The MassHealth Demonstration Extension 2022–2027:

Building on Success, Focusing on Equity

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ABOUT THIS REPORT

This report describes MassHealth's Demonstration Extension, as approved by the Centers for Medicare and Medicaid Services (CMS) in September 2022.

An earlier version of this report, authored by ForHealth Consulting, described the Demonstration Extension proposal that MassHealth submitted to CMS in December 2021.

Robert W Seifert substantially revised that first report, updating it to reflect the final Demonstration Extension approved by CMS in September 2022.

ABOUT THE MASSACHUSETTS MEDICAID POLICY INSTITUTE

The Massachusetts Medicaid Policy Institute (MMPI)—a program of the Blue Cross Blue Shield of Massachusetts Foundation—is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, MassHealth. MMPI's mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

ABOUT FORHEALTH CONSULTING AT UMASS CHAN MEDICAL SCHOOL

At ForHealth Consulting at UMass Chan Medical School, we focus on empowering organizations to make health care and human services more equitable, effective, and accessible. We dive deep into our clients' worlds to understand their goals and develop actionable strategies to help them do better—for themselves, for the people they serve, and for the health care system as a whole. Together, we can create a better health care experience for everyone.

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I. INTRODUCTION

MassHealth is Massachusetts' combined Medicaid program and Children's Health Insurance Program (CHIP), providing coverage to more than one in four Massachusetts residents. Each state runs its own Medicaid program, and those programs must meet certain federal standards unless the state obtains a "section 1115 demonstration waiver" from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicaid. Demonstration waivers must be renewed (or "extended") periodically (typically every 5 years). Massachusetts administers much of MassHealth under a "demonstration waiver" (referred to in this report as the Demonstration), which it has extended several times since it was originally approved in 1995. On September 28, 2022, CMS approved Massachusetts' request for a five-year extension of its Demonstration. This new Demonstration showcases Massachusetts' vision for MassHealth over the next five years and includes many new initiatives, with health equity taking center stage. It will be in effect from October 1, 2022 through December 31, 2027.[1]

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

II. BACKGROUND

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

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

BRIEF HISTORY OF THE MASSHEALTH DEMONSTRATION

The original MassHealth Demonstration was approved in 1995 and went into effect on July 1, 1997. It has now been extended seven times, often with major revisions to reflect new or expanded goals. Figure 1 shows a timeline of the major reforms included in the MassHealth Demonstration over its history.

The first iteration of the Demonstration focused on expanding eligibility to about 300,000 additional Massachusetts residents, introducing managed care to the MassHealth program, and instituting "supplemental payments" (payments to hospitals and health plans that treat large numbers of MassHealth members, and which are not payments for specific services) for the purpose of supporting "safety net" providers.

BUDGET NEUTRALITY

Federal support for state demonstrations is not a blank check. Approval depends on a state being able to show that its program will be "budget neutral" (meaning that the demonstration will not require more federal spending than what would be required without a demonstration). The budget neutrality methodology compares the projected "with waiver" spending with hypothetical spending in a "without waiver" program. For the Demonstration extension, Massachusetts will have a substantial budget neutrality cushion, possibly as much as $18.7 billion, to support MassHealth initiatives.

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

Cycle	Year	Reforms
INITIAL DEMONSTRATION CYCLE	1997	Expanded eligibility by about 300,000 Introduced managed care Introduced supplemental payments
SECOND CYCLE	2002	Extended the same terms and conditions as the original five-year waiver
THIRD CYCLE	2005	Created Safety Net Care Pool Created Commonwealth Care 2006: Massachusetts Health Care Reform Bill (Chapter 58 of the Acts of 2006) enacted
FOURTH CYCLE	2008	Set savings targets
FIFTH CYCLE	2011	Created Delivery System Transformation Incentives (DSTI) 2014: Conformed with Affordable Care Act
SIXTH CYCLE	2015	Created Public Hospital Transformation and Incentive Initiative
SEVENTH CYCLE	2017–2022	Created Accountable Care Organizations, Community Partners, and the Flexible Services Program Expanded substance use disorder services Authorized $1.8 billion for the Delivery System Reform Incentive Program (DSRIP) to help set up new care delivery models

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

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

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

The immediate past Demonstration began July 1, 2017 and expired September 30, 2022. The centerpiece of that Demonstration was delivery system restructuring, including:

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

The expansion of **substance use disorder (SUD) services** was another important feature of the 2017–2022 Demonstration.

These reforms have had some success in their first few years. According to an independent interim evaluation of the 2017–2022 Demonstration, patients reported satisfaction with coverage, there were increasing rates of primary care visits and decreasing rates of low-value care, many ACOs, CPs, and FSPs reported positive outcomes, and costs largely stayed within range.[6] However, the evaluation also noted that ACOs were not completing screenings of HRSN (such as housing, nutrition, and transportation) at expected rates,[7] that better collection of race, ethnicity, language, and disability data would help show how payment and delivery system reforms affect different groups, and that the methods of payment to ACOs, meant to incentivize attention to improved health outcomes, were not always reflected in how ACOs pay primary care practices.[8]

GOALS OF THE NEW DEMONSTRATION

Massachusetts' latest Demonstration was approved September 28, 2022 and includes most of the features Massachusetts requested in its December 22, 2021 proposal to CMS. This new Demonstration period largely aims to continue the restructuring that began in 2017 and improve upon the programs and initiatives that were part of the prior Demonstration. It focuses on improving health outcomes and reducing health inequities, as articulated in these five stated goals:

1. Continue the path of restructuring and re-affirm accountable, value-based care [by] increasing expectations for how ACOs improve care and refining the [ACO and CP] model[s].
2. Make reforms and investments in primary care, behavioral health, and pediatric care that expand access and [continue to] move the delivery system away from siloed, fee-for-service health care.
3. Continue to improve access to and quality and equity of care, with a focus on initiatives addressing HRSN [social barriers to health such as housing instability and food insecurity] and specific improvement areas relating to health quality and equity, including maternal health and health care for justice-involved individuals who are in the community.
4. Sustainably support the Commonwealth's safety net [through] level, predictable funding for safety net providers.
5. Maintain near-universal coverage, [through] updates to eligibility policies to support coverage and equity.[9]

The following Sections III through VIII describe the details of the approved Demonstration in these categories:

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

A discussion of the implications of the Demonstration for various stakeholder groups follows.

