (the Health Connector), the first statewide cost growth benchmarking program, and one of the most innovative Medicaid programs (MassHealth) in the country. Massachusetts is consistently recognized as being one of the best states in which to receive health care due to its near universal coverage programs and access to world-leading medical experts, research, and facilities.<sup>3,4</sup> Yet, there remains work to do to ensure equitable and affordable access to high-quality and coordinated health care for all residents of the Commonwealth.

In early 2022, anticipating the election of a new governor and slate of legislative leaders, the Blue Cross Blue Shield of Massachusetts Foundation solicited broad and diverse health care stakeholder perspectives on the most pressing health care issues in the Commonwealth (see [Appendix I](#) for methodology).<sup>5</sup> Stakeholders reflected on a complex health care environment in which there is no shortage of challenges facing incoming state leaders, including racial, ethnic, and other health inequities; declining consumer affordability; a severe and growing mental health crisis among children and youth; persistent long-term services and supports (LTSS) financing and access issues; and acute health care workforce shortages. Based on stakeholder reflections, this report identifies health care reform priorities for new state leaders in the executive and legislative branches, including potential actions state leaders can take to advance these priorities.

Despite decades of progress, the COVID-19 pandemic made it impossible to ignore that not all Massachusetts residents are able to access, afford, or experience health care equally. Stakeholders note that the remaining gaps in health insurance coverage, access to health care services, and affordability impact all Massachusetts residents, but particularly people of color, people with cultural and linguistic barriers to accessing care, and people living in rural parts of the state. The COVID-19 pandemic also fundamentally changed the health care system in the Commonwealth. The pandemic prompted mental health and workforce crises and interrupted access to care and social services, and it disproportionately impacted older adults, people with disabilities, and communities of color.

At the same time, the COVID-19 crisis catalyzed rapid, collaborative, and innovative action across all levels of government, advocates, and the private sector. For example, the state established one of the most expansive free COVID-19 testing programs in the country, created new training and grant programs to bolster regional public health services, passed one of the most comprehensive telehealth laws in the nation, deployed resources to recruit and retain critical health care workers, and distributed over \$2.5 billion in COVID-19 relief funding. Massachusetts also commissioned and convened health equity legislative bodies and implemented new health equity-driven data collection processes to better understand health disparities and inequities and target resources across the state. Massachusetts again emerged as a vanguard state in coalescing leaders from all sectors and industries to solve daunting health care challenges.

With the new administration and legislative leaders poised to enter office, there is a stark need and a unique opportunity for decisive leadership to address remaining reforms to ensure equitable access to quality health care for all Massachusetts residents. Indeed, the emergence of new leadership holds fresh potential for focus, collaboration, and give-and-take solution development across stakeholders with diverse and, often, divergent interests. These new leaders will be charged with sustaining the Commonwealth's health care reform achievements while advancing a bold vision for additional reforms that further improve the health and well-being of the residents of the Commonwealth in a turbulent and uncertain time. This "sustain and build" balance will rely on the new state leaders' ability to set clear goals, lead with a united vision, and establish points of accountability, bridging public and private sector interests, to address the Commonwealth's remaining, most challenging issues in health care.

# HEALTH CARE PRIORITIES FOR A NEW ADMINISTRATION AND LEGISLATIVE LEADERS

Five priorities emerged as common themes in stakeholder interviews, requiring immediate and focused action by the new administration and legislative leaders:

1. Addressing Systemic Racism and Inequities in Health
2. Ensuring Consumer Health Care Affordability
3. Confronting the Mental Health Crisis for Children and Youth
4. Improving Access to Long-Term Services and Supports, Including Long-Term Care
5. Mitigating Critical Health Care Workforce Shortages

These challenges in the Commonwealth's health system are complex and multicausal and impact other sectors in the state's economy. The role of the health care sector in Massachusetts as a significant employer and state revenue source renders some reforms particularly challenging. Several stakeholders labeled these challenges as “last mile” issues because they remain persistent barriers to achieving equitable access to health coverage and care in the Commonwealth. Solving these problems will require intentionality, political will, and long-term focus and investment.

## 1. ADDRESSING SYSTEMIC RACISM AND INEQUITIES IN HEALTH

Racial and ethnic health inequities among Massachusetts residents are stark realities that require the urgent attention of the next administration and legislative leaders. As compared to White people, Black and Hispanic people in Massachusetts, for example:

- Are more than twice as likely to be uninsured;
- Are less likely to report being in “excellent or very good” health;
- Report higher rates of “fair or poor” mental health;
- Are more likely to be diagnosed with and die from HIV; and
- Experience disproportionate rates of pregnancy- and post-partum-related deaths.<sup>6</sup>

Racial inequities in health, while long-standing, are finally being broadly acknowledged in the wake of the tragic impacts of the COVID-19 pandemic on Black and Hispanic individuals in the Commonwealth, who experienced disproportionate illness and death from the virus. At the height of the pandemic, Black and Hispanic people were two to three times as likely to contract COVID-19, twice as likely to be hospitalized for treatment, and three times more likely to die as compared to White and Asian people in Massachusetts.<sup>7</sup>

Stakeholders interviewed for this report consistently point out that health inequities are the result of structural racism in social and economic systems, which influence things like access to education, employment, and financial opportunity. These factors have an even greater impact on health than what happens within the health care system—and structural racism in the health care system itself makes these inequities worse. Further, structural racism is only one factor that influences health inequities. People's health and access to equitable care is also influenced by discrimination and structural barriers related to gender/gender identity, sexual orientation, age, disability status, economic status, and geography. The “intersectionality” of these social, economic, political, physical, and other identities act in combination to create experiences of oppression in the health care and other social systems in Massachusetts that lead to poorer health outcomes.

Racism in health care and other social systems takes many forms but can generally be categorized as either interpersonal/personally mediated racism or systemic/institutionalized/structural racism.

**Interpersonal/personally mediated racism.** Prejudice and discrimination, where prejudice is making differential assumptions about the abilities, motives and intents of others by “race,” and discrimination is taking differential actions toward others by “race.” These can be either intentional or unintentional.

**Systemic/institutionalized/structural racism.** Structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by “race” (e.g., how major systems—the economy, politics, education, criminal justice, health, etc.—perpetuate unfair advantage).

Source: “Health Equity Style Guide for the COVID-19 Response: Principles and Preferred Terms for Non-Stigmatizing, Bias-Free Language,” Centers for Disease Control and Prevention. Aug. 11, 2020.

Stakeholders provide many examples of how the major health care system challenges facing the next governor and legislative leaders have health equity implications. These include a workforce that on the one hand fails to reflect and respond to the diversity of the people it serves, while on the other disproportionately employs people of color in direct care positions that offer low wages and few benefits. Stakeholders also point to persistent underinvestment in health care, public health, and social systems in communities of color and rural communities in the state, as well as uncontained health care cost growth that is making coverage and care less affordable for consumers, especially consumers of color. The Center for Health Information and Analysis' 2021 report on health insurance coverage and care in the Commonwealth found that from 2015–2019 the cost of health care was a higher barrier to access for Black and Hispanic residents with health issues as compared to White residents.<sup>8</sup>

Stakeholders acknowledge that leaders across the Commonwealth, within state and local governments, business, and health care, are taking unprecedented steps to understand and address racial and ethnic inequities in the health care system. But they express frustration that these efforts largely lack input from people with lived experience, are uncoordinated, and have no specific, measurable goals or accountability for achieving them. They also express skepticism that leaders have a significant and sustained sense of urgency and empowerment to act to advance health equity.

**PRIORITY ACTION:**

**ADVANCE HEALTH EQUITY THROUGH IMMEDIATE, RESOLUTE ACTION**

Systemic racism in Massachusetts' social and economic systems including health care, and resulting health inequities, requires a sense of urgency, leadership, and action from the next administration and legislature.

Stakeholders highlight the need for the incoming governor to have a “long-term view” to addressing systemic racism (which has become entrenched over 300 years), while also acting decisively to drive near-term change. To achieve that balance, stakeholders urge the next administration to:

- Take a “whole of government” approach to advancing equity now and in the long-term;
- Craft a bold vision, goals, and plan to reduce racial and ethnic inequities; and
- Empower and fund communities to lead health equity advancement at the community-level.

Stakeholders urge the next administration to build on the work of the Health Equity Task Force (HETF), the Health Equity Compact, and other recent health equity studies and recommendations (see Appendix II for additional health equity resources).

Indeed, many of the recommendations emerging from stakeholder interviews, discussed in more detail below, are based on existing and recent health equity studies and recommendations from these and other organizations.

**Establish and codify in the General Laws of the Commonwealth a leadership structure that is accountable for a “whole of government” and community-informed approach to enacting the administration’s health equity vision and goals** (see Figure 1 on page 4). As discussed earlier, stakeholders consistently raise the concern that health inequities and health disparities have many root causes that are outside of the health care system, and they caution that impacting these root causes within and outside of health care will require long-term, intensive commitment and effort across all social and economic systems.

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*“Brown and black men overdose at disproportionately high rates. ... Why are they not accessing treatment? Or why is it not working for them? Part of it is because the workforce doesn’t look like the patient population and [it] isn’t [a] culturally responsive care experience.”*

— Behavioral Health Provider

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*“[A Blueprint for Health Equity] should be turned into an action plan, but I’m not sure that the people in power who can turn it into an action plan have the same sense of urgency about the issues.”*

— Member of the Health Equity Task Force

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*“We cannot chew on this forever. There is a level of importance and immediacy. ... We are many years—decades—behind. There is a need to be action-oriented.”*

— Member of the Health Equity Task Force

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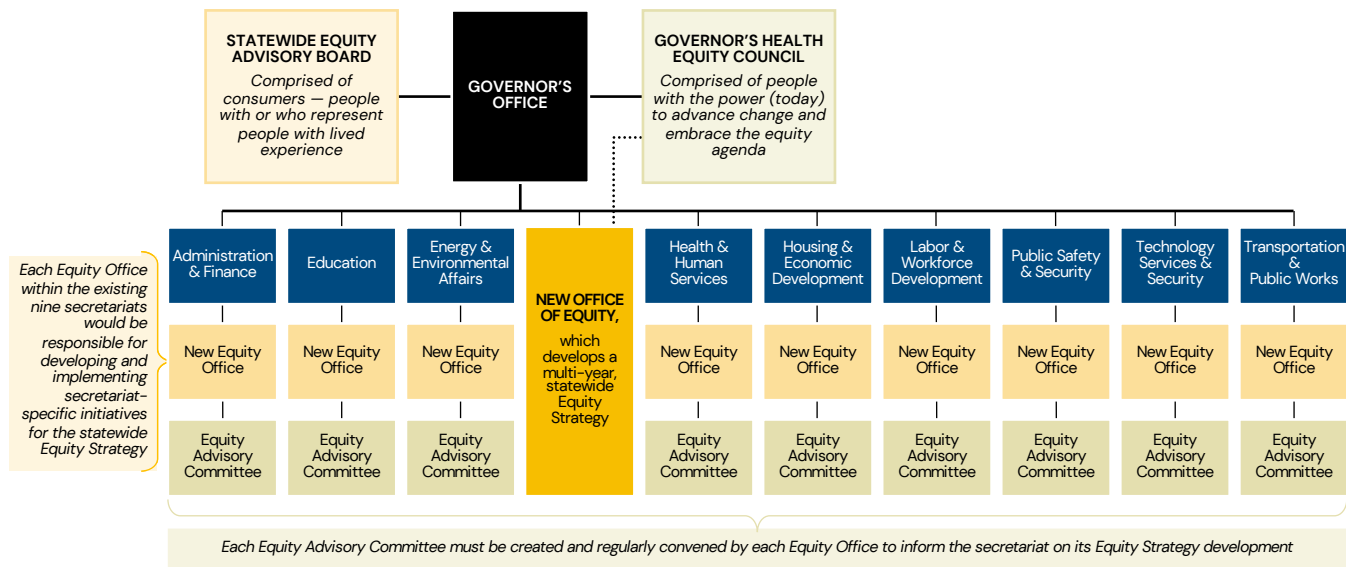
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*“We don’t need the new administration to show up and study the equity and health equity problem as though nobody has done any work on it ... [we need the new administration to] step into an action frame, utilizing the data that has been generated already.”*

— Community Health Care Provider

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**FIGURE 1. PROPOSED LEADERSHIP STRUCTURE TO ADVANCE ADMINISTRATION'S HEALTH EQUITY VISION AND GOALS**



To be healthy and have a sense of well-being, people need access to affordable health care, as well as quality food and housing, safe communities, excellent education, meaningful employment for which they are paid a living wage, affordable transportation and child care, and more. The urgent charge of advancing health equity will require a “whole of government” structure and leadership across government agencies and departments with influence in all of these areas. It will also require government leaders to engage community members with lived experience to help leaders understand systemic racism, its impact on the health and well-being of Massachusetts residents, and solutions that will help to address it.

Actions that a new administration should consider taking to create an executive branch structure to achieve these ends include (see Figure 1 for how these suggested structures relate to one another):

- *Designate a new, permanent cabinet-level Executive Office of Equity led by a new secretary of Equity.* The new office and secretary would be charged with developing a multi-year Equity Strategy for the Commonwealth<sup>9</sup> and accountable to the governor for its implementation, oversight, evaluation, and improvement. The Equity Strategy would be “cross-cutting,” meaning it would address problems and solutions across all social programs and structures that influence racial and ethnic equity generally, and health equity specifically. The cross-cutting nature of the strategy will require the secretary of Equity to work collaboratively with fellow cabinet members.<sup>10</sup>
- *Establish “Equity Offices” within each of the existing nine executive offices<sup>11</sup>* (Administration and Finance, Technology Services and Security, Energy and Environmental Affairs, Education, Health and Human Services, Housing and Economic Development, Labor and Workforce Development, Public Safety and Security, and Transportation and Public Works<sup>12</sup>). These Equity Offices would be responsible for developing and implementing secretariat-specific initiatives for the statewide Equity Strategy. For example, the Executive Office of Health and Human Services (EOHHS) Equity Office would develop a specific plan to address health inequities. As part of the charge of these new offices, the governor could *require each Equity Office to create and convene regularly an “Equity Advisory Committee”* comprised of community members who will inform and advise the secretariat on its Equity Strategy development.