III. IMPROVING DELIVERY SYSTEM REFORMS

To build on the progress made under the prior Demonstration periods and make improvements where necessary, Massachusetts will continue the ACO, CP, and FSP programs, using more sustainable funding for the CP and FSP programs (with DSRIP funding, which used to support these programs, expiring). In response to challenges identified through the interim evaluation, CMS approved Massachusetts' request for some changes to these programs, described below. Furthermore, as $1.8 billion in DSRIP funding for MassHealth payment and delivery system reforms comes to an end, MassHealth is incorporating the experience and lessons from DSRIP initiatives into its ongoing models of care. According to materials Massachusetts issued following approval of the Demonstration extension, MassHealth will transition approximately 80 percent of DSRIP funding into ongoing funding streams to support the ACO and CP programs.[10]

ACCOUNTABLE CARE ORGANIZATIONS

When the MassHealth ACO program began in 2018, three models of ACO were available. The models varied in their management of clinical and financial responsibilities, in the networks of doctors and other health care providers they included, in how MassHealth paid them, and in their relationships to MCOs. The three ACO models were:

- **Accountable Care Partnership Plans** (ACPP, also known as "Model A ACOs"), provider-led entities that partner with MCOs. Partnership Plans receive a set monthly payment per member from MassHealth and operate a provider network. As of December 2022, there were about 730,000 members in 13 ACPPs.
- **Primary Care ACOs** (PCACO, "Model B ACOs"), provider-led entities that are held accountable by MassHealth for the cost of care provided through a calculation of shared savings and shared losses against a benchmark spending target. As of December 2022, there were about 495,000 members in three PCACOs.
- **MCO-Administered ACOs** ("Model C ACOs"), provider-led organizations that contract with MCOs and are held accountable for the cost of care provided through shared savings and shared losses similar to PCACOs. Model C was adopted by only one organization. Citing operational challenges and lack of interest, MassHealth discontinued Model C ACOs, effective April 1, 2023.

In Model A and Model C ACOs, MCOs performed financial and administrative functions usually associated with an insurer, such as assembling a network and authorizing and paying for services.

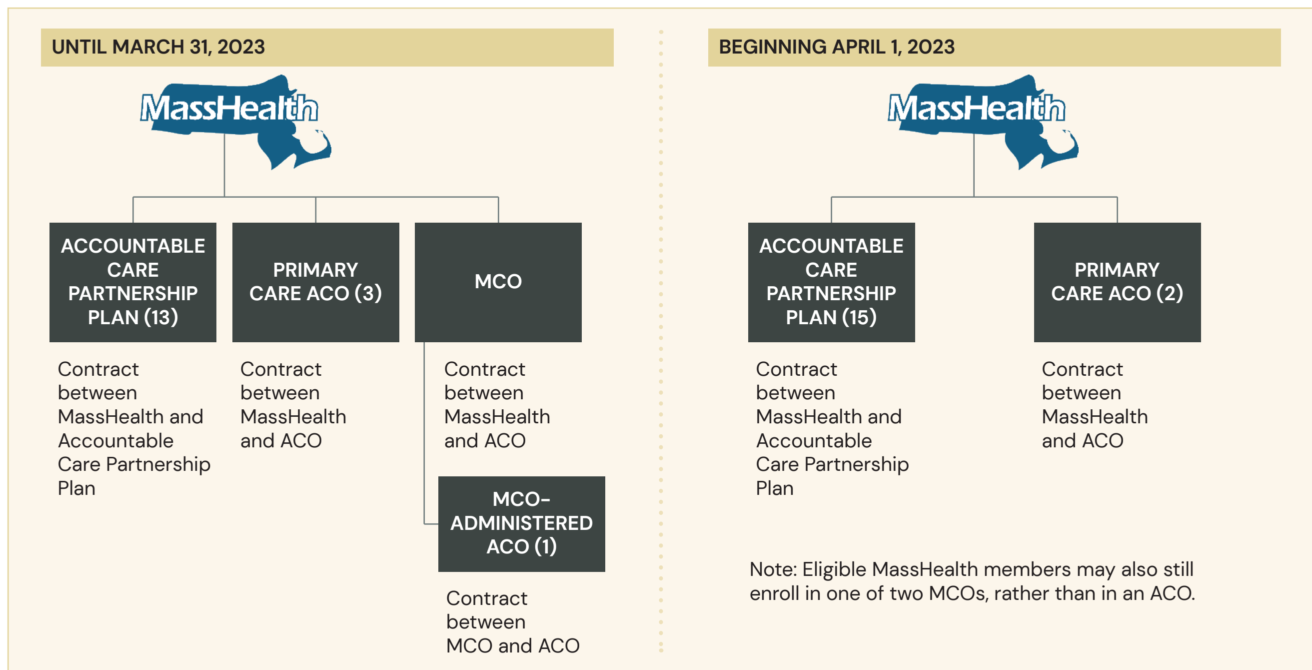
Alternatively, eligible MassHealth members may choose to enroll in one of two MCOs, rather than in an ACO. Eligible members also have the option to enroll in the Primary Care Clinician (PCC) Plan, receiving care from a primary care provider not affiliated with an ACO.

Enhancements to the ACO program. In November 2022, MassHealth selected 17 Massachusetts health care organizations in a re-procurement of the ACO program. There are 15 ACPPs and two PCACOs. Many of the ACOs from the prior demonstration will continue under the new contract; several of the ACPPs are new to the program or are reconfigured

partnerships of providers and MCOs. These new contracts were effective April 1, 2023.[11] MassHealth used the procurement to introduce "enhancements" to the ACO model, "based on lessons learned in the first five years of the program"[12] including:

- New opportunities for ACOs to pay primary care practices using payment models that reward value (described in Section VII below).
- Enhanced requirements for ACOs for population health, care coordination, network access, and cost growth, as well as increased focus on children and families.
- ACO payments that include incentives based on their equity performance, in addition to continuing incentives based on quality performance.

FIGURE 2. CHANGES TO THE ACO PROGRAM UNDER THE NEW MASSHEALTH DEMONSTRATION



UPDATES TO THE COMMUNITY PARTNERS PROGRAM

MassHealth introduced CPs in 2018, to provide specialized care coordination and management to members with heightened needs.[13] There are two types of CPs, Behavioral Health (BH) CPs and Long-Term Services and Supports (LTSS) CPs. The two types of CPs support different populations:

- BH CPs support members age 18 and older with a serious mental illness or SUD and who use a high level of health care services.
- LTSS CPs support members age 3 and older with a complex LTSS need (which may derive from having physical disabilities, acquired or traumatic brain injury, intellectual or development disabilities, and others, as defined by the state).

In the prior Demonstration, MassHealth contracted with 18 BH CPs and nine LTSS CPs. Program updates from MassHealth during the prior Demonstration reported that the CP program has had success, including reduced emergency department use and inpatient admissions among BH CP members, and declining Total Cost of Care for members in BH

and LTSS CPs across the span of their engagement with the CP.[14] These updates also reported some challenges for CPs, in particular communication and staffing challenges during the COVID-19 pandemic.[15]

As of April 1, 2023, there are 12 BH CPs and eight LTSS CPs (the results of a procurement of CPs that MassHealth conducted in 2022).[16] Under the new Demonstration, MassHealth is making these changes to the CP program:

Change the funding flow. MassHealth will continue to select CPs using a public procurement process and will still require ACOs and MCOs to partner with CPs. However, the funding flow will change. This change is intended both to support ACO/MCOs in taking an active role in managing enhanced care coordination services for their population and because DSRIP funds, the prior CP funding source, have expired. Massachusetts will now require ACOs and MCOs to pay CPs directly, using administrative payments that MassHealth makes to ACOs and MCOs. Unlike DSRIP, these administrative payments are not time limited.

Expand requirements for BH CPs. In its latest CP procurement, MassHealth introduced some changes to the BH CP model, including:

- Requiring BH CPs to have formalized processes for communication with and referral to all Community Behavioral Health Centers (CBHCs) in each of their service areas, if the BH CP is not a CBHC itself. CBHCs are a new type of MassHealth provider and a key component of Massachusetts' Roadmap for Behavioral Health Reform, a series of initiatives intended to create a comprehensive, effective outpatient behavioral health delivery system in the Commonwealth.
- Requiring the BH CPs to perform an HRSN screening and provide connections to Options Counseling for seniors and members with disabilities who need services and supports.
- BH CPs will take on some accountability for a subset of quality measures.

Expand requirements for LTSS CPs. As with the BH CPs, MassHealth introduced some changes to the LTSS CP model in its latest procurement, including:

- LTSS CPs will be newly accountable for comprehensive assessments and HRSN screening and will have responsibility for organizing and leading the care team, aligning them with requirements for BH CPs.
- LTSS CPs will take on a new role as the "lead Care Coordination entity" for enrolled members, replacing ACOs and MCOs in that capacity.
- There will be substantially higher requirements for clinical staffing – required ratios per enrollee of care coordinators, registered nurses, and clinical care managers, at the same levels as for BH CPs.
- LTSS CPs will take on some accountability for a subset of quality measures.

THE FLEXIBLE SERVICES PROGRAM

Because the Flexible Services Program (FSP) started halfway into the prior Demonstration period, CMS approved Massachusetts' request that its authority to operate this program continue largely the same during the first few years of the new Demonstration period, with some changes to services offered, described below in Section IV. In the Demonstration approval, CMS also laid out a framework for Massachusetts to integrate Flexible Services within the ACO program, including transitioning FSP from being funded by DSRIP (which operated like a grant program), towards a more traditional service model provided through the managed care structure by 2025.

IV. ENHANCING SERVICES AND SUPPORTS

Under the new Demonstration, Massachusetts will expand services and supports to meet specific member needs, including through an extension of the FSP, expanded BH services, and improved care coordination.

EXTENDING THE FLEXIBLE SERVICES PROGRAM

MassHealth started the FSP in 2020, providing housing and nutrition supports to certain members identified by ACOs. These services address important social drivers of health and are not usually covered as part of a Medicaid benefit. FSP gives ACOs a larger toolbox with which to improve members' health and manage the costs of care. The HRSN FSP addresses, along with health behaviors such as diet, smoking, and exercise, are the primary drivers of members' health, more so than medical care.[17]

When FSP was funded by DSRIP during the prior Demonstration period, flexible services were not an entitlement, meaning members with a need did not automatically receive them simply by being enrolled in MassHealth, as is the case with most MassHealth benefits. Members must meet broader eligibility criteria (enrollment in an ACO and having specified health needs and social risk factors), then must be selected by an ACO to receive flexible services. Flexible services include help with housing search assistance, housing deposits, other help maintaining housing, meal delivery, cooking supplies, and nutrition education.[18] There have been promising early results for this program: ACOs found improvements in diabetes management, reductions in emergency department visits, and reductions in total cost of care associated with their FSPs.[19]

Massachusetts will extend the FSP through the new Demonstration period. In the Demonstration approval, CMS laid out a framework for Massachusetts to integrate Flexible Services within the ACO program, including transitioning FSP from being funded by DSRIP (which operated like a grant program), towards a more traditional service model provided through the managed care structure. CMS also approved extending nutritional supports to a member's entire household, not just the individual member, when the eligible member is a child or pregnant person. This change acknowledges the communal aspect of food assistance and is intended to help the household to avoid difficult choices about whose nutritional needs should be met first with limited resources.

Under the new Demonstration, CMS also approved continued funding for infrastructure and capacity building to enable Social Service Organizations (SSOs) to participate in the FSP.

EXPANDING BEHAVIORAL HEALTH SERVICES AND SUPPORTS

Massachusetts has included "diversionary behavioral health services" in the Demonstration for years. These services are designed to help individuals at risk of needing inpatient mental health or SUD treatment receive services in community-based settings instead. Examples of diversionary services include community crisis stabilization, intensive day treatment programs for mental health and addiction, the Community Support Program (CSP) (defined below), and others. Other services are in the Medicaid State Plan and do not require Demonstration authorization but are part of MassHealth's comprehensive set of diversionary services. These include psychiatric day treatment, partial hospitalization, intensive outpatient program, structured outpatient addiction program, and mobile crisis intervention.[20]

CSP provides a navigator to assist an individual with outreach and supportive services, including:

- Providing service coordination
- Assisting with obtaining public benefits (such as Social Security, SNAP, and others), housing, and health care
- Developing a plan in the event of a psychiatric or SUD crisis
- Fostering empowerment and recovery

Under the new Demonstration, Massachusetts will (1) extend eligibility for diversionary BH services to more members and (2) add specialized services under the CSP framework to address the needs of particular populations.

Extending eligibility for diversionary BH services. The diversionary BH services authorized through the previous Demonstration were available only to people enrolled in managed care.[21] In the new Demonstration, Massachusetts extends those services to individuals who are not in managed care, except for those in MassHealth Limited. Most MassHealth members under age 65 are in managed care, except certain members who have another source of primary insurance, such as Medicare or a commercial health plan, and use MassHealth for secondary coverage.

Adding specialized diversionary BH services. Under the prior Demonstration, Massachusetts offered CSP to members with BH needs and a specialized form of CSP targeted to individuals experiencing chronic homelessness. At the end of the prior Demonstration period, Massachusetts also offered a type of specialized CSP to individuals with Justice Involvement (CSP-JI). In the new Demonstration, Massachusetts expands CSP for individuals experiencing homelessness, continues its CSP-JI service, and creates an additional specialized CSP:

1. CSP for Homeless Individuals (CSP-HI), for those members experiencing homelessness. The new Demonstration expands eligibility for this specialized CSP to people who did not meet the narrower definition of "chronically homeless" under prior Demonstrations.

2. CSP for Individuals with Justice Involvement (CSP-JI), for individuals who live in the community and have been released from a correctional institution within the past year and are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board. CSP-JI provides specialized services to improve and maintain health while transitioning back to the community and to promote successful community tenure. This enables the state to expand the Behavioral Health Supports for Justice-Involved Individuals (BH-JI) program, in which health care navigators engage with individuals prior to release from incarceration, post-incarceration, on parole, and on probation and assist them with accessing BH services and community supports.