In addition to establishing a permanent, accountable executive branch leadership structure to advance health equity, the new governor could also:

- *Create and convene a central, statewide Equity Advisory Board* comprised of community members and community leaders. This statewide body could be drawn from representatives of each Secretariat Equity Advisory Committee described above. The board would inform and advise the governor and governor’s cabinet on development and implementation of the Equity Strategy.<sup>13</sup>

- *Designate and regularly convene a governor’s “Health Equity Council”* that would include the governor’s office, state health care leadership, local government, health sector and business leaders, and leaders from communities most impacted by health inequities and disparities. The Health Equity Council could be convened by the secretary of Equity and serve as the governor’s vehicle for coalescing leaders across the state and garnering political support and funding for the administration’s health equity agenda. This would include contributing to developing and endorsing the Equity Strategy and the EOHHS plan to reduce health inequities. Importantly, members of this council would also be accountable for leading implementation of health equity actions in their respective sectors.

**Establish a bold vision and plan with specific and measurable goals for reducing inequities in health care coverage, access, quality, consumer experience, and outcomes during the administration’s first term.** Stakeholders advise that the next administration needs to develop a bold, data- and community-informed vision and plan for reducing racial and ethnic health care inequities in the Commonwealth. Despite acknowledged limitations in availability and quality of data on racial and ethnic health inequities, stakeholders note that Massachusetts has ample data showing that Black and Hispanic people are presently experiencing significant harm as a result of health inequities. For instance, health coverage is strongly associated with positive health outcomes and access to health care services.<sup>14</sup> But while Massachusetts has one of the lowest rates of uninsured people in the country, uninsurance rates for Black and Hispanic people are twice as high as for White and Asian people.<sup>15</sup> This coverage gap is driven by several factors that disproportionately impact people of color, including the lack of public coverage for some immigrant populations, “churn” on and off health coverage because of the consumer administrative burden to get and keep insurance, and lack of affordable coverage for lower-income people. There are also stark, well-documented gaps in quality and health outcomes for people of color in Massachusetts that require immediate action, including disproportionately high rates of infant/neonatal mortality, diabetes, asthma, HIV mortality, heart disease, and drug overdose.<sup>16</sup>

The new governor should direct the secretary of EOHHS in conjunction with the new EOHHS Equity Office described above, to implement a community-informed process to develop a four-year vision and plan for reducing racial and ethnic health inequities by the end of the administration’s first term. The process and its output could be modeled on prior successful processes, such as the EOHHS Behavioral Health Roadmap. But the process should go further in engaging with the community by embracing a vision and solution “co-design” approach with communities (as opposed to more traditional community engagement approaches that rely on listening sessions).<sup>17</sup> Co-design in health care policymaking relies on equal partnership of health care professionals who work within the system, people who have lived experience of using the health care system (e.g., patients and their families), and the policymakers charged with designing the policy—in this case the four-year vision and plan for reducing racial and ethnic health inequities.<sup>18</sup>

**Empower and fund communities to lead health equity advancement at the community level.** Stakeholders repeatedly point to the response to the COVID-19 pandemic in Massachusetts as a lesson in the power of community-level solutions to advance health equity, which should be continued and expanded. Stakeholders highlight several reasons for successful, community-designed COVID-19 testing and vaccination efforts, including that funding was prioritized for communities that were being most harmed by the pandemic and interventions were devised and implemented by people who live in the community.

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*“The surprise from the pandemic was prioritizing communities that were most likely to suffer most. ... This was an exceptional thing. What if the exception becomes the new rule?”*  
 — Member of the Health Equity Task Force

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Stakeholders encourage the new administration and legislature to invest in sustaining the community-based infrastructure and networks that were developed during the pandemic, and to fund that infrastructure to drive health equity advancement in all policy at the community level. The next administration, with the support of the legislature, should consider taking the following actions to implement this recommendation:

- *Create a Health Equity Trust Fund to sustain community-based outreach and engagement infrastructure developed during the pandemic* and fund community-run partnerships to decide on and make the local, tailored investments to advance health equity at the community level (e.g., funding for community health workers, navigators, pop-up health care sites, and behavioral health screenings). The Health Equity Trust Fund would be designed to delegate investment decision-making authority to the community in which investments are being made, with parameters for linking those investments



that align with the measurable goals to advance health equity that are developed through the EOHHS process described above.

- *Allocate health equity funding and delegate policy decision-making to communities that are suffering the most harm from systemic racism and the resulting health inequities.* Stakeholders encourage the next administration to align funding and break down silos across state agencies and departments. In particular, the health care, education, housing, transportation, public safety, and environmental sectors should work cohesively and collaboratively to fund communities disproportionately impacted by inequity and empower people in those communities to make the policy and investment decisions around the best strategies and tactics to advance health equity.

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*“I’m thinking we flip the script. What if government pulled all different streams of money together for Springfield [for instance] and then have the folks on the ground determine the best way to distribute the funding to meet community needs?”*

— Community Health Provider

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## 2. ENSURING CONSUMER HEALTH CARE AFFORDABILITY

Stakeholders universally raise consumer health care affordability as another high priority for the next administration and legislature. “Consumer affordability” of health care, an often used but seldom defined term, refers to a person’s financial ability to pay for *health insurance* (in the form of monthly premiums) and *health care services* (in the form of out-of-pocket, “point-of-service” costs like deductibles and co-payments) without cutting into spending for other necessities like food, housing, child care, and transportation. Despite high rates of insurance coverage in Massachusetts in 2021, 41 percent of residents reported that they or their families had health care affordability issues in the past 12 months,<sup>19</sup> and one-third of middle-class families in Massachusetts with employer-sponsored insurance devote more than a quarter of their income to health care.<sup>20</sup>

As health care costs in Massachusetts continue to rise, health care is becoming increasingly unaffordable for residents of the Commonwealth both in terms of the cost to obtain insurance and the costs to use health care services, even with insurance (see [Appendix III](#) for additional consumer affordability resources). In 2020, the average combined employee premium contribution and deductible in Massachusetts was 8.4 percent of median household income, up from 6.1 percent in 2010, although lower than the national average of 11.6 percent.<sup>21</sup> Consumers, especially those with lower incomes but who are not eligible for free, government subsidized coverage (through MassHealth or ConnectorCare), are highly “price sensitive” to monthly health insurance premium levels,<sup>22</sup> which continue to rise across the employer, individual, and small group markets in Massachusetts at a rate that outpaces earnings growth. From 2017 to 2019, private insurance premiums grew 8 percent, as compared to 6 percent average wage growth.<sup>23</sup> Average premiums for plans on the Health Connector (see below) will increase by 7.6 percent from 2022 to 2023 for members who do not receive subsidies for their coverage.<sup>24</sup>

Studies show that a growing number of people in Massachusetts are enrolled in high-deductible health plans (HDHPs), which come with a lower monthly premium obligation in exchange for the consumer paying more medical expenses out-of-pocket, at the point of service, before their insurance begins to cover their health care costs. Nearly half (45%) of residents with private insurance in Massachusetts reported being enrolled in an HDHP in 2021, up from 37.7 percent in 2019.<sup>25</sup> State data from 2019 also shows a rapid rise in HDHPs, comprising more than 60 percent of plans held by employees of small and mid-sized firms (which tend to employ workers with lower incomes) and, separately, that a majority of residents with low incomes with HDHPs experience affordability issues with their coverage.<sup>26</sup> There is ample evidence that even small payment obligations at the point of service cause consumers to forego health care services,<sup>27</sup> and privately insured residents in Massachusetts who were covered by an HDHP in 2019 were indeed more likely to report health care affordability issues than other insured Massachusetts residents.<sup>28</sup>

Some consumers decide to (or must) use services despite the cost of care “crowding out” spending on other necessities or otherwise adversely impacting their financial well-being. In 2019, almost one in six insured Massachusetts residents reported that their family had incurred medical debt, with individuals at family income levels between 139–400 percent of the federal poverty level (FPL) and individuals in poorer health most likely to have incurred medical debt.<sup>29,30</sup> Other consumers delay

or forgo using health care services because of affordability concerns, leaving their health care needs unmet until they become so serious that they cannot continue to avoid using the health care system. The 2021 Massachusetts Health Insurance Survey (MHIS) found that nearly one-third of insured residents reported forgoing health care due to cost.<sup>31</sup>

These types of difficult affordability decisions consumers face—choosing between and among health care, other life necessities, and family financial security—likely disproportionately affect lower-income communities and Black and Hispanic residents. In its 2021 Annual Cost Trends Report, the Health Policy Commission found that in 2019, the burden of affordability was greater for Black and Hispanic residents relative to non-Hispanic White residents. The same report also found that residents living in lower-income communities had disproportionately higher spending for prescription drugs, inpatient services, and emergency department services.<sup>32</sup> High out-of-pocket spending on health care services is likely related, at least in part, to lack of insurance. These findings also suggest that even insured people in lower-income, historically marginalized communities may forgo or delay care likely due to affordability challenges, until more serious health needs arise. Stakeholders interviewed for this report validate this conclusion.

It is also worth noting that immigrant residents face unique coverage challenges in Massachusetts and throughout the nation that may impact their ability to afford their health care costs. Over 40 percent of undocumented immigrants residing in the United States who do not have a legal immigration status are uninsured because they are generally ineligible for subsidized health insurance in Medicaid, the Children’s Health Insurance Program (CHIP), or through the Affordable Care Act (ACA) (and are not even legally permitted to buy insurance through ACA marketplaces like the Health Connector).<sup>33</sup> Moreover, 26 percent of lawfully present immigrants are uninsured nationally, despite most being eligible for government-funded health coverage programs.<sup>34</sup>

Massachusetts has gone to considerable lengths to improve consumer affordability of health coverage and access through government programs and initiatives, including:

- **MassHealth:** The Commonwealth’s comprehensive health insurance program provides free or very low-cost health coverage to one in four Massachusetts residents, including children, people who are lower-income, people with disabilities, and older Commonwealth residents who require long-term care.
- **Health Connector:** Created under Massachusetts’ pioneering health care reform law, Chapter 58 of the Acts of 2006, and expanded under the ACA, the Massachusetts Health Connector is a state health insurance “marketplace” that makes affordable, high-quality health insurance available to residents of the Commonwealth, including by administering federal and state subsidies to help people purchase health coverage.
- **ConnectorCare:** Through ConnectorCare, Massachusetts provides additional premium and cost-sharing subsidies, above and beyond federal ACA subsidies, for people with incomes up to 300 percent FPL to purchase private health insurance coverage through the Health Connector.<sup>35</sup>
- **Health Policy Commission (HPC) and Center for Health Information and Analysis (CHIA):** Created under Chapter 224 of the Acts of 2012 to rein in health care cost growth and mitigate cost-growth impacts on Commonwealth employers and residents. HPC and CHIA administer a statewide cost growth benchmarking program establishing a cost growth target for total health care expenditures (THCE) in the state across all lines of business and across all health care markets.<sup>36</sup>

Despite these efforts, stakeholders note that health care affordability is diminishing for many consumers in the Commonwealth, impacting their decisions to buy or keep insurance, as well as their ability to seek health care services. Existing policy levers to directly address health care cost growth (which drives up the cost of insurance and care for consumers), to hold health care provider and insurers accountable for controlling cost growth, and, most critically, to ensure consumer affordability of health care for all residents of the Commonwealth remain limited and diffuse across agencies.<sup>37</sup> Stakeholders urge the new administration and other state leaders to strengthen the role and accountability of state

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*“We fail to control health care costs, which leads to direct impacts in terms of ... ability to afford care. And the lack of being able to afford care leads to patients that do not get the care that they need. ... [T]hose patients are disproportionately lower income, disproportionately [people of color], and disproportionately employees of small businesses. [T]hat failure perpetuates the health inequities that have been persistent in our health care system.”*

— State Health Data Leader

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government in monitoring and ensuring consumer affordability of health care, so that all state residents have access to high-quality, affordable health care coverage and services.

**PRIORITY ACTION:**

**DIRECT AND EMPOWER THE HEALTH CONNECTOR AND THE HEALTH POLICY COMMISSION TO IMPROVE CONSUMER AFFORDABILITY OF HEALTH CARE**

Stakeholders assert that Massachusetts leaders need to do more to ensure that Commonwealth residents have access to affordable health insurance coverage and health care. Among the actions stakeholders urge the next administration to take are to:

- Expand affordable health insurance offerings through the Health Connector and strengthen the Connector’s role in enrolling and retaining people in subsidized individual market coverage; and
- Expand the authority and charge of the HPC to more directly address consumer affordability.

**Expand affordable health insurance offerings through the Health Connector and strengthen the Connector’s role in enrolling and retaining people in individual market coverage.**

The nation’s first health insurance exchange, the Massachusetts Health Connector, has long played a critical role in facilitating access to and enrollment in affordable health insurance. Stakeholders urge the next administration to expand and enhance this role by:

- *Expanding ConnectorCare.* The Commonwealth could expand income eligibility for its ConnectorCare program to allow consumers with incomes above 300 percent FPL who are otherwise eligible for coverage through the Health Connector (e.g., residents who are citizens and eligible immigrants) to participate in the program, with additional state subsidies to offset the cost of their premiums and cost sharing. The Commonwealth would be building on a long-standing, successful, and popular affordable coverage program for its residents. ConnectorCare members report lower out-of-pocket spending compared to non-ConnectorCare members and Massachusetts residents overall; they are also less likely to report delayed or forgone health care due to cost.<sup>38</sup> The fiscal year (FY) 2023 budget approved by the state legislature authorized and appropriated funding for a similar two-year pilot expansion of ConnectorCare for individuals and families with incomes up to 500 percent FPL. The pilot program, which was vetoed by Governor Baker, would have been funded using state savings accruing from enhanced federal subsidies under the American Rescue Plan Act (ARPA), which will continue to flow to the state through 2025 under the recently passed Inflation Reduction Act.
- *Creating and Funding an Affordable Coverage Program for Low-Income Immigrants.* The next administration could also direct the Health Connector to collaborate with MassHealth to design a state-funded subsidized coverage program or programs for immigrant residents who do not currently have access to government-funded MassHealth coverage or ACA coverage through the Health Connector. This could include expanding Medicaid/CHIP coverage using state funds, as California is doing.<sup>39</sup> The Commonwealth could also expand ConnectorCare, as described above, to include uninsured immigrant populations. In addition to California, the Commonwealth could look to state models like Colorado, Washington, and New York, which are designing Marketplace-administered, subsidized coverage programs for immigrants and pursuing federal 1332 waiver authority to help fund these programs.<sup>40,41</sup>
- *Directing the Health Connector to Craft a Multi-Year Plan to Improve Enrollment and Retention of Eligible Consumers.* More than 200,000 people in Massachusetts who are eligible to enroll in free, subsidized, or unsubsidized coverage in the state remain uninsured.<sup>42</sup> As noted above, Hispanic, Black, and Asian people—and other historically marginalized racial and ethnic groups in Massachusetts—are more likely to be uninsured than White people. And churn—the cycle of gaining and losing coverage—is endemic. Affordability of coverage is clearly one barrier to insurance take up among this group. Another barrier is that many people face persistent, high burdens to getting and keeping insurance coverage, including lack of clear information about coverage programs, administrative requirements related to applying for those programs, and lack of help in applying for coverage (see Figure 2 on page 9). In short, some people are not accessing coverage that would make health care more accessible and affordable to them because of the challenges inherent in getting that coverage and keeping it over time. In 2020, the Health Connector adopted a strategic plan that aims to strengthen the ConnectorCare program, improve the coverage and experience for consumers, improve the overall member experience, cover the remaining

uninsured, and adopt an equity framework that underpins all of these goals.<sup>43</sup> Stakeholders urge the next administration to continue to invest in the Health Connector, particularly in efforts related to improving the consumer experience of applying and being determined eligible for subsidized health insurance coverage. Stakeholders note that investments to support coverage access and continuity through the Health Connector should include intensifying and expanding outreach to remaining uninsured populations, engaging more with community organizations to reach people who are eligible for coverage, improving language access, and incorporating consumer feedback into strategies to bring new members into coverage.

## FIGURE 2. CONSUMER COVERAGE TRANSITION AT THE END OF THE COVID-19 PUBLIC HEALTH EMERGENCY

Although “churn” is a chronic problem in Medicaid, it has been effectively eliminated over the past two years as a result of the Families First Coronavirus Response Act (FFCRA). Under FFCRA, states received enhanced federal funding for Medicaid with the condition that they maintain continuous Medicaid enrollment for people determined eligible for the program during the COVID-19 public health emergency (PHE). When the PHE ends, which is currently anticipated sometime after mid-January 2023, the Medicaid continuous coverage guarantee will also end, and Massachusetts will begin redetermining eligibility for over 2.2 million MassHealth enrollees over a 12- to 14-month period ending in 2024.<sup>1</sup> The risk of coverage loss among Commonwealth residents during this period will be high, including for people who remain eligible for MassHealth or are eligible for other coverage such as ConnectorCare, other subsidized coverage through the Health Connector, or employer-sponsored insurance (ESI). Some people renewing their MassHealth coverage will face traditional, burdensome application and renewal processes and paperwork. Those who are not eligible for Medicaid, and transitioning to eligibility for subsidized Health Connector coverage or ESI, will also confront a cost-sharing cliff of moving from free MassHealth coverage to private coverage that comes with premium and cost-sharing obligations. The administrative and affordability barriers to insurance coverage will be paramount for thousands of Commonwealth residents at the end of the PHE.

In preparation for the end of the PHE, MassHealth has developed a comprehensive plan to increase member outreach and coordinate with key partners, including community-based organizations and managed care plans, to ensure members are aware of the importance of updating eligibility information and responding to any MassHealth requests for information related to redeterminations.<sup>2</sup> Additionally, many of the individuals that are ultimately determined ineligible for MassHealth coverage will be directed to the Health Connector for enrollment into coverage on the individual market. The Health Connector will be responsible for ensuring the individuals determined ineligible for MassHealth coverage are informed of the various coverage options and sources of financial assistance available to them, and are provided the necessary enrollment support to facilitate and effectuate coverage. Given the critical role of MassHealth and the Health Connector during this transition process, the next administration must prioritize and ensure both of these agencies are adequately resourced and staffed to facilitate this monumental transition process through the end of the federal PHE.

1. “MassHealth Snapshot Enrollment Summary of July 2022 Caseload.” Available at: <https://www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-july-2022-0/download>.

2. Boozang, P., & Serafi, K. “The End of the Federal Continuous Coverage Requirement in MassHealth,” Blue Cross Blue Shield of Massachusetts Foundation. Apr. 2022. Available at: [https://www.bluecrossmafoundation.org/sites/g/files/cspkhw2101/files/2022-04/ContinuousCoverage\\_IssueBrief\\_Apr22\\_FINAL.pdf](https://www.bluecrossmafoundation.org/sites/g/files/cspkhw2101/files/2022-04/ContinuousCoverage_IssueBrief_Apr22_FINAL.pdf).

### Expand the authority and charge of the Health Policy Commission to more directly address consumer affordability.

Stakeholders call for the next administration and legislative leaders to revisit and revamp the charge of the HPC related to health care cost growth containment to explicitly include and address consumer affordability of health insurance premiums and cost sharing. Specific actions the next governor and legislature could take to empower the HPC to improve consumer affordability include:

- **Create a consumer cost growth benchmark.** Massachusetts could update its statewide cost growth benchmark methodology to incorporate a new consumer cost benchmark that would limit annual cost growth of consumer out-of-pocket costs for health insurance, including premiums, deductibles, and co-pays.<sup>44</sup> The HPC would be responsible for tracking and reporting on insurer plan performance against the consumer benchmark and hold entities accountable consistent with existing (and perhaps new) accountability mechanisms under the statewide cost growth benchmark.
- **Incorporate provider price caps into the cost growth benchmark.**<sup>45</sup> Consumer health care costs are significantly influenced by provider prices for health care services. Stakeholders report that provider prices are difficult to address within the HPC’s existing cost growth benchmark framework, which does not specifically measure or hold providers accountable for the prices (or increases in prices) charged for health care services. In 2021, the HPC proposed to begin regulating provider prices by establishing price caps and limiting price growth for certain services among the highest-priced providers.<sup>46</sup> Several other states, including Montana,<sup>47</sup> Oregon,<sup>48</sup> and Washington,<sup>49</sup> have already incorporated price caps in their health care markets to more directly address health care costs and improve consumer affordability.

- *Give the HPC more authority to enforce compliance with the benchmarks, including stronger financial penalties.*<sup>50</sup> Under current statute, entities that exceed the benchmark are required to submit a Performance Improvement Plan (PIP) when the HPC “identifies significant concerns about the entity’s costs and determines that a PIP could result in meaningful, cost-saving reforms.” If the HPC determines that the entity has failed to comply with PIP submission and/or implementation requirements, the HPC may impose a financial penalty of no more than \$500,000.<sup>51</sup> Stakeholders view the HPC’s current enforcement mechanisms as weak and penalties as ineffective, and they urge the new administration to bolster the HPC’s tools to incentivize cost-growth containment. Other states newly establishing cost growth benchmarking programs have begun to take more aggressive stances on accountability enforcement,<sup>52</sup> and stakeholders uniformly recommend adopting these or other mechanisms to leverage more significant insurer and provider monetary incentives and penalties to promote benchmark compliance.
- *Revise the composition of the HPC Board to appoint racially, ethnically, and culturally diverse members and appoint a Consumer Advisory Board.* Statute requires the 11-member HPC Board of Commissioners to include a range of individuals appointed by the governor with broad expertise in health care delivery, health care management, finance and administration, behavioral health, health economics, workforce, etc.<sup>53</sup> Stakeholders note that given the inequitable and disproportionate impacts of rising health care affordability on communities of color, and the HPC’s own updated priorities around health equity, the governor should appoint a more racially, ethnically, and culturally diverse HPC Board. Additionally, stakeholders advise improving consumer affordability of health care will require the HPC leadership, staff, and board to meaningfully and consistently engage with community leaders and community members with lived experience who are making the hard health care affordability choices discussed above.<sup>54</sup>

### 3. CONFRONTING THE MENTAL HEALTH CRISIS FOR CHILDREN AND YOUTH

Stakeholders raise the alarm that new state leaders will inherit a burgeoning mental health crisis for children and youth when they come into office.<sup>55</sup> Between 2016 and 2020, the percentage of children ages 3–17 in Massachusetts who had anxiety or depression jumped from 12.2 percent to 18.4 percent, a 50 percent increase, which is nearly double the national increase of 25.5 percent over the same time period.<sup>56</sup> The COVID-19 pandemic accelerated and intensified this growing demand for mental health services among children in Massachusetts, due to a combination of reduced stigma and greater need and acuity, while also worsening pre-existing mental health workforce and community-based service gaps.<sup>57</sup> The pandemic disrupted children’s access to schools and health care providers—and the communication channels between these two systems of care—all of which are critical for identifying and supporting children’s physical and mental health needs. In 2022, nearly half of Massachusetts youth surveyed reported “feeling [so] sad or hopeless almost every day for two weeks or more during the pandemic that they stopped doing some usual activities,” 21 percent higher than pre-pandemic levels.<sup>58</sup> These effects are most acute for LGBTQ+ youth and children and youth of color.<sup>59</sup> These factors are culminating in the most acute emergency department (ED) boarding crisis in decades in the Commonwealth, with children and youth waiting for behavioral health placements stuck in EDs for days, weeks, or even months, due to staffing shortages (see Figure 3).<sup>60</sup>

*“We cannot allow ourselves to say ‘kids are resilient’ anymore. That was an excuse for inaction.”*  
— Health Plan Leader

#### FIGURE 3. MASSACHUSETTS IS IN THE MIDST OF AN ED BOARDING CRISIS FOR CHILDREN AND YOUTH

Emergency department or ED boarding occurs when a person in mental health or other behavioral health crisis is admitted to a hospital ED or other medical unit and then must wait in that setting until a bed in a behavioral health residential treatment setting becomes available. Typically, ED boarding occurs due to staffing shortages in inpatient behavioral health care settings—one report suggests that 568 licensed psychiatric beds (20% of total beds) in Massachusetts are unavailable due to lack of staffing—but a growing demand for children’s mental health services is also contributing to the problem. The Massachusetts Department of Public Health estimates that ED boarding has increased by up to 400 percent over the past two years. As of August 2022, 50 hospitals in Massachusetts reported that 540 behavioral health patients were boarding in their facilities, including 65 children.<sup>12</sup>

1. “Behavioral Health–Related Emergency Department Boarding in Massachusetts,” Massachusetts Health Policy Commission. Nov. 2017. Available at: <https://www.mass.gov/doc/behavioral-health-related-emergency-department-boarding/download>.
2. Youmans, L. S. “A Crisis Within a Crisis: MHA Response to Psychiatric Boarding,” Massachusetts Health & Hospital Association.

According to stakeholders, addressing the mental health crisis for children and youth will require a coordinated approach “on all fronts.” The physical health, mental health, and social systems supporting children’s health and well-being have myriad touchpoints with children and their families and are highly interdependent. For example, public schools—primarily through school-based health centers and MassHealth school-based Medicaid programs—provide physical and mental health screening and services, supports for children with physical and developmental disabilities, and social services such as free or reduced-cost food and enrollment support for public programs.<sup>61</sup> Early intervention programs and day care centers similarly provide critical services to young children and their families. Services and supports provided in these and other educational and social service settings intersect with and impact the efficacy of the services provided by a child’s pediatrician, health care specialists, and mental health providers, and vice versa.

Stakeholders point out that like other priority issues in this report, the mental health crisis in Massachusetts has been studied, solutions have been developed with stakeholder engagement, and in many cases, the legislature has allocated funding for those initiatives, in particular:

- Implementation of the multi-year **Roadmap for Behavioral Health Reform** is under way,<sup>62</sup> which focuses on building community-based infrastructure, workforce capacity, and services for all Massachusetts residents, with specific initiatives focused on children, youth, and families.<sup>63</sup>
- Governor Baker recently signed the legislatively-driven **Mental Health ABC Act (An Act Addressing Barriers to Care for Mental Health)** in August 2022.<sup>64</sup> The Mental Health ABC Act dedicates funds to expanding access to specialized treatment programs for children with serious emotional disturbance; prioritizing the creation of new inpatient mental health acute care beds for children, adolescents, and underserved communities to help address the ED boarding crisis; providing financial incentives to recruit and retain child psychiatrists at community mental health and health centers; and improving identification of mental health and other behavioral health needs for children entering the foster care system.<sup>65</sup>
- The **MassHealth 1115 demonstration**, which the state has used as a vehicle for integrating primary care and behavioral health and improving access to behavioral health services for children for many years, was recently extended for the 2022–2027 time period.<sup>66</sup> This demonstration extension includes numerous strategies and initiatives that focus on the unique needs of children in these areas.