3. CSP Tenancy Preservation Program (CSP-TPP), for individuals facing risk of eviction as a result of behavior related to a disability (e.g. mental illness, intellectual disability, substance abuse, aging-related impairments).

The new variations of CSP again directly acknowledge MassHealth's interest in stable housing for its members as an important driver of their health.

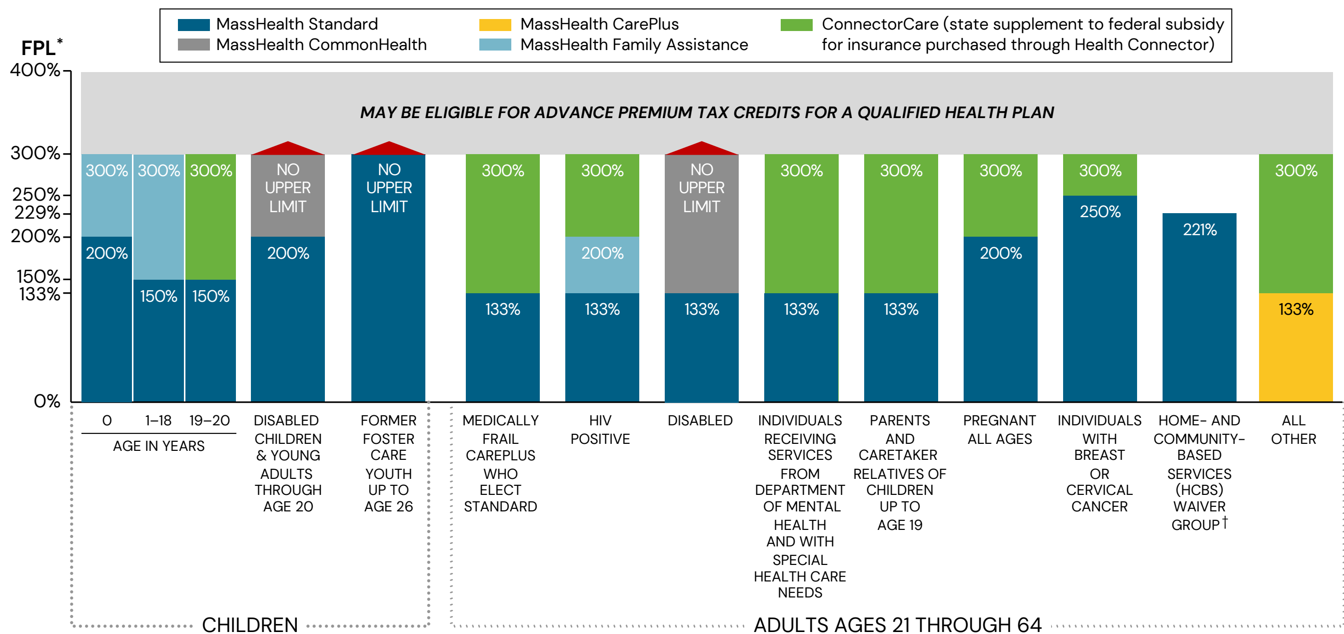
CONTINUED AUTHORITY FOR EXPANDED BENEFITS

CMS also approved Massachusetts' requests for authority to continue offering enhanced benefits already in the most recent Demonstration. These include SUD benefits; premium assistance for members with access to other sources of insurance; Medicare cost-sharing (premiums, deductibles, and copayments) assistance for certain members eligible for both MassHealth[22] and Medicare; and ConnectorCare, which provides enhanced premium and cost-sharing subsidies to individuals with low- and moderate-incomes who purchase coverage through the Massachusetts Health Connector.

V. UPDATING ELIGIBILITY POLICIES

Earlier eligibility expansions under the Demonstration brought MassHealth coverage to hundreds of thousands of Massachusetts residents who otherwise would be uninsured because they did not have access to or could not afford private health insurance. Figure 3 shows the current MassHealth income cutoffs for different population groups. Eligibility gaps remain, however. In this Demonstration, CMS approved Massachusetts' request for some updates to eligibility policies to support coverage for people with disabilities, pregnant people and children, people experiencing homelessness, and individuals experiencing incarceration, while maintaining existing eligibility criteria for all other members. These updates do not affect the income cutoffs illustrated in Figure 3; instead, they improve coverage by addressing other eligibility constraints, described in Figure 4.

FIGURE 3. ELIGIBILITY FOR MASSHEALTH FOR INDIVIDUALS UNDER AGE 65



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

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

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

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

FIGURE 4. SUMMARY OF ELIGIBILITY UPDATES IN DEMONSTRATION

CHARACTERISTIC OF MASSHEALTH MEMBER	PREVIOUS ELIGIBILITY CONSTRAINT	CHANGE IN NEW DEMONSTRATION
Adults with disabilities, age 21–64, enrolled in CommonHealth	One-time deductible required if working less than full-time.	Eliminate the deductible.
Adults with disabilities, age 65 and older, enrolled in CommonHealth	Member must work at least 40 hours per month to maintain eligibility.	Work not required if member has been enrolled in CommonHealth for 10 years or longer.
Pregnant people and children up to age 19	Coverage begins 10 days prior to the date of application; federal requirement for "retroactive eligibility" to three months prior to application is waived.	End waiver of retroactive eligibility for this group; retroactive coverage may be up to three months prior to application for members who would have been eligible during that period.
People experiencing homelessness	Standard eligibility determination and redetermination rules apply, often resulting in loss of eligibility due to frequent change of address, failure to respond to communications, etc.	Eligibility continues for 24 months regardless of changes in circumstances.
People experiencing incarceration	Eligibility is suspended (with narrow exceptions) while incarcerated; standard eligibility determination and redetermination rules apply after release.	MassHealth members receive 12 months of continuous eligibility upon release from correctional settings.

STREAMLINED ELIGIBILITY FOR PEOPLE WITH DISABILITIES

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

CommonHealth allows Massachusetts residents with disabilities to "buy in" to MassHealth, continuing coverage even while working and earning income.[23] There is no income limit to CommonHealth enrollment; it is available to all people with disabilities, and those with higher incomes pay a premium on a sliding scale. While the program was initially designed for people under the age of 65, as part of a previous Demonstration MassHealth expanded coverage for CommonHealth for people with disabilities who continue working past age 65.

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

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

EXPANDED RETROACTIVE ELIGIBILITY FOR PREGNANT INDIVIDUALS AND CHILDREN

Federal law requires states to extend most Medicaid coverage backwards in time, to three months prior to the application date.[24] This is a crucial tool in addressing medical debt, supporting safety net hospitals (by paying recent hospital bills), and improving health care; expensive health crises do not wait for application paperwork. Because the American health care system is largely based on employer-sponsored insurance, catastrophic events that could land a person in the hospital or nursing facility could also end a person's employment and health coverage, during a time when a person is least able to fill out a Medicaid application.[25] Rapid changes in both employment and health status during the COVID-19 pandemic highlighted the need for retroactive coverage.[26]

MassHealth has long had a waiver to allow it not to comply with this retroactive eligibility requirement, meaning that most MassHealth enrollees are *not* entitled to coverage for the three months prior to a Medicaid application.[27] In the new Demonstration period, Massachusetts will eliminate the waiver from retroactive eligibility for pregnant people and children, thus extending eligibility for these members to three months prior to the date of application if they would have met eligibility requirements during that period.[28]

ENSURING CONTINUITY OF COVERAGE FOR PEOPLE EXPERIENCING HOMELESSNESS OR INCARCERATION

Like all states, Massachusetts received enhanced federal Medicaid funding under the Families First Coronavirus Response Act, the federal stimulus package passed by Congress in 2020.[29] As a condition of receiving these funds, Massachusetts was required to maintain continuous Medicaid coverage for those who were enrolled at the start of the federal COVID-19 public health emergency and for anyone who became eligible during the emergency. When the continuity of coverage requirement expired on April 1, 2023, MassHealth returned to its standard renewal process, in which it redetermines the eligibility of each member every 12 months.

In addition to the annual redetermination process, members are expected to notify MassHealth of any changes to their income no later than 10 days from the date of the change, so that their eligibility can be redetermined. MassHealth also conducts regular computer matches with other state agencies; if it finds evidence of a change in circumstances (increased income, for example), it will ask the member to verify. If during this process the member does not return requested

documentation within a specified time, eligibility may be terminated or reduced. This enrollment "churn" is more likely to occur among certain groups in unstable circumstances, for whom a break in coverage would have serious consequences. In the new Demonstration, MassHealth will offer a period of continuous coverage, regardless of changes in circumstances, to two such groups in order to mitigate such coverage disruptions.

People experiencing homelessness. People with unstable housing are at risk of losing eligibility because a frequently changing address affects their ability to receive and respond to communications necessary to maintain MassHealth coverage. According to the Demonstration extension request, about 15 percent of MassHealth members experiencing homelessness lose their coverage due to missing paperwork.[30] CMS approved Massachusetts' request to provide up to 24 months of continuous eligibility for individuals experiencing homelessness. Continuous eligibility means that once someone has established their eligibility, they would remain enrolled in MassHealth for 24 months regardless of changes in their circumstances.

People transitioning from incarceration. CMS also approved Massachusetts' request for authority to maintain MassHealth eligibility continuously for one year following release from incarceration or Department of Youth Services (DYS) custody. Massachusetts stated in its Demonstration proposal that the intent of the 12-month continuous eligibility policy is "to reduce administrative eligibility churn during the post-release period when the risk of adverse health outcomes is particularly high."[31] Massachusetts has implemented several policies over the past several years to ease the effects of the federal "inmate exclusion policy," which can create a break in coverage that can be particularly disruptive for people with chronic diseases, those with mental health disorders, and those with SUDs. For example, MassHealth suspends (rather than terminates) coverage during incarceration, so it is easier to reinstate coverage when people leave incarceration and re-enter the community. MassHealth also supports the BH-JI program, which provides assistance before and after release by connecting people to BH services and other supports.

CMS did not approve Massachusetts' request for another measure related to coverage for people experiencing incarceration but indicated that it may approve it soon. Massachusetts had asked CMS to extend MassHealth coverage and services to people in county and state correctional facilities who meet MassHealth eligibility requirements and who have a chronic physical condition, mental health condition, or SUD within 30 days of their release. The proposed change would have been even more extensive for those engaged in the juvenile justice system: Massachusetts requested authorization to provide services to eligible youth committed to the care and custody of DYS for the duration of their custody.

This request is part of a trend among a handful of states asking for extension of Medicaid to incarcerated individuals. In January 2023, CMS approved the first of these requests: California will cover a package of reentry services for certain groups of incarcerated people 90 days prior to their release. Congress is also considering legislation that would soften the inmate exclusion in federal law.[32] Massachusetts asserted that this updated eligibility policy would "improve health care outcomes for newly released MassHealth members by increasing continuity of care, improving transitions from correctional facilities and juvenile justice facilities."[33] In its letter transmitting the terms of its Demonstration approvals, CMS said that it "is generally supportive of increasing pre-release services for justice-involved populations in order to assist in making successful transitions from the carceral system back into the community and will continue to work with the Commonwealth on this request."

VI. ADVANCING HEALTH EQUITY

"Advancing health equity," an imperative that has vexed health care providers and policymakers for decades, is one of the five goals Massachusetts has set for MassHealth to achieve in this Demonstration extension. Simply stated, access to and quality of health care services and health status in general varies across groups with certain characteristics, including race, ethnicity, disability status, sex, gender identity, and sexual orientation.[34] There are multiple sources of these inequities. Some originate in the health care system itself, including discrimination, implicit bias, and cultural misunderstanding. Certain communities also mistrust the medical care system because of historical or current experiences of discrimination. Other health inequities

are created by social and economic injustices, such as inequitable access to housing stability and quality, nutritious food, healthy environments, educational and employment opportunities, and more.

THE MASSHEALTH APPROACH TO EQUITY

The MassHealth program has addressed health equity through coverage, benefits, and attention to HRSN.

Coverage. Lack of health insurance is a significant barrier to care for people with low incomes, who are disproportionately people of color. While access to health coverage alone will not solve entrenched health inequities, it is an essential step toward equitable health care access. MassHealth is a key source of health coverage for populations that face significant health inequities. While the majority of MassHealth members are White, there is significant racial diversity. Four in 10 self-report a race/ethnicity other than White, and Hispanic and Black members make up 30 percent of the total MassHealth population.[35] The state also took up the option under the American Rescue Plan Act (ARPA) to extend postpartum coverage from 60 days to 12 months to address challenges to maternal health, particularly maternal mortality, which disproportionately affects people of color.[36] This benefit extends to new birthing parents regardless of their immigration status, so that people who would otherwise not qualify for Medicaid can access postpartum care.

Benefits. MassHealth has many benefits and programs targeted to better meet the needs of specific populations that have experienced health inequities. For example, the One Care program is designed to better meet the needs of people with disabilities who are under age 65 by offering coordinated, comprehensive medical care and LTSS through specialized health plans. Massachusetts' BH-JI program addresses health inequities by connecting people reentering the community following incarceration with needed BH services.[37] Because people of color are disproportionately incarcerated,[38] these services have the potential to reduce health inequities.