Despite many years of these and other efforts to improve integration of physical and behavioral health care delivery and coordination of services across all systems of care for children and youth with mental health needs, stakeholders lament that these systems still are not working in tandem to prevent or swiftly identify and treat mental health and related needs. Stakeholders also note that the state does not have a unifying vision or overarching policy for children across state agencies and systems serving children and does not effectively align oversight, planning, and resource allocation across agencies. For example, a child experiencing mental health challenges may see their pediatrician, a mental health provider, a school-based mental health support program, and a coach for a recreational activity, but stakeholders suggest there is limited communication or coordination across these providers and, therefore, limited ability to identify and treat a child’s physical health, mental health, and social needs holistically.

Stakeholders urge the next administration to establish a “whole-person-centered approach” to identifying and addressing children’s mental health needs and ensuring their overall health and well-being.<sup>67</sup>

#### PRIORITY ACTION:

### CREATE CROSS-SECTOR PARTNERSHIPS AND ACCOUNTABILITY TO IMPROVE CHILDREN AND YOUTH MENTAL HEALTH

The alarming rates of mental health conditions among Massachusetts’ children and youth and the related ED boarding crisis are catalysts for the next administration to take immediate action on improving children’s mental health. While the new administration and legislative leaders are inheriting a crisis for children and youth, they are also inheriting a wide-ranging set of solutions in progress (see [Appendix IV](#) for additional resources).

But even with the current and planned progress in the state, significant opportunities remain for policymakers to better integrate primary care, behavioral health care, and other services and supports; expand access to community-based and residential treatment programs; and align and coordinate cross-system care for children and youth with mental health needs.

Stakeholders urge new state leaders to sustain and build on initiatives in progress by taking action to adopt a whole-person approach to addressing the needs of Massachusetts' children and youth, including their mental health needs, by breaking down silos across state agencies and services. To do so, state leaders specifically should:

- Establish a Children and Youth Cabinet of leaders charged with and accountable for cross-sector planning and collaboration to improve the health and well-being of Massachusetts children and youth;
- Conduct a comprehensive assessment and gap analysis of the children's mental health care system, including its intersection points with other sectors, community programs, child care programs, and education;
- Develop a 10-year Children and Youth Strategy; and
- Establish a Children's Health and Welfare Fund that pools and strategically allocates federal and state public funding and other funding to support the Children and Youth Strategy.

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*"There needs to be a way to resolve competing oversight, planning and resource allocation, both for individual children and systematically."*

— Health System Leader

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*"The new administration should be willing to pivot on things that aren't working and continue things that are."*

— Advocacy Organization

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Stakeholders also suggest that new state leaders revisit proposed policies that were never implemented, such as shifting more health care system spending to primary care and behavioral health. This could help to prevent the onset of mental health and other behavioral health conditions for children and youth, as well as to identify and treat these conditions, when they do occur, in the earliest stages. Additionally, state leaders can consider new proposals, such as providing continuous MassHealth eligibility and coverage for children for at least 12 months, or even longer as some other states are doing, which would stabilize access to mental health treatment services for children up to age 19 (see Figure 4).

#### FIGURE 4. CONTINUOUS MASSHEALTH COVERAGE FOR CHILDREN

Continuity of health insurance coverage for children and youth provides an essential and stable base for accessing primary and preventive health care, and the early diagnosis and treatment for mental health and other behavioral health conditions that will improve children's long-term health and well-being. COVID-19 disrupted early childhood services and programs, severely impacting the development and emotional and behavioral health of children and youth. Now, more than ever before, there is an urgent need to ensure stable coverage and access to health care for children.

Coverage gaps among children eligible for subsidized coverage reduce access to preventive and primary care and increase unmet health care needs.<sup>1</sup> Young children are at greatest risk of harm from coverage and care gaps, given how significantly the early years impact lifelong growth and development.<sup>2</sup> A strong foundation of coverage and continuity of care can help children and youth be school-ready, ensure timely referrals to early intervention, and potentially lower special education and child welfare costs.<sup>3</sup>

As of August 2022, 23 states had adopted the 12-month continuous coverage Medicaid state plan option for children; Massachusetts is not among them. As a bold initiative to further invest in the long-term health and well-being of children and youth, the Commonwealth could extend continuous MassHealth eligibility for children to at least 12 months, or longer. Several states, including Oregon<sup>4</sup> and Washington,<sup>5</sup> have approved or proposed Medicaid demonstration authority to extend continuous Medicaid eligibility for children up to age 6. Oregon also has demonstration authority for 24-month continuous eligibility for children over age 6 as well as adults, and for expanding Medicaid, including Early and Periodic Screening, Diagnostic, and Treatment benefits, to young adults up to age 26 who have complex health care needs such as serious mental illness. Massachusetts could pursue similar coverage guarantees for children, adolescents, and young adults in the Commonwealth as part of a bold agenda to improve the health and well-being of Massachusetts' youngest residents.

1. Sugar, S., Peters C., DeLew. N., Sommers, B. D. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (Issue Brief No. HP-2021-10)," Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Apr. 12, 2021. Available at: <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>.
2. Magie, K., Shuell, J., Hron, J., et al. "Preventing early childhood adversity before it starts: Maximizing Medicaid opportunities," Center for Health Care Strategies. Feb. 7, 2019. Available at: <https://www.chcs.org/maximize-medicaid-opportunities-prevent-early-childhood-adversity-starts/>.
3. Currie, J. "Early Childhood Intervention Programs: What Do We Know?" Jun. 2000. Available at: [https://www.researchgate.net/publication/23551126\\_Early\\_Childhood\\_Intervention\\_Programs\\_What\\_Do\\_We\\_Know](https://www.researchgate.net/publication/23551126_Early_Childhood_Intervention_Programs_What_Do_We_Know).
4. "2022-2027 Waiver Approval," Oregon Health Authority. Sept. 2022. Available at: <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-1115-Demonstration-Approval.pdf>.
5. "Medicaid Transformation Project Waiver Renewal Application," Washington State Health Care Authority. Jun. 2022. Available at: <https://www.hca.wa.gov/assets/program/wa-mtp-renewal-application.pdf>.

**Establish a Children and Youth Cabinet of leaders charged with and accountable for cross-sector planning and collaboration to improve the mental health of Massachusetts children and youth.**

Stakeholders urge the new administration to create a Children and Youth Cabinet comprised of leaders from state agencies and cross-sector stakeholder organizations that serve children to develop and implement a long-term vision and plan for investing in Massachusetts children and youth, with an immediate focus on their mental health needs. The cabinet would be charged with and accountable for creating a cross-system leadership structure and infrastructure that could centralize accountability, monitoring, and coordination of programs, services, and training initiatives that affect the healthy development of children and youth in the Commonwealth, and provide a forum for information-sharing and resource alignment and allocation. Stakeholders note that it will be critical for the Children and Youth Cabinet to integrate with other existing forums or advisory councils related to improving children's mental health, such as an advisory council on school-based behavioral health, as proposed by pending state legislation,<sup>68</sup> or an EOHHS Office of Behavioral Health Promotion, as dictated by the Mental Health ABC Act.<sup>69</sup> Stakeholders suggest that the charge of the Children and Youth Cabinet for the first term of the new administration include:

- *Conducting a comprehensive assessment of the mental health care continuum for children and youth and developing initiatives to address gaps, taking a whole-person and long-term view.* While analyses of Massachusetts' overall behavioral health care continuum have been conducted,<sup>70</sup> stakeholders highlight the need to specifically consider and assess the mental health care continuum for children and youth. Stakeholders recommend that as a first 100-days priority, the Children and Youth Cabinet complete an assessment of the mental health continuum of care for children and youth, taking a broad view that considers multiple systems providing services to children and youth, like school-based mental health and trauma services and early childhood services and family supports, in addition to mental health services provided by the physical and behavioral health care systems. Important issues that should be addressed by such an assessment, according to stakeholders, include:
  - The number of additional pediatric behavioral health beds needed to meet the demand for this level of care, and help alleviate the ED boarding crisis, in Massachusetts;
  - Whether and how specific subpopulations of children and youth with mental health needs, such as children receiving services from the Department of Children and Youth, early intervention programs, or the state's interagency Unified Planning Teams,<sup>71</sup> should be prioritized for action;
  - The specific barriers to accessing care in particular settings, such as workforce shortages, lack of training, or lack of funding;
  - Whether there are sufficient pediatric behavioral health providers of color within specific care settings and across care settings for children;
  - Workforce development or service delivery (e.g., telehealth) approaches that might work best to mitigate barriers particular to care settings; and
  - How the state can improve navigation of the mental health and related care continuum for children and youth in need of services.
- *Crafting a 10-Year Children and Youth Strategy.* Stakeholders would charge the new Children and Youth Cabinet with developing a 10-Year Children and Youth Strategy. The strategy would provide a vision, framework, and set of unifying goals for the health, education, social, and other sectors serving Massachusetts' children and youth to improve the health and well-being of the state's youngest residents. The strategy would identify the long-term, sustainable, and broad investments to children's overall health and well-being required to achieve the cabinet's vision and goals. The near-term priorities for the state should include a focused set of initiatives to improve children's and youths' behavioral health based on the care continuum assessment discussed above. California has similarly recently funded a multi-agency, multi-year Children and Youth Behavioral Health Initiative.<sup>72</sup>

The 10-year scope of the strategy is essential given that investments and improvements in health care access and affordability for children, and improved coordination across sectors, will require a long-term implementation and impact horizon, and should be measured over at least a decade if not over children's lifespans. For example, increased collaboration



and coordination between EOHHS and the Department of Elementary and Secondary Education, or between the Department of Children and Families and MassHealth, could enable the Commonwealth to achieve long-term placements for foster children with complex medical conditions or behavioral health needs, which has been particularly challenging.

- ***Establishing a Children’s Health and Welfare Fund.*** The Children and Youth Strategy should also identify opportunities to leverage, pool, and strategically allocate federal and state public funding (and potentially align private funding) to support the strategy’s vision and whole-person initiatives that may involve multiple sectors serving the same population. One potential mechanism for doing this is through the establishment of a Children’s Health and Welfare Fund,<sup>73</sup> which could pool money from MassHealth, the Department of Children and Families, and schools, for example, and help policymakers determine how best to use resources for a child.<sup>74</sup> Creation of such a fund would foster greater transparency and accountability and, potentially, streamline the state budget appropriations process for these agencies. As part of this effort, the Commonwealth should maximize participation in cross-sector federal funding opportunities such as those available under the Safer Communities Act of July 2022,<sup>75</sup> bipartisan gun control legislation that included significant funding to support children’s mental health services, with an emphasis on school-based mental health.

#### 4. IMPROVING ACCESS TO LONG-TERM SERVICES AND SUPPORTS, INCLUDING LONG-TERM CARE

According to stakeholders, Massachusetts is a leader in LTSS system reforms in myriad ways. The state has made significant investments in expanding utilization of LTSS in community settings (compared to long-term care in nursing homes) and improving care coordination for people who use LTSS (see Figure 5). The state has leveraged federal dollars to advance these efforts and now ranks 10th among states across comprehensive LTSS measure sets, according to AARP’s LTSS State Scorecard.<sup>76,77</sup>

##### FIGURE 5. A GROWING DEMAND FOR LONG-TERM SERVICES AND SUPPORTS

**Long-Term Services and Supports (LTSS)** include a range of medical and non-medical services provided in people’s homes, communities, and in facilities (e.g., nursing homes) that older adults and people of all ages with disabilities and chronic diseases, such as diabetes, heart disease, and dementia, use to meet their clinical, personal care, and other daily living needs. LTSS are inclusive of institutional/facility-based care, often referred to as “long-term care.” LTSS include adult day health, durable medical equipment (e.g., wheelchairs, walkers, hospital beds, and home oxygen equipment), home care, home health, meal preparation, medication management, personal care, physical therapy, private duty nursing, and skilled nursing. LTSS improve people’s quality of life and, for many people, support their ability to live independently in their homes and communities. LTSS providers also play a critical role in ensuring continuity of care for individuals and addressing complications that can reduce hospital admissions, readmissions, and emergency department use. The demand for LTSS is growing given the aging of the population. Massachusetts’ population aged 65 and over is projected to grow by 30 percent over the next 20 years, with a 40 percent growth rate for people ages 85 and over.<sup>1</sup> National and state data indicate that most of us will eventually need LTSS for some period of time or will need to establish or provide these services and supports for a loved one.<sup>2</sup>

1. “National Population Projections,” University of Virginia Weldon Cooper Center, Demographics Research Group. 2018. Available at: <https://demographics.coopercenter.org/national-population-projections>.

2. “What Is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports?” ASPE Research Brief. 2019. Available at: [https://aspe.hhs.gov/sites/default/files/migrated\\_legacy\\_files/188046/LifetimeRisk.pdf](https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/188046/LifetimeRisk.pdf). “What Is Long Term Care Insurance,” Massachusetts Division of Insurance. Available at: <https://www.mass.gov/info-details/what-is-long-term-care-insurance>.

Despite Massachusetts’ many successes and investments in strengthening its LTSS system for older residents and residents with disabilities, stakeholders note that significant challenges remain, all of which were exposed and made worse by the pandemic. Stakeholders identified broad challenges that impact overall access to affordable LTSS in Massachusetts, as well as specific challenges related to accessing and coordinating LTSS within MassHealth, the largest payer of LTSS. These include:

- ***Dire LTSS workforce shortages*** at a time when demand for LTSS is growing (workforce gaps are discussed in Section 5).
- ***Lack of affordable payment options for LTSS***, particularly for people with moderate incomes who do not qualify for MassHealth (the primary payer of LTSS in the state). Despite ranking near the top on the LTSS State Scorecard, Massachusetts ranked near the bottom of the pack (43rd) for affordability of nursing home care.