Attention to health-related social needs. MassHealth also addresses equity through its attention to HRSN. The FSP and specialized CSP programs acknowledge housing instability and food insecurity as significant determinants of health and as circumstances that disproportionately affect people of color.[39]

ELEMENTS OF THE NEW DEMONSTRATION THAT ADDRESS EQUITY

This MassHealth Demonstration extension makes equity a specific goal for the first time in the history of the state's Demonstration requests. Notably, the Demonstration proposal included as aims of its equity initiatives the reduction in disparities by race, ethnicity, language, disability status, sexual orientation, and gender identity.[40]

Several key equity-related elements of the Demonstration addressing HRSN, services for people who are justice-involved, and improvements to maternal and child health were introduced in earlier sections of this report and are further described here. In addition, Massachusetts will introduce financial incentives to address structural racism and reduce disparities in quality and access.

HEALTH-RELATED SOCIAL NEEDS

CMS has recently expanded opportunities for states to address HRSN in their Medicaid programs, citing evidence that HRSN are "a critical driver of an individual's health outcomes." Housing and nutrition supports in this context are "upstream services" that help avert more intensive medical intervention, analogous to the home and community-based services that have long been available to people with disabilities to avert nursing facility care.[41] CMS is inviting states to use 1115 waivers to address HSRN as part of its strategy to promote health equity.[42]

Massachusetts will use the flexibility from CMS to expand existing features that address equity and HRSN and build onto them with new initiatives. Beginning in the prior Demonstration period, the FSP and CSP-CHI acknowledged housing instability and food insecurity as significant determinants of health and as circumstances that disproportionately affect people of color.[43] The new Demonstration continues this support and, via the FSP, extends meal support to an entire household when the eligible member is a child or a pregnant person.

The Demonstration includes enhancements to several programs aimed at addressing housing. Housing instability is a major factor associated with negative health outcomes, including maternal depressive symptoms, nutritional deficits, psychological distress, and infectious disease.[44] Elements of the Demonstration related to homelessness include:

- Offering 24 months of continuous eligibility to individuals experiencing homelessness (described in Section V)
- Expanding CSP to MassHealth members not enrolled in managed care (described in Section IV)
- Broadening the definition of homelessness for participation in the specialized CSP-HI (described in Section IV)
- Adding CSP for individuals facing eviction due to behavior related to a disability (e.g. mental illness, intellectual disability, substance abuse, aging-related impairments) (described in Section IV)

MassHealth also accounts for HRSN in its payment policies. Payments to ACOs and MCOs are risk adjusted, not only for the health and disability status of their member populations, as is typically done, but also for social drivers of health such as housing deficits and neighborhood-level stressors. These risk adjustments mean that ACOs and MCOs receive higher payments to care for people with more significant HRSN.[45] And the ACOs face financial incentives based in part on a measure focused on the annual HRSN screening, meaning that how well an ACO performs on this measure may ultimately impact its compensation.

SERVICES FOR INDIVIDUALS WHO ARE JUSTICE-INVOLVED

As described in Section V, Massachusetts received authority to provide 12 months of continuous MassHealth coverage to members following their release from incarceration. Improving access to coverage and quality of care for individuals with experience in the criminal justice system is an equity issue. Massachusetts has one of the lowest incarceration rates in the nation, but one of the highest in the world.[46] Black and Hispanic individuals are disproportionately affected by this system. For example, when adjusting for the severity of the charged crimes and other factors, Black and Hispanic individuals receive disproportionately higher sentences in Massachusetts[47] and make up a disproportionate share of the prison population.[48] Maintaining MassHealth coverage for 12 months post-release would improve continuity of care during the early months of this transition, with the potential to reduce health inequities based on race and ethnicity.

A FOCUS ON IMPROVING MATERNAL AND CHILD HEALTH

The state's Demonstration includes a focus on maternal and child health. This focus directly addresses the Demonstration's goal of advancing health equity because maternal and child health is an area of significant racial inequities in Massachusetts. Though Massachusetts has one of the lowest infant mortality rates in the nation for Black infants, it is more than 2.5 times the rate for White infants.[49] Elements of the Demonstration that reflect a focus on improving maternal and child health outcomes include:

- Extending MassHealth eligibility for three months prior to the application date for pregnant people and children (see Section V)
- Attention to pediatric needs in a new primary care payment model (see Section VII)
- New requirements that Flexible Service programs will be tailored to better recognize and serve the needs of children and families, such as expanding nutritional services to the whole household when the eligible member is a child or pregnant person (see Section IV)

Beyond the Demonstration, Massachusetts is taking other approaches to bolster coverage for maternal and child health, including:[50]

- Expansion of MassHealth postpartum coverage eligibility from 60-days postpartum to 12 months[51]
- Addition of doula services to the MassHealth benefit
- A new targeted case management benefit, MassHealth Coordinating Aligned, Relationship-Centered, Enhanced Support (CARES) for Kids, for the highest risk children with medical complexities to provide comprehensive, high-touch

care coordination for children and their families. MassHealth CARES for Kids providers will serve as lead entities to coordinate prompt and individualized care across the health, educational, state agency, and social service systems.

- New requirements for ACOs and MCOs to offer enhanced care coordination for members with high-risk pregnancies
- Coverage for preventive BH services to youth who screen positive for BH symptoms and would benefit from preventive interventions[52]
- Partnership with Massachusetts Child Psychiatry Access Project to create a program through which mobile crisis clinicians can consult with autism experts while working with youth and young adults with autism spectrum disorder or intellectual disability who are having a BH crisis

QUALITY AND EQUITY INCENTIVE PAYMENTS

In addition to these programmatic elements, CMS approved financial incentives for hospitals to improve the quality of care and advance health equity.[53] The initiative includes $400 million annually for incentive payments to acute care hospitals partnering with ACOs and, separately, $90 million available annually for Cambridge Health Alliance (CHA), the Commonwealth's only non-state-owned public acute care hospital. The CHA incentive replaces the Public Hospital Transformation and Incentive Initiative (PHTII) pool, a component of the SNCP in the prior Demonstration. This arrangement recognizes CHA's critical role in providing targeted services to a very high percentage of Medicaid and uninsured patients. The incentive program for CHA will parallel the one designed for other hospitals and will additionally ensure accountability for serving its unique population, while helping to sustain its services for the Commonwealth's MassHealth and uninsured populations.[54]

Under this initiative, hospitals can earn incentive payments for "meeting data collection requirements, reporting expectations, and achieving quality and equity improvement standards that demonstrate improvement in health care quality and equity."[55] There are three domains of the Hospital Quality and Equity Initiative:[56]

1. **Demographic and health-related social needs data** (25 percent of the incentive pool). A performance-based incentive requires complete and accurate data to gauge achievement. Currently, data that facilitate the measurement of health inequities across various groups are incomplete and inconsistent. MassHealth will offer incentives for hospitals to collect data on the social risk factors of their members and patients. Social risk factor categories will include, at least: race, ethnicity, primary language, disability status, gender identity, sexual orientation, and HRSN. As a fundamental element of measuring and then reducing health inequities, the Demonstration will create incentives to meet ambitious targets for data completeness, for example: race and ethnicity data for 80 percent of members served at participating hospitals by the end of Year 3, data on primary language, disability status, sexual orientation and gender identity for 80 of members served at hospitals by the end of Year 5, and significant improvements in rates of HRSN screening by hospitals by the end of Year 5. Data completeness will be assessed separately for each data element, and details about data submission will be part of an implementation plan MassHealth will develop.