- *Fragmentation of LTSS coverage and care delivery* from other parts of the health care system for all residents, but particularly for people who qualify for MassHealth. The Commonwealth also ranked poorly (46th) on the percentage of home health patients who have a hospital admission—indicating that the health and complex conditions of people in Massachusetts who use LTSS are not being well managed.

Part of why LTSS is so unaffordable is because it is difficult to obtain insurance coverage to help pay for these services. Medicare, which covers seniors and people living with long-term disabilities, does not cover most LTSS. MassHealth does cover LTSS, but people must have very low incomes in order to qualify, and seniors also must have very limited assets. Approximately 8 percent of Massachusetts residents ages 55 and older have private long-term care (LTC) insurance coverage to defray *some* of their LTSS costs (compared to nearly 98 percent of Massachusetts residents with medical insurance coverage<sup>78</sup>).<sup>79</sup> Barriers to enrolling in and maintaining LTC insurance include that coverage must be purchased well in advance of one’s *potential* need for services in order to be affordable. Policyholders also often experience significant premium increases as insurers and state regulators seek to stabilize an often volatile market.<sup>80</sup>

Without insurance for their LTSS needs, most Massachusetts residents pay for LTSS through their personal resources. But LTSS costs in Massachusetts are well above the national average and difficult for most people to afford. The cost of a semi-private skilled nursing facility (SNF) room across Massachusetts ranges from \$136,000 to \$157,000 per year, compared to roughly \$95,000 nationally. Similarly, home health costs in Massachusetts range from \$70,000 to \$80,000 per year, compared to \$60,000 per year nationally.<sup>81</sup> LTSS costs are also growing due to inflation and rising labor costs, yet policymakers have largely avoided addressing LTSS consumer affordability issues in recent health care payment reform or cost containment initiatives.<sup>82,83</sup>

Without financial protection, most people cannot afford the cost of this care over an extended period of time. Many moderate-income people “spend down” their resources and ultimately become eligible for MassHealth. Indeed, MassHealth pays for roughly half of all paid LTSS in the state.<sup>84</sup> But this cycle of impoverishment and the continued disproportionate impact on MassHealth of paying for LTSS is not sustainable and should not continue.

In addition to the overall lack of coverage and affordability for people who need LTSS, people who do have LTSS coverage through MassHealth (roughly 350,000 of MassHealth’s 2.2 million members) mainly access services through a separate delivery system from their primary and preventive care, hospital care, and behavioral health services. This means the LTSS they need remains administratively, financially, and clinically disconnected from their medical and other services, causing confusion for consumers trying to access services and often leading to suboptimal care.

People who are dually eligible for MassHealth and Medicare, for example, are high users of LTSS. For dually eligible individuals who use LTSS, their LTSS needs are covered by MassHealth, while the majority of their other service needs (primary care, hospital, behavioral health, pharmaceutical care) are covered by Medicare.

Dually eligible members do have the option to enroll in two state-of-the-art integrated care programs—Senior Care Options (SCO) for individuals ages 65 and older and One Care for individuals under age 65—that provide their enrollees with access to all Medicare- and Medicaid-covered services (including LTSS) and to comprehensive care management services through an integrated managed care model.<sup>85</sup> Members enrolled in SCO or One Care report extremely high overall satisfaction with their health plan.<sup>86</sup> Enrollment in SCO and One Care has grown steadily since their inception in 2004 (SCO) and 2013 (One Care), and Massachusetts is working with the federal government to enhance and expand enrollment in these programs, but only one-third of dually eligible individuals (104,000 people) are currently enrolled in either program.

Most non-dually eligible MassHealth members are enrolled in ACOs (newly established in 2017 for most MassHealth members) or Medicaid managed care organizations (MCOs). While the state initially envisioned that MassHealth ACOs and MCOs would cover and manage comprehensive LTSS for their MassHealth members,<sup>87</sup> it is unlikely these services will be incorporated into the ACOs’ or MCOs’ care delivery or financial responsibilities in the near future. Instead, MassHealth members enrolled in ACOs

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*“Consumers are experiencing a sense of disconnect from or inability to connect with a really complicated, multi-layered health care system, particularly [immigrants/ people with cultural or linguistic barriers] who may be unfamiliar with our health care system generally.”*

Advocacy Leader

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or MCOs still access LTSS through the MassHealth fee-for-service system. Stakeholders suggest that consumer advocate opposition and lack of will, capacity, or competency on the part of the ACOs/MCOs have stymied this integration effort to date. The state has established specialized care management entities to help coordinate and manage LTSS for ACO/MCO members with significant needs, but only 10,000–20,000 individuals (1–2 percent of the 1.3 million ACO/MCO enrollees) can access this service.<sup>88</sup>

Thus, most Massachusetts residents who need LTSS, including those with MassHealth coverage for their LTSS needs, must access multiple delivery systems, provider networks, and informational materials to understand their options and seek and receive care. This fragmentation of LTSS coverage, financing, and care delivery results in suboptimal care for individuals, confusion for families who have to navigate myriad processes and multiple systems of care, disincentives for providers and plans to share data and collaborate on care management and treatment planning, and inefficient use of public and private health care resources. These issues are most acute for people with cultural and linguistic barriers and social support needs, who need to “connect the dots” across an even more complicated, multi-layered health care system.

While the state has leveraged significant federal COVID-19 relief dollars to bolster parts of its MassHealth LTSS system, including to help address system fragmentation, access, and navigation issues, stakeholders noted that these investment dollars are time-limited (available through March 2025) and do not fully and sustainably close these long-standing LTSS system gaps.<sup>89</sup> Stakeholders suggest that significant opportunity remains to improve LTSS financing options and affordability so that all Massachusetts residents can access affordable LTSS and to better integrate the LTSS delivery system with other parts of the health care continuum, particularly for MassHealth members.

#### PRIORITY ACTION:

### **ENSURE ALL MASSACHUSETTS RESIDENTS CAN AFFORD AND ACCESS LTSS AS PART OF AN INTEGRATED HEALTH CARE SYSTEM**

For many stakeholders, the pandemic created or renewed a call to action to ensure that all Massachusetts residents who need LTSS can find and access that care quickly, safely, holistically, and affordably as part of a social right to overall health and well-being. Dignity Alliance Massachusetts,<sup>90</sup> an advocacy group that organized during the pandemic as a direct result of the COVID-19 deaths in Massachusetts’ nursing and veteran’s homes, is “dedicated to transformative change to ensure the dignity of older adults, people with disabilities, and their caregivers” in both institutional and community LTSS settings.<sup>91</sup>

Massachusetts has implemented many reforms over the past two decades to strengthen its LTSS system (see [Appendix V](#) for additional LTSS resources). While these efforts have contributed to Massachusetts being a national leader on LTSS system performance, stakeholders identified two priority areas for new state leaders to focus their immediate attention:

- Making LTSS more affordable for more people, and
- Ensuring that people who need LTSS receive person-centered, coordinated, and integrated care.<sup>92</sup>

In both of these priority areas, Massachusetts has ample research and studies of the problems. Stakeholders are emphatic that it is time to muster the political will, resources, and leadership to solve the LTSS challenges in the state. The approaches outlined below synthesize recommendations for the new administration to improve LTSS system transparency, simplification, and navigation. Stakeholders emphasize that in advancing these recommendations, state leaders need to take deliberate steps to engage the input and voices of historically marginalized communities and populations to ensure that their needs are understood and addressed; these groups include people of different races and ethnicities, people with linguistic barriers, people living in rural areas of the state, people with specialized health care needs, people with intellectual or developmental disabilities, and people with housing or transportation instability.

**Task a senior executive branch leader (e.g., at the cabinet level or in the governor’s office) to solve long-standing challenges around LTSS planning, affordability, and financing.** In 2009–2010, Governor Patrick established a Long-Term Care Financing Advisory Committee as a major initiative of the state’s Olmstead Plan.<sup>93</sup> The Advisory Committee, which met 15 times over 18 months, developed proposed strategies for improving public and private LTSS financing options.

These financing strategies are embodied in the Committee's final 2010 report, *Securing the Future*,<sup>94</sup> including discrete sets of detailed recommendations for:

- Promoting planning for one's LTSS needs;
- Increasing uptake of existing or enhanced private LTSS financing mechanisms;
- Expanding MassHealth coverage to achieve equity in access to LTSS by age and type of disability; and
- As a fail-safe, designing and implementing a state-sponsored individual contribution program to enable people to prepare and pay for their LTSS needs.

While components of the MassHealth strategies outlined in this report were implemented over time, most of the private financing strategies were not. Just as Massachusetts was a pioneer in achieving near universal health insurance coverage for its residents and establishing an approach for tackling health care cost growth, the Commonwealth now can and should lead the nation in ensuring that all Massachusetts residents can afford LTSS services. To do this, the next governor should designate a senior-level executive branch leader, such as the lieutenant governor, the secretary of Elder Affairs, or the commissioner of insurance, to develop and implement a statewide LTSS planning and affordability strategy, working in partnership with other state agencies (such as MassHealth, Division of Insurance, Department of Public Health) and the private sector. The executive branch leader would be charged with reviewing work done to date in this area, assessing the promising strategies identified in *Securing the Future* and other prior reports or studies, and developing a comprehensive set of proposals for implementation, including any budgetary requests or legislative changes necessary to implement the proposals. Strategies that should be prioritized for immediate consideration include:

- *Implementing a comprehensive, multi-phase, statewide LTSS financing awareness and education campaign* to educate the public and employers about private LTSS financing options, and about increasing the use of these options (with appropriate beneficiary protections), including LTC insurance, reverse mortgages, and life insurance with LTSS riders.
- *Promoting the purchase of private LTC insurance through a federal Long-Term Care Partnership Program.* The LTC Partnership Program provides financial protection for people who purchase "qualified" LTC insurance, exhaust their LTC insurance benefits, and still have LTC needs. For example, the program reduces how many assets individuals in this situation will need to "spend down" in order to qualify for MassHealth coverage. Approximately 40 states have implemented the program for their residents. Massachusetts has a similar program to the LTC Partnership Program, but its asset protection rules vary from the federal program and, in some cases, are narrower in scope.<sup>95</sup>
- *Standardizing state oversight of beneficiary protections and rate stabilization around LTC insurance* in Massachusetts, as informed by the National Association of Insurance Commissioners (NAIC) model legislation. Massachusetts remains one of the few states that has not fully adopted the NAIC model legislation.<sup>96</sup>
- *Developing a state-sponsored or employer-based individual contribution program that helps Massachusetts residents finance their LTSS needs.*<sup>97</sup> Under this option, people whose LTSS needs exceed the program's LTC benefit could still access private LTC insurance and MassHealth, as appropriate (see Figure 6 on page 18).

**Advance a state discussion about MassHealth LTSS coordination and integration with other covered services.** The next governor should task the secretary of Health and Human Services, in partnership with the MassHealth director and secretary of Elder Affairs, with reinvigorating a public discussion on and pursuing MassHealth LTSS purchasing and care delivery strategies that result in a less fragmented and more connected continuum of care for MassHealth members who use LTSS, including dually eligible individuals. As the Commonwealth was embarking on significant MassHealth delivery system transformation through the creation of the MassHealth ACOs in 2015–2016, policymakers did consider integrating LTSS with physical and behavioral health services over time for ACO and MCO enrollees. Other approaches were outlined in the report, *Massachusetts Long-Term Services and Supports: Achieving a New Vision for MassHealth*,<sup>98</sup> and elevated for discussion at a convening supported by the Blue Cross Blue Shield of Massachusetts Foundation.

While MassHealth has expanded enrollment in One Care and SCO, its integrated care programs for dually eligible individuals, and established specialized LTSS care management entities for high-need ACO members, the majority of

## FIGURE 6. PRIORITIZING HOW WE CARE FOR OLDER ADULTS AND PEOPLE WITH DISABILITIES AND PAY FOR THEIR LONG-TERM CARE NEEDS

The United States is one of the few developed countries that does not have a national long-term care planning and financing strategy to respond to the needs of a growing aging population that wants to receive affordable care in their homes and communities. Federal policymakers created a voluntary, self-funded public long-term care insurance program in the ACA, but this program was repealed less than three years later due to its cost. Since then, policymakers and researchers have introduced numerous LTSS financing proposals at the federal and state levels, most of which have not gained traction due to the complexities and potential costs of such endeavors, as well as a general lack of political and societal will to prioritize this issue.<sup>1</sup>

Washington state is one exception. In 2019, Washington state passed a first-in-the-nation law to create an employee payroll contribution-based long-term care fund to help people pay for their future long-term care needs.<sup>2</sup> The program has been modified over time to address stakeholder concerns, including costs, but the program is scheduled to begin in July 2023 when workers begin contributing into the fund for benefits that will become available for eligible individuals in July 2026. Due in part to the impact of the COVID-19 pandemic on older adults and people with disabilities in nursing homes and other congregate living settings, federal policymakers also have reintroduced LTSS financing legislation in 2021 through the Well-Being Insurance for Seniors to be at Home, or WISH, Act.<sup>3</sup>

1. Mulvey J., & Colello, K. J. "Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA)," Congressional Research Service. May 3, 2010. Available at: <https://www.ncsl.org/documents/health/CLASS.pdf>; "Commission on Long-Term Care, Report to the Congress," Commission on Long-Term Care. Sep. 30, 2013. Available at: <https://www.govinfo.gov/content/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf>; "A Consensus Framework for Long-Term Care Financing Reform," Long-Term Care Financing Collaborative. Feb. 2016. Available at: [http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTFCF-FINAL-REPORT-Feb-2016.pdf?TB\\_iframe=true&width=921.6&height=921.6](http://www.convergencepolicy.org/wp-content/uploads/2016/02/LTFCF-FINAL-REPORT-Feb-2016.pdf?TB_iframe=true&width=921.6&height=921.6); "Bipartisan Solutions to Improve the Availability of Long-term Care," Bipartisan Policy Center. Sep. 2021. Available at: [https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/09/BPC\\_Health\\_Long\\_Term\\_Care\\_RV4-min.pdf](https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/09/BPC_Health_Long_Term_Care_RV4-min.pdf).
2. "About the WA Cares Fund," WA Cares Fund. Available at: <https://wacaresfund.wa.gov/about-the-wa-cares-fund/>.
3. Congress, House. "WISH Act," HR 4289, 117<sup>th</sup> Congress. Available at: <https://www.congress.gov/bill/117th-congress/house-bill/4289/text?q=%7B%22search%22%3A%3A%22WISH+Act%22%5D%7D&r=1&s=1>.

MassHealth members who use LTSS receive these services in an uncoordinated, fee-for-service delivery system. As the state begins the sixth year of its ACO delivery system transformation effort for the majority of its 2.2 million MassHealth members and continues to consider ways to improve its One Care and SCO programs, the next governor should resurrect a discussion about LTSS purchasing strategies and system improvements *as part of* broader discussions about MassHealth payment and care delivery reform. MassHealth consumers who use LTSS, their families, and consumer advocates must be included in and central to these discussions from their inception. The pandemic underscored the interdependencies among medical care, LTSS, behavioral health services, and social support services, such as housing and transportation, in promoting the health, well-being, independence, and quality of life for older adults and people with disabilities in Massachusetts, and LTSS should not continue to be fragmented from the rest of the health care system.

*"The state has supported 1115 waiver components that drive toward integration of primary care, behavioral health, and LTSS for some MassHealth enrollees, but the new administration needs to do more, including more coordinated financing and service delivery for dual eligibles."*

— Advocacy Leader

## 5. MITIGATING CRITICAL HEALTH CARE WORKFORCE SHORTAGES

While the COVID-19 pandemic disrupted the Commonwealth's entire labor market, the health care system—which employs roughly 18 percent of workers in the state—was uniquely impacted.<sup>99</sup> Frontline workers in hospitals, skilled nursing facilities (SNFs), and people's homes and communities faced high rates of burnout<sup>100</sup> and disproportionately experienced COVID-19 exposures, cases, and deaths (particularly SNF staff), and many small community-based providers temporarily or permanently closed due to severe worker shortages.<sup>101,102,103</sup> Not all health care sectors are rebounding from the pandemic or able to compete for new workers equally.<sup>104</sup>

According to a report released by the Massachusetts Health and Hospital Association (MHA) in October 2022, an estimated 19,000 acute care hospital positions are unfilled. These vacancies reflect openings across a wide range of roles.<sup>105</sup> Stakeholders nearly unanimously identified workforce shortages among paraprofessional LTSS and behavioral health workers as particularly dire. According to one stakeholder, there are over 7,000 vacancies for certified nursing assistant positions in nursing homes throughout the state. At the same time, the shortage of behavioral health staff at all provider levels and across the care continuum (e.g., in inpatient and community-based settings) is resulting in the closure of beds in both inpatient

and outpatient settings. For example, nearly 20 percent of inpatient psychiatric beds in Massachusetts are not available as a result of staffing shortages.<sup>106</sup> Moreover, among respondents of a survey sponsored by the Association for Behavioral Healthcare, community-based clinics have a total of 640 staff vacancies—across a range of provider types—throughout all of their mental health clinics. This translates to an average of 17 staff vacancies in each clinic.<sup>107</sup>

The health care workforce includes a wide range of positions with varying skill levels and education, training, licensure, and certification requirements. Positions in the health care workforce also garner a wide spectrum of wages and benefits. Historical underinvestment in LTSS and behavioral health paraprofessional workers (see sidebar for more information on this sector of the workforce)—and in the providers who employ them—has suppressed worker wages, benefits, and other supports and created long-standing challenges with recruitment and retention in these demanding and in-demand professions.

According to one report, wages for LTSS direct care workers were stagnant between 2004 and 2017 and are well below other sectors of the state’s health care workforce.<sup>108</sup> Another report found that community health workers also receive wages well below other workers with similar skill sets.<sup>109</sup> The vast majority of these paraprofessionals’ wages are below the living wage in Massachusetts for a household with one full-time working adult and no children, and all are below the living wage in Massachusetts for a household with one full-time working adult and one child or for a household with two full-time working adults and two children (see Figure 7).<sup>110</sup>

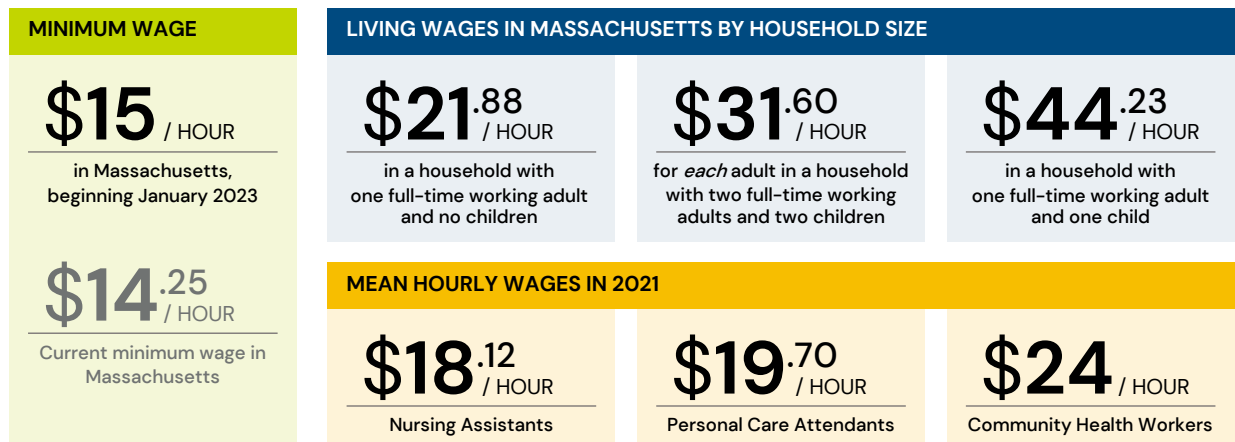
Salaries for behavioral health professionals have been and remain persistently low relative to other positions. For example, the U.S. Bureau of Labor Statistics reports that in 2021, annual mean wages for Massachusetts mental health and substance use disorder social workers; substance abuse, behavioral disorder, and mental health counselors; and marriage and family therapists were between \$53,000 and \$56,000 per year, well below the Commonwealth’s \$72,940 annual mean wage for all occupations.<sup>111</sup> And there are notable salary disparities across care settings. In 2019–2020, on average, hospitals paid almost 38 percent more than behavioral health

**Paraprofessional workers**

include, but are not limited to, long-term services and supports (LTSS) direct care workers—such as certified nursing assistants (CNAs), home health aides (HHAs), and personal care attendants (PCAs)—and behavioral health care workers—such as peer support specialists, community health workers (CHWs), and recovery coaches. LTSS and behavioral health paraprofessional workers are some of the fastest-growing occupations, given an aging population and a growing behavioral health crisis, yet these workers receive low wages, face structural barriers to entry including education and training costs, have high turnover rates (e.g., 40–60 percent among home care workers), have limited opportunities for career advancement, are often marginalized from the broader health care system, and are under-supported. Additionally, these workers, particularly LTSS direct care workers, are disproportionately women, people of color, and foreign-born.

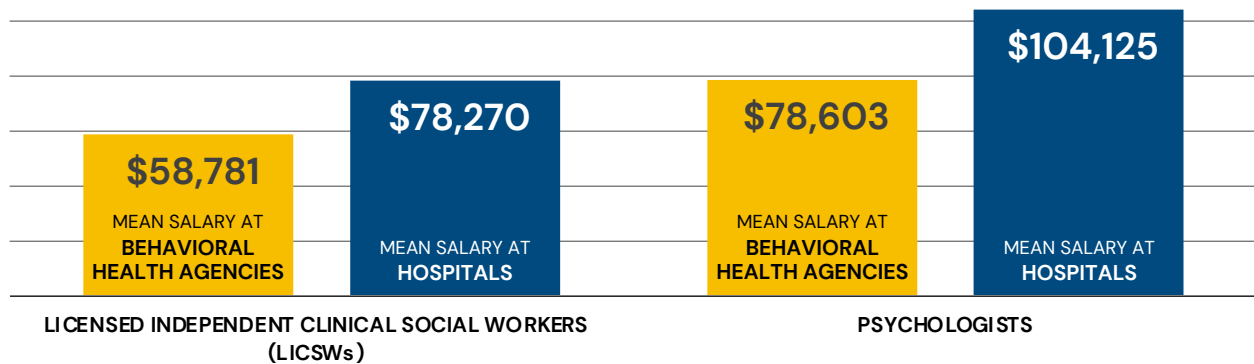
Source: “Care Work in Massachusetts: A Call for Racial and Economic Justice for a Neglected Sector,” Boston Indicators, SkillWorks, Boston Foundation. Sep. 2022. Available at: [https://www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/care\\_report\\_083122.pdf?la=en&hash=1C3AD2D84C4342C2AB186839C7B07B9993148041](https://www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/care_report_083122.pdf?la=en&hash=1C3AD2D84C4342C2AB186839C7B07B9993148041).

**FIGURE 7. PARAPROFESSIONAL WAGES IN 2021 COMPARED TO MINIMUM AND LIVING WAGES IN MASSACHUSETTS**



1. “Living Wage Calculation for Massachusetts,” Massachusetts Institute of Technology. 2022. Available at: <https://livingwage.mit.edu/states/25>.  
 2. “May 2021 State Occupational Employment and Wage Estimates Massachusetts.” U.S. Bureau of Labor Statistics. Updated Mar. 31, 2022. Available [https://www.bls.gov/oes/current/oes\\_ma.htm#00-0000](https://www.bls.gov/oes/current/oes_ma.htm#00-0000).

**FIGURE 8. MEAN SALARIES AT BEHAVIORAL HEALTH AGENCIES VS. HOSPITALS, 2019–2020**



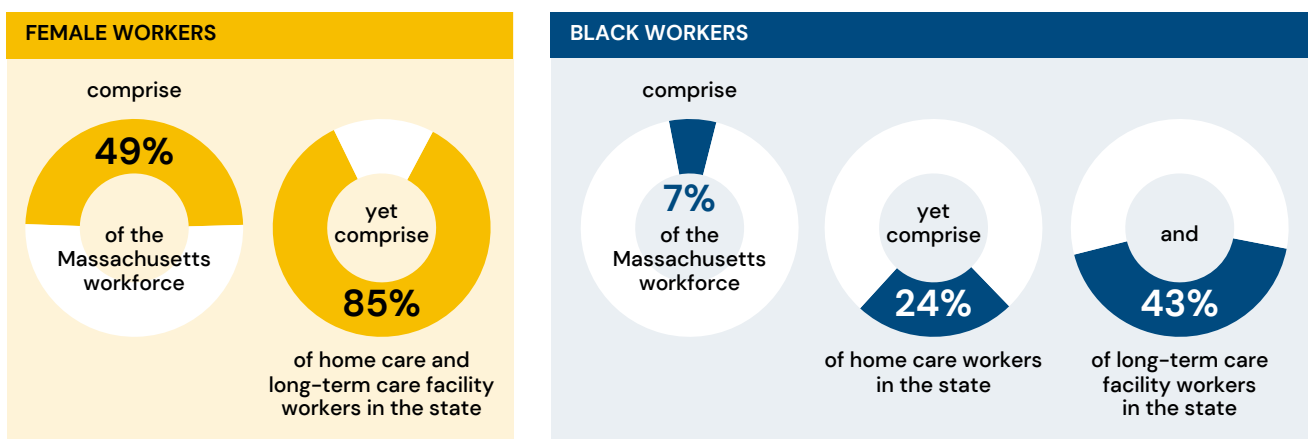
Source: "Outpatient Mental Health Access"; "Behavioral Healthcare Compensation versus Hospital Compensation," Association for Behavioral Healthcare and Arthur J. Gallagher & Co. 2020.

agencies to individuals with the same degree. For example, the mean salary at hospitals for licensed independent clinical social workers (LICSWs) was \$78,270 versus \$58,781 at behavioral health agencies, and for psychologists, it was \$104,125 at hospitals as compared to \$78,603 at behavioral health agencies (see Figure 8).<sup>112</sup>

For paraprofessional LTSS workers in nursing facilities and community settings and for paraprofessional and community-based behavioral health workers, who are disproportionately paid by MassHealth or through grant funds, the pandemic exacerbated pre-existing workforce shortages, accelerating attrition and further slowing the pipeline into these fields at a time when demand is growing.

These issues have multiple, complex impacts on the Commonwealth's efforts to advance equitable access to care. Workforce shortages in these areas impact care most acutely for people living in non-urban areas and people and communities of color. Additionally, because both the LTSS direct care workforce and paraprofessional behavioral health workforce are predominantly comprised of women, people of color, and immigrants (particularly with respect to home care workers), suppressing wages and benefits inhibits the economic mobility, income stability, and health and well-being of this part of the health care workforce—arguably the only part of the health care workforce that reflects the diversity of the people it serves.<sup>113</sup> The data is particularly stark in the LTSS direct care workforce (see Figure 9).<sup>114</sup>

**FIGURE 9. REPRESENTATION OF WOMEN AND BLACK WORKERS IN THE MASSACHUSETTS WORKFORCE AND HEALTH CARE PARAPROFSSIONAL WORKFORCE**



Source: "Care Work in Massachusetts: A Call for Racial and Economic Justice for a Neglected Sector," Boston Indicators, SkillWorks. Sep. 2022. Available at: [https://www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/care\\_report\\_083122.pdf?la=en&hash=1C3AD2D84C4342C2AB186839C7B07B9993148041](https://www.bostonindicators.org/-/media/indicators/boston-indicators-reports/report-files/care_report_083122.pdf?la=en&hash=1C3AD2D84C4342C2AB186839C7B07B9993148041).