2. **Equitable Access and Quality** (50 percent of the incentive pool). The goal of improving data collection and reporting is, ultimately, to improve quality and reduce inequities. MassHealth and participating hospitals will be assessed on performance in (1) reporting on access and quality measures, stratified by demographic factors (such as race, ethnicity, language, disability status, sexual orientation, and gender identity), HRSN and other markers of social risk; (2) developing and implementing interventions aimed at improving quality and reducing measured disparities; and (3) improving quality and/or closing disparities. The measures targeted for stratified reporting and disparities reduction will be selected from MassHealth's Acute Hospital Clinical Quality Incentive Program and CMS's Health Equity Measure Slate.

3. **Capacity and Collaboration** (25 percent of the incentive pool). MassHealth and the hospitals will be assessed on improvements to provider and workforce capacity and collaborations to improve quality and reduce health care disparities. The measures, which CMS will approve, may be related to cultural competence and other

externally validated equity standards. The target for MassHealth and participating hospitals is that 80 percent of hospitals will achieve "rigorous standards regarding service capacity, access, and delivery of culturally and linguistically appropriate care" by the end of Year 3 of the Demonstration.

MassHealth will submit its detailed plan for implementing the Hospital Quality and Equity Initiative for CMS approval in the first year of the Demonstration, and incentive payments will be available retroactive to the start of the Demonstration period.

In addition to the quality and equity incentive payments that hospitals will face, ACOs will also face incentives based on their equity performance. In the previous demonstration period (2017–2022), ACOs faced financial incentives based on a quality slate; beginning in the current Demonstration period, ACOs will continue to face financial incentives based on a quality slate but will now also face financial incentives based on improving equity as well. The ACO's Health Equity Score will depend on its performance in reporting member-level risk factor data (including race, ethnicity, language, disability, sexual orientations, and gender identity); identifying and reporting on disparities across these social risk factors in certain measures from the quality slate; and, eventually, reducing the identified disparities.

VII. INVESTING IN PRIMARY CARE AND BEHAVIORAL HEALTH

One of the Commonwealth's goals for this Demonstration is to make significant investments in primary care and BH. To that end, CMS approved MassHealth's request to transition primary care payment in ACOs away from the fee-for-service model and towards a model that offers more flexibility and helps support enhanced care delivery expectations, such as BH integration. Additionally, Massachusetts received CMS approval to continue two loan repayment and professional training programs from the previous Demonstration. This section focuses on these key components; there are many other ways in which the Demonstration focuses on primary care and BH described in other sections of this brief.

PRIMARY CARE SUB-CAPITATION

In the previous ACO contracts, Massachusetts required ACOs to "develop, implement, and maintain value-based payments for participating PCPs [primary care providers]."[57] Value-based payments, also called alternative payment models, reward quality of care and positive health outcomes, rather than simply paying a fee for every service that is delivered. ACOs met this contractual requirement, but the value-based incentives were often relatively small-scale and often layered on top of a fee-for-service model; PCPs within ACOs were still primarily reimbursed fee-for-service.[58]

In the new Demonstration, MassHealth will invest $115M per year in primary care through a new payment model for ACO-affiliated primary care practices. ACO-affiliated primary care practices will be paid using a sub-capitation payment—a fixed monthly amount per member (adjusted for the practice's specific population characteristics such as age and health risks) regardless of the health care services the member uses in that month. MassHealth will continue to pay Accountable Care Partnership Plans a set monthly payment per member (a capitation payment) and direct the ACOs to use a portion of that capitation fee to pay their participating primary care practices. For Primary Care ACOs, MassHealth will make capitation payments for certain primary care services to the ACO, which will then be required to make sub-capitation payments to their participating primary care practices, in line with MassHealth's prescribed model.

Primary care practices will be placed into one of three tiers, based on their capabilities.[59] Tier placement will depend on the extent of advanced integration that practices have achieved, and sub-capitation payments will reward that integration accordingly. To be eligible for sub-capitation payments in Tier 1, primary care practices must offer certain clinical features, including:

- Care coordination
- Screening and appropriate referral for oral health, BH, and HRSN
- Services tailored to the needs of children and families

- Culturally and linguistically appropriate care
- Preventative services including provision of fluoride varnish to eligible children
- Video telehealth capability

Tier 2 and 3 practices will receive higher capitation payments and have additional responsibilities, including:

- Integration of BH care
- Meeting certain heightened staffing requirements to address the clinical features listed above (for example, using community health workers for care navigation and to address HRSN)
- If the practice serves children, employing non-clinical staff with expertise addressing the BH needs and HRSN of children, youth, and families, to act as a family's point of contact with the Children's Behavioral Health Initiative, state Family Resource Centers, and schools and early childhood settings
- Offering enhanced evening and weekend availability
- Offering expanded telehealth capabilities and developing capacity for primary care providers to use e-consults with specialists

PRIMARY CARE WORKFORCE INVESTMENTS

The Demonstration includes three workforce initiatives focused on primary care.[60] Two are student loan forgiveness programs:

- Repayment of student loan obligations up to $100,000 for PCPs, in exchange for a four-year commitment to working in community-based settings that serve a significant number of MassHealth members. A total of $13.56 million is authorized for this incentive over the Demonstration period.
- Repayment up to $50,000 per clinician for advanced practice registered nurses, pediatric clinical nurse specialists, nurse practitioners, and physician's assistants who make a similar four-year commitment. A total of $4.84 million is authorized for this part of the program.
- MassHealth may prioritize clinicians for these programs who have cultural and linguistic competence in the communities they would serve.

The third primary care workforce initiative is a family nurse practitioner (FNP) residency grant program for community health centers. The grants would provide up to $105,000 for each of 10 residency slots per year for four years and, as with the loan repayment programs, would prioritize programs that target FNP applicants with cultural and linguistic competence and that serve a diverse MassHealth population.