Stakeholders acknowledge that state leaders have implemented numerous targeted programs and initiatives to strengthen the LTSS and behavioral health workforce, but assert that Massachusetts needs a comprehensive health care workforce plan that:

- Gathers more comprehensive data on the health care workforce and aligns workforce capacity with its population’s growing and evolving needs;
- Prioritizes investment in the LTSS and behavioral health workforce through wage increases and other supports, but also addresses shortages in other parts of the workforce, including nurses and social workers, so the state is prepared to address its population’s needs today and in the future; and
- Ensures resources are used efficiently so the *entire* health care workforce is valued, well-trained, paid a living wage, provided insurance and other benefits (e.g., paid sick leave and time off, and behavioral health supports), and deployed sufficiently across geographies, communities, and provider settings statewide.

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*“Whether you’re a recipient of institutional or community-based care, you are impacted by one of the worst workforce crises we’ve ever had, and for some providers, this workforce shortage is existential.”*

— Provider of Community-Based Care

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#### PRIORITY ACTION:

### **DEVELOP A 10-YEAR MASSACHUSETTS HEALTH CARE WORKFORCE PLAN THAT PRIORITIZES LONG-TERM SERVICES AND SUPPORTS AND BEHAVIORAL HEALTH WORKERS**

Massachusetts has implemented several broad and targeted health care workforce development programs and initiatives both prior to and as a result of the pandemic.<sup>115</sup> Various state agencies, divisions, and bodies administer health care workforce development programs, including programs to help grow and support the LTSS and behavioral health workforce.<sup>116</sup> In October 2019, the state launched a Health Care Workforce Collaborative<sup>117</sup> to combat health care workforce shortages, although this effort appears to have stalled as the state’s attention turned to addressing the COVID-19 public health emergency.

Yet, stakeholders raise concerns that letting “1,000 flowers bloom” without an organizing framework, oversight, and accountability could dilute their collective impact. The strategies that have been implemented to date are critical building blocks for a strong, resilient, and diverse LTSS and behavioral health workforce, but stakeholders assert they are not sufficient to solve the chronic workforce shortages in these professions given that they are piecemeal, often tied to time-limited investments or temporary programs, under-resourced, and are not part of a cohesive state health care workforce strategy and long-term investment. As such, stakeholders urge state leaders to:

- Develop a cohesive, long-term vision and action plan for strengthening the state’s overall health care workforce, with a particular focus on LTSS direct care workers and paraprofessional behavioral health workers, and
- Immediately prioritize existing or new efforts to incrementally increase all LTSS and behavioral health workers’ wages to a living wage in Massachusetts.

#### **Develop and implement a 10-year health care workforce plan that prioritizes the LTSS and behavioral health workforce where demand for services is significantly outpacing supply.**<sup>118</sup>

In developing its 10-year health care workforce plan, the Commonwealth could model its effort on the U.S. Department of Health and Human Services’ Health Workforce Strategic Plan 2021,<sup>119</sup> but adapt the vision, goals, and organizing framework based on the state’s workforce values, activities to date, and priorities.<sup>120</sup> For the greatest impact, executive and legislative branch leaders would jointly direct or lead the development of the health care workforce plan, but the legislature also could task one or more of the executive branch agencies (e.g., the Executive Office of Labor and Workforce Development or the Executive Office of Health and Human Services) with developing this plan with broad public and private stakeholder engagement throughout the state. Key stakeholders include, but are not limited to, other public agencies, including the Department of Education and the Commonwealth Corporation, employer and workforce representatives, payers, consumers, families, and consumer advocates. The health care workforce plan itself would identify the executive or legislative branch body or mechanism for overseeing and monitoring implementation of the plan.



State leaders should develop the health care workforce plan within the first six to nine months of 2023. The plan should include, at a minimum:

- A 10-year vision for the health care workforce in Massachusetts that aligns with recommendations for building the professional and paraprofessional behavioral health workforce outlined in the Blue Cross Blue Shield of Massachusetts Foundation’s recently released report, *Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts*. This could include expanding the focus of the newly created Behavioral Health Trust Fund and Behavioral Health Advisory Commission to include efforts to assess and grow the LTSS workforce.<sup>121</sup>
- Goals for strengthening Massachusetts’ health care workforce.
- An organizing framework for categorizing, aligning, and advancing existing and newly developed policies and strategies, such as that recommended by researchers in a recent Health Affairs article, titled “Investing in a 21st Century Health Workforce: A Call for Accountability” (see [Appendix VI](#)).<sup>122</sup>
- A set of near-term, actionable, and measurable strategies to address the LTSS direct care and behavioral health paraprofessional workforce shortages that identify the specific policies, partnerships, administrative actions, legislation, and/or funding necessary to implement the strategy within six months of release of the plan *to the extent that they are not already being implemented (see below)*, in which case the plan would identify how these strategies would be monitored, evaluated, and sustained over time.
- A sequenced approach, milestones, funding sources, and accountable parties for addressing other health care workforce shortages over a 10-year period, which could coordinate with efforts to establish the behavioral health Workforce Center, referenced below.

To support this effort, Massachusetts should seek to participate in the National Governors Association’s (NGA) Centers for Best Practices Next Generation of Health Care Workforce Learning Collaborative project,<sup>123</sup> which launched in 2022. This effort brings participating states together for six months to assess their current workforce environment, share best practices and ideas, learn from workforce subject matter experts, and develop and execute an action plan to implement strategies to grow and retain the next generation of the health care workforce.<sup>124</sup> The Next Generation opportunity builds on the NGA’s 2014 Building a Transformed Health Care Workforce: Moving from Planning to Implementation policy academy, through which Oklahoma<sup>125</sup> and six other states developed comprehensive health care workforce action plans.

The 10-year plan should build on existing initiatives for these and other health care workers, align efforts across the health care sector as appropriate, and identify and strategically leverage public and private resources to ensure the state’s efforts to grow and support the health care workforce are sustainable. This workforce plan should be informed by a workforce needs assessment and coordinate with efforts to establish a behavioral health Workforce Center, which would seek to improve the supply, distribution, competency and diversity of the behavioral health workforce, as recommended in the report, *Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts*. The workforce plan should focus on three key areas:

- Growth (e.g., pipeline, recruitment, retention, and extension);
- Stability (e.g., wages, benefits, social supports, training, and career pathways); and
- Diversity.

The workforce plan should immediately prioritize increasing the wages and other supports for LTSS direct care workers and behavioral health paraprofessionals. At the same time, the plan should create longer-term strategies to address the underlying causes of chronic shortages in other parts of the health care workforce, including nurses, social workers, and behavioral health clinicians, among others, to ensure a healthy health care workforce systemwide and statewide.

**Immediately implement existing or newly proposed initiatives to support paraprofessional LTSS and behavioral health workers, with an explicit goal of incrementally increasing wages to a living wage in Massachusetts.** As the state develops its 10-year health care workforce plan, it must simultaneously pursue to fruition existing efforts to direct resources

to increasing LTSS and behavioral health worker wages. These efforts, and subsequent initiatives to build and sustain them, also will be embedded in the state’s 10-year health care workforce plan.

The state has successfully implemented workforce wage increases and development strategies for these workers in the past and should build on these to implement broader, sustainable workforce reforms. These past efforts include the establishment of the Personal Care Attendant (PCA) Quality Home Care Workforce Council,<sup>126</sup> which has improved recruitment, training, and wages for PCAs and sponsors a PCA provider registry, and the MassHealth 1115 waiver’s Delivery System Reform Investment Program (DSRIP) Statewide Investments,<sup>127</sup> which focused substantially on growing and training the behavioral health workforce.

The state and its partners are currently pursuing or have newly identified strategies that should be leveraged, aligned, and sufficiently resourced (see Appendix VII for additional workforce resources). To ensure public and private workforce development dollars are being used efficiently, the state should assess opportunities to align strategies across health care workers where it makes sense, tailor strategies for other parts of the health care workforce, and leverage public-private partnerships and multiple funding sources to support implementation of the plan. Strategies discussed in other parts of this report, including reallocating public and private health care dollars to behavioral health services (as referenced in Section 3), integrating LTSS with primary and behavioral health care, and expanding LTSS financing options, among others, could create efficiencies in the system that could be reinvested in strengthening the state’s health care workforce.

There is no simple or single solution for solving the state’s health care workforce crisis, which is most acute for paraprofessional LTSS and behavioral health workers, where demand for services is skyrocketing. State leaders must demonstrate will, commitment, diligence, and ingenuity in solving this issue, and the development and execution of a 10-year health care workforce plan will help guide their path.

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*“[The next administration] needs to target the ‘fourth quarter’ issues of health care workforce development and diversity. [We] need to create a pipeline of the providers of tomorrow that represent the people and communities they serve.”*  
— Member of the Health Equity Task Force

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## CONCLUSION

Key leaders across Massachusetts’ government and health care sector, including consumers, providers, health plans, business, and labor, have identified five pressing issues facing the state’s health care system that the new governor and state legislative leaders must prioritize as they come into office in 2023. As described in this report, these include addressing racism and inequities in health; ensuring consumer affordability of health care; confronting the mental health crisis for children and youth; improving the affordability of and access to LTSS; and solving severe health care workforce shortages, particularly in the paraprofessional LTSS and behavioral health workforce. Stakeholders also identified potential, impactful actions for addressing each of these challenges, prioritizing those for immediate attention. Many of the proposed priority actions build on existing initiatives and proposals, so state leaders would not need to start anew in analyzing or problem-solving these issues. State leaders do, however, have to break new ground in creating a government culture and approach to health care policy development that engages a diversity of people with lived experience—community members and community leaders—who can help state leaders understand the root causes and impacts of these challenges and participate in co-designing solutions.

State leaders in Massachusetts have demonstrated that they can tackle complex, seemingly intractable health care issues, such as covering the uninsured and working to contain health care cost growth, as well as advancing a core mission of promoting the health and well-being of Massachusetts’ residents. Massachusetts’ new generation of health care leaders must pick up the mantle of bold leadership and ingenuity to solve what many stakeholders have called “last mile” issues plaguing Massachusetts health coverage and care delivery systems, and carry on Massachusetts’ legacy of health care leadership.

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## APPENDIX I. METHODOLOGY

Manatt Health, in partnership with the Blue Cross Blue Shield of Massachusetts Foundation, conducted 29 interviews from February through May 2022 with a range of Massachusetts stakeholders to inform development of this report. Stakeholders included a geographically, racially, and ethnically diverse group of state executive and legislative branch officials, private and public health plans, providers and provider associations, advocacy organizations (e.g., consumer advocates and maternal health advocates), business leaders, workforce representatives, and other stakeholders. A full list of interviewees is provided below.

Because interviews were conducted before the Supreme Court issued its ruling on *Dobbs v. Jackson Women's Health Organization* in June 2022, this report does not discuss or address the implications of the Supreme Court's decision for the Massachusetts health care system and its stakeholders.

- Josh Archambault  
*Pioneer Institute*
- Allison Bovell-Ammon, Stephanie A. Ettinger De Cuba, Megan Sandel  
*Children's Health Watch*
- Amanda Cassel Kraft  
*Executive Office of Health and Human Services (EOHHS)*
- JD Chesloff  
*Massachusetts Business Roundtable*
- Kevin Churchwell and Christine Schuster  
*Massachusetts Health & Hospital Association (MHA)*
- Jessica Collins and Frank Robinson  
*Public Health Institute of Western Massachusetts and Baystate Health*
- Lydia Conley  
*Association for Behavioral Healthcare (ABH)*
- Jessica Costantino and Mike Festa  
*AARP of Massachusetts*
- Michael Curry, Juan Fernando Lopera, Manuel Lopes, Jeffrey Sanchez  
*Health Equity Compact*
- Andrew Dreyfus  
*Blue Cross Blue Shield of Massachusetts (BCBSMA)*
- Leslie Diaz and Dennis Heaphy  
*Massachusetts Disability Policy Consortium and My Ombudsman*
- Guy Fish  
*Greater Lawrence Family Health Center*
- Tim Foley and Jamie Willmuth  
*1199 SEIU*
- Sen. Cindy Friedman  
*Massachusetts Legislature*
- Kate Ginnis  
*MassHealth*
- Josh Greenberg  
*Boston Children's Hospital*
- Health Equity Task Force Members, including Michael Curry, Kiame Mahaniah, Myechia Minter-Jordan, Stacey Nwachukwu, Cassandra Pierre, Frank Robinson, Assaad Sayah, and Donald Wong  
*Massachusetts Legislature*
- Jallicia Jolly and Yaminah Romulus  
*Massachusetts COVID-19 Maternal Equity Coalition*
- Jake Krilovich and Tara Gregorio  
*Home Care Alliance of Massachusetts and Massachusetts Senior Care Association*
- Claire Levesque, Kristin Lewis, Adam Martignetti, and Kevin Rasch  
*Point32Health*
- David Matteodo  
*Association of Behavioral Health Systems*
- Danna Mauch  
*Massachusetts Association for Mental Health*
- Eileen McAnneny  
*Massachusetts Taxpayers Foundation*
- Audrey Morse Gasteier  
*Massachusetts Health Connector*
- Vicky Pulos  
*Massachusetts Law Reform Institute*
- Amy Rosenthal and team  
*Health Care For All Massachusetts*
- David Seltz  
*Health Policy Commission*
- Christina Severin  
*Community Care Cooperative*
- Ilana Steinhauer  
*Volunteers In Medicine Berkshires*

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## APPENDIX II. ADDITIONAL HEALTH EQUITY RESOURCES

Additional reports and research on health equity trends in Massachusetts include:

- A Blueprint for Health Equity, Massachusetts Legislature Health Equity Task Force. July 1, 2021. Available at: <https://malegislature.gov/Reports/11522/Final%20Health%20Equity%20Task%20Force%20Final%20Report-%20A%20Blueprint%20for%20Health%20Equity%207.1.21.pdf>.
- Building Toward Racial Justice and Equity in Health: A Call to Action, Massachusetts Attorney General's Office. Available at: <https://www.mass.gov/info-details/building-toward-racial-justice-and-equity-in-health-a-call-to-action>.
- Giving Birth in a Pandemic: Policy Recommendations to Improve Maternal Equity During COVID-19, Massachusetts COVID-19 Maternal Equity Coalition. Available at: <https://static1.squarespace.com/static/5ec9763f4215f5026a66f967/t/5f0f1ee598c70c766f32bea9/1594826470104/Maternal+Equity+Coalition+Report+FINAL.pdf>.
- Greater Boston Housing Report Card 2021—Pandemic Housing Policy: From Progress to Permanence, UMass Donahue Institute, June 2021. Available at: <https://donahue.umass.edu/our-publications/greater-boston-housing-report-card-2021>.
- HPC Policy Brief, Serious Illness Care in Massachusetts: Differences in care received at the end of life by race and ethnicity. September 2020. Available at: <https://www.mass.gov/doc/policy-brief-serious-illness-care-in-massachusetts-differences-in-care-received-at-the-end-of/download>.
- Massachusetts COVID-19 Health Equity Advisory Group. Available at: <https://www.mass.gov/orgs/covid-19-health-equity-advisory-group>.
- Public Infrastructure in Western Massachusetts: A Critical Need for Regional Investment and Revitalization, Massachusetts Office of the State Auditor, Division of Local Mandates, October 5, 2021. Available at: <https://www.mass.gov/report/public-infrastructure-in-western-massachusetts-a-critical-need-for-regional-investment-and-revitalization>.
- Racism and Racial Inequities in Health: A Data-Informed Primer on Health Disparities in MA, BCBSMA Foundation, December 21, 2021. Available at: <https://www.bluecrossmafoundation.org/publication/racism-and-racial-inequities-health-data-informed-primer-health-disparities>.
- Structural Racism and Racial Inequities in Health: Summary of Focus Group Key Themes and Findings, BCBSMA Foundation, May 17, 2022. Available at: <https://www.bluecrossmafoundation.org/publication/structural-racism-and-racial-inequities-health-summary-focus-group-key-themes-and-0>.

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## APPENDIX III. ADDITIONAL CONSUMER AFFORDABILITY RESOURCES

Additional reports and research published by the Health Policy Commission and the Center for Health Information Analysis on consumer costs and affordability trends in Massachusetts include:

- 2022 Health Care Cost Trends Report and Policy Recommendations. Massachusetts Health Policy Commission (HPC), September 2022. Available at: <https://www.mass.gov/doc/2022-health-care-cost-trends-report-and-policy-recommendations/>.
- Chapter 224 of the Acts of 2012, “An Act Improving the Quality Of Health Care And Reducing Costs Through Increased Transparency, Efficiency And Innovation.” Available at: <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>.
- Health Insurance Coverage and Care in Massachusetts, 2015-2019: A Baseline Assessment of Gaps by Geographic Region. Massachusetts Center for Health Information Analysis (CHIA), April 2022. Available at: <https://www.chiamass.gov/assets/docs/r/pubs/2022/health-equity-report-region.pdf>.
- HPC DataPoints, Issue 11: Insulin Price Growth and Patient Out-of-Pocket Spending. Massachusetts Health Policy Commission (HPC), May 1, 2019. Available at: <https://www.mass.gov/info-details/hpc-datapoints-issue-11-insulin-price-growth-and-patient-out-of-pocket-spending?auHash=RSFnw7rJRkNfPqGQHOikoLxasA-XPem7zYzobUVrKBE>.
- HPC DataPoints, Issue 12: Cracking Open the Black Box of Pharmacy Benefit Managers. Massachusetts Health Policy Commission (HPC), June 5, 2019. Available at: <https://www.mass.gov/info-details/hpc-datapoints-issue-12-cracking-open-the-black-box-of-pharmacy-benefit-managers>.
- HPC DataPoints, Issue 14: The Price is Right? Variation in Potential Out-of-Network Provider Payment Benchmarks. Massachusetts Health Policy Commission (HPC), August 14, 2019. Available at: <https://www.mass.gov/info-details/hpc-datapoints-issue-14-the-price-is-right-variation-in-potential-out-of-network-provider-payment-benchmarks>.
- HPC DataPoints, Issue 19: Persistently High Out-of-Pocket Costs Make Health Care Increasingly Unaffordable and Perpetuate Inequalities in Massachusetts. Massachusetts Health Policy Commission (HPC), January 13, 2021. Available at: <https://www.mass.gov/info-details/hpc-datapoints-issue-19-persistently-high-out-of-pocket-costs-make-health-care-increasingly-unaffordable-and-perpetuate-inequalities-in-massachusetts>.
- HPC DataPoints, Issue 20: Oral Health Access and Equity in the Commonwealth. Massachusetts Health Policy Commission (HPC), July 14, 2021. Available at: <https://www.mass.gov/info-details/hpc-datapoints-issue-20-oral-health-access-and-equity-in-the-commonwealth>.
- HPC DataPoints, Issue 22: Growth in Out-of-pocket Spending for Pregnancy, Delivery, and Postpartum Care in Massachusetts. Massachusetts Health Policy Commission (HPC), March 29, 2022. Available at: <https://www.mass.gov/info-details/hpc-datapoints-issue-22>.
- Massachusetts Primary Care and Behavioral Health Expenditures: Baseline Report. Massachusetts Center for Health Information Analysis (CHIA), September 2022. Available at: <https://www.chiamass.gov/assets/docs/r/pubs/2022/PCBH-Report.pdf>.

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## APPENDIX IV. ADDITIONAL MENTAL HEALTH FOR CHILDREN RESOURCES

Complementary initiatives within Massachusetts' 1115 waiver and Roadmap for Behavioral Health Reform are intended to establish an accessible “front door” to a full continuum of mental health services for adults and children. These initiatives are outlined in the following:

- Children’s Behavioral Health Initiative (CBHI), MassHealth. Available at: <https://www.mass.gov/childrens-behavioral-health-initiative-cbhi>.
- Massachusetts Demonstration Approval. September 28, 2022. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-ca1.pdf>.
- Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it. Massachusetts Executive Office of Health and Human Services (EOHHS), February 2021. Available at: <https://www.mass.gov/doc/stakeholder-presentation-on-the-roadmap-for-behavioral-health-reform/download>.
- Roadmap for Behavioral Health Reform: FAQs. Massachusetts Executive Office of Health and Human Services (EOHHS). Available at: <https://www.mass.gov/info-details/roadmap-for-behavioral-health-reform-faqs>.
- Senate Bill 2774, An Act Investing in the Future of Our Health. March 17, 2022. Available at: <https://malegislature.gov/Bills/192/S2774>.
- S. 2774, An Act Investing in the Future of Our Health Fact Sheet. March 2022. Available at: <https://www.mass.gov/doc/an-act-investing-in-the-future-of-our-health/download#:~:text=This%20legislation%20authorizes%20the%20Executive,%2C%20providers%2C%20and%20state%20lines>.
- Senate Bill 2572, An Act Addressing Barriers to Care for Mental Health. November 9, 2021. Available at: <https://malegislature.gov/Bills/192/S2572>.
- S. 2572, Mental Health ABC Act 2.0 Fact Sheet. November 21. Available at: <https://cindyfriedman.org/wp-content/uploads/2021/11/Mental-Health-ABC-2.0-Fact-Sheet.pdf>.

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## APPENDIX V. ADDITIONAL LTSS RESOURCES

Notable initiatives to strengthen Massachusetts' LTSS system include:

- Money Follows the Person (MFP) Demonstration, MassHealth. Available at: <https://www.mass.gov/money-follows-the-person-mfp-demonstration>.
- Personal Care Attendant (PCA) Workforce Council. Available at: <https://www.mass.gov/orgs/personal-care-attendant-workforce-council>.
- Massachusetts Balancing Incentive Program Application. January 2014. Available at: <https://www.mass.gov/doc/balancing-incentive-program-bip/download>.
- MassHealth to Improve Management of Long-Term Services and Supports, Press Release. Executive Office of Health and Human Services (EOHHS) and MassHealth, February 28, 2017. Available at: <https://www.mass.gov/news/masshealth-to-improve-management-of-long-term-services-and-supports>.
- Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0, Final Concept Paper. MassHealth, August 20, 2018. Available at: <https://www.mass.gov/doc/final-concept-paper-duals-demonstration-20/download>.
- Massachusetts Home and Community-Based Services (HCBS) Spending Plan American Rescue Plan Act (ARPA) Enhanced Federal Funding. Executive Office of Health and Human Services (EOHHS), June 17, 2021. Available at: <https://www.mass.gov/doc/massachusetts-arpa-hcbs-initial-spending-plan-june-2021-0/download>.

## APPENDIX VI. WORKFORCE DEVELOPMENT ORGANIZING FRAMEWORK

**Production** refers to policies and programs to better align the number and type of workers to the population's needs, including a consideration of how workers are recruited, trained, and retrained during their careers. These policies and programs include, but are not limited to, apprenticeships, residency and other field training programs, pipeline programs, scholarships, and loan repayment opportunities. Production includes a focus on increasing the diversity of the workforce to ensure representation of racially, ethnically, socially, or otherwise marginalized communities.

**Distribution** refers to policies and programs that address the maldistribution of providers, not only in terms of geography, but also in terms of specific communities that lack adequate access to behavioral health services, including those who have been economically, socially, or culturally marginalized. Distribution policies include initiatives to expand telehealth and specific recruitment strategies that are specifically focused on increasing supply in areas where there are workforce shortages and among specific communities that have historically lacked access to behavioral health care.



**Resilience** refers to policies and programs that promote workforce resilience, advance safer working conditions, and support the mental health and well-being of all health care workers to counter burnout and attrition, especially among providers from communities who have been economically, socially, culturally, or racially marginalized. The issue of resilience is particularly important given the heightened stress and emotional toll associated with the pandemic.

**Maximizing potential** refers to policies and programs designed to leverage the scope and reach of the behavioral health workforce. These policies and programs include promoting behavioral health and primary care integration, and flexibility in regulations related to billing, scope of practice, and interstate mobility of licensure.

Source: "Investing In A 21st Century Health Workforce: A Call For Accountability," *Health Affairs*. September 15, 2021. Available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20210913.133585/full/>.



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## APPENDIX VII. ADDITIONAL WORKFORCE RESOURCES

Additional LTSS and behavioral health workforce development strategies advanced in Massachusetts are delineated in:

- Executive Office of Health and Human Services Grant Funding to Support Provider Home and Community Based Service (HCBS) and Human Services Workforce Development. October 2022. Available at: <https://www.mass.gov/news/new-425m-in-grant-funding-to-support-provider-home-and-community-based-service-hcbs-and-human-services-workforce-development>.
- Creating a Robust, Diverse and Resilient Behavioral Health Workforce in Massachusetts. Blue Cross Blue Shield of Massachusetts Foundation and Manatt Health, September 2022. Available at: [https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2022-09/BH\\_Workforce\\_Final.pdf](https://www.bluecrossmafoundation.org/sites/g/files/cspkws2101/files/2022-09/BH_Workforce_Final.pdf).
- Massachusetts Home and Community-Based Services (HCBS) Quarterly Spending Plan Narrative. Executive Office of Health and Human Services (EOHHS), October 2021. Available at: <https://www.medicaid.gov/media/file/ma-apra-hcbs-quarterly-spending-plan-update.pdf>.
- Massachusetts Nursing Facility Task Force Report, Established by Chapter 41, Section 91 of the Acts of 2019. Presented and Approved by the Task Force January 31, 2020. Available at: <https://www.mass.gov/doc/nursing-facility-task-force-final-report/download>.
- Roadmap for Behavioral Health Reform. Executive Office of Health and Human Services (EOHHS) and MassHealth. Available at: <https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform>.

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## ENDNOTES

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- 5 A description of this report’s methodology and a full list of interviewees is available in Appendix I. Because interviews were conducted before the Supreme Court issued its ruling on *Dobbs v. Jackson Women’s Health Organization* in June 2022, this report does not discuss or address the implications of the Supreme Court’s decision for the Massachusetts health care system and its stakeholders.
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- 7 Ibid.
- 8 “Health Insurance Coverage and Care in Massachusetts, 2015-2019: A Baseline Assessment of Gaps by Region,” Massachusetts Center for Health Information and Analysis (CHIA). Available at: <https://www.chiamass.gov/health-insurance-coverage-and-care-in-massachusetts/>.
- 9 “A Blueprint for Health Equity: Health Equity Task Force Final Report,” Massachusetts Legislature Health Equity Task Force. Jul. 1, 2021. Available at: <https://malegislature.gov/Reports/11522/Final%20Health%20Equity%20Task%20Force%20Final%20Report-%20A%20Blueprint%20for%20Health%20Equity%207.1.21.pdf>.
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- 19 “Findings from the 2021 Massachusetts Health Insurance Survey.”
- 20 “2021 Annual Health Care Cost Trends Report.” Massachusetts Health Policy Commission (HPC). Sep. 2021. Available at: <https://www.mass.gov/doc/2021-health-care-cost-trends-report/download>.

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