BEHAVIORAL HEALTH WORKFORCE INVESTMENTS

Although Massachusetts was among the first states to require coverage of BH services, this care is not always easily accessible because of a shortage of BH providers. A 2019 BCBSMA Foundation report highlights how workforce shortages across the BH sector create significant access challenges for most residents.[61] And in 2020, during the COVID-19 pandemic, the number of people reporting mental health challenges increased by 11 percent from the previous year, according to the Department of Public Health's COVID-19 Community Impact Survey.[62] This increase has further exposed the BH care needs in the state. According to a recent survey commissioned by the BCBSMA Foundation, more than 1 in 3 adults report needing BH care for themselves or a family member during the first year of the pandemic and among those who report needing BH care, 26 percent did not receive any BH care.[63]

A 2017 report on the outpatient mental health system in Massachusetts found that reimbursement rates for mental health services are not enough to reliably retain providers.[64] Stakeholders overwhelmingly report that reimbursement rates in most cases do not cover the actual cost of providing services, creating a difficult situation for providers. Mental health advocates

and representatives from associations of safety net organizations report that reimbursement rates for outpatient mental health services under MassHealth are lower than those for commercial insurance.[65] There is evidence that incentivizing BH providers through loan forgiveness can help alleviate financial strain and increase retention rates.[66]

PROGRAMS TO BOOST THE BH WORKFORCE

In the Demonstration approval, CMS authorized two student loan repayment programs, amounting to $20 million for the Demonstration period, with the aim of increasing retention rates among BH providers, particularly those of diverse backgrounds.[67] This aligns with the goals of the Commonwealth's Roadmap for Behavioral Health Reform to recruit and retain a diverse and culturally competent workforce and improve access to high quality BH care.

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

VIII. SUSTAINING THE SAFETY NET CARE POOL

The Safety Net Care Pool (SNCP) became part of the Demonstration in 2005. It has been a key source of funding for Disproportionate Share Hospitals (DSH) [see sidebar] and other facilities that treat populations with limited access to care, for delivery system innovations in those facilities, and for subsidies to people purchasing insurance through the Health Connector. In 2016, MassHealth restructured the SNCP to align with the introduction of ACOs and CPs, while continuing to provide sustaining funds for Massachusetts safety net providers. In the approved Demonstration, the SNCP design reaffirms the state's commitment to these providers.

DISPROPORTIONATE SHARE HOSPITALS

Federal law requires that state Medicaid programs make additional payments to hospitals that serve a large proportion of Medicaid and uninsured individuals; these hospitals are designated Disproportionate Share Hospitals (DSH). The federal share of DSH payments is limited by an annual allotment. In Massachusetts, the DSH allotment is incorporated into the SNCP.

SAFETY NET CARE POOL COMPONENTS

The structure of the SNCP in the new Demonstration is similar to past Demonstrations but there are some changes. The most significant change is that the authorization of ConnectorCare subsidies is now separate from the SNCP.[68] The Health Connector is the Commonwealth's marketplace for individuals and small businesses to purchase health insurance. Under the Affordable Care Act (ACA), some purchasers are eligible for federal subsidies of their premiums.[69] Massachusetts offers an additional state subsidy for premiums and cost sharing to purchasers who are at or below 300 percent of the federal poverty level (FPL), through a program called ConnectorCare, a remnant of the state coverage expansions that preceded the ACA. These state subsidy payments receive federal matching funds through the Demonstration. While ConnectorCare remains a part of the Demonstration, it is no longer a component of the SNCP. ConnectorCare coverage otherwise remains the same as in the past.

The remaining components of the SNCP are:[70]

1. **Disproportionate Share Hospital-Like Pool**
   The largest component of the SNCP is the DSH Pool, which provides support to hospitals serving high numbers of patients who have low incomes, are MassHealth members, or are under- or uninsured. DSH Pool expenditures include:

- Funding for the Health Safety Net (HSN), which pays hospitals and community health centers for care provided to people with low incomes and inadequate or no insurance
- A Public Service Hospital payment to Boston Medical Center, for services to patients eligible for HSN
- Payments for uncompensated care to non-acute hospitals operated by the Department of Mental Health and Department of Public Health
- Payments to Institutions for Mental Disease (hospitals or community-based detox centers) for otherwise unreimbursed BH care provided to MassHealth members age 21–64[71]
- Safety Net Provider Payments

Safety net providers are defined for this purpose as hospitals (*except* Cambridge Health Alliance and hospitals in the University of Massachusetts [UMass] system) that have a "patient mix" of 20 percent or more MassHealth members or patients without insurance combined with no more than 50 percent of patients with commercial insurance. Because patients without insurance often cannot pay for their care and MassHealth typically has lower reimbursement rates for hospital services than commercial insurance, these hospitals receive less revenue per patient (often much less) than hospitals with more commercially insured patients. The SNCP payments are intended to shore up safety net providers' operational sustainability.

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

The Demonstration authorizes federal matching funds for DSH pool expenditures up to a maximum allotment. That allotment is calculated annually; for federal fiscal year (FFY) 2023 it was $382.2 million. Because Massachusetts generally receives 50 cents of federal reimbursement for every dollar it spends in MassHealth, this means that Massachusetts could spend up to a total of $764.3 million and receive its full federal match.[72] In December 2020, Congress delayed until FFY 2024 DSH reductions that were scheduled to begin in FFY 2021 and continue for four more years.[73] If these reductions occur as they are now scheduled, Massachusetts would see a dramatic reduction in its allotment (which is not currently accounted for in the allotment figures cited above and in the Demonstration agreement) and, therefore, in federal financial participation in the SNCP.

2. **Closeout Payments for DSRIP and PHTII**
   As explained in Section III, the DSRIP program was intended to be time-limited, lasting only the five years of the prior Demonstration. DSRIP was the funding source that enabled the launch of the CP program and the FSP, two of the key innovations of the Demonstration. In the new Demonstration, CMS authorized Massachusetts to use remaining DSRIP funds (about $253.2 million) to make incentive payments to serve as a bridge until the new ACO and CP contracts became effective and for prior periods of performance and administrative activities to close out the program. PHTII, a time-limited incentive payment targeted to Cambridge Health Alliance, is also no longer part of the Demonstration. As described in the discussion of health inequities in Section VI, PHTII is replaced by the "Non-State-Owned Public Hospital Health Equity Incentives" payment, a potential payment to Cambridge Health Alliance of $90 million per year. Massachusetts is authorized to use the small amount of PHTII funds remaining from the prior Demonstration (about $6.4 million) for close-out activities.[74]

3. **Uncompensated Care Pool**
   The Uncompensated Care (UC) Pool reimburses hospitals and community health centers for care provided to people without health insurance and can be accessed when the DSH Pool has been exhausted. The expenditure limit (including state and federal spending) for the Uncompensated Care Pool portion of the SNCP is $500 million.[75]

IX. IMPLICATIONS

IMPLICATIONS FOR HEALTH EQUITY

With its new Demonstration, MassHealth has included advancing health equity as an explicit goal for the first time in the 20-plus years of the Demonstration. While health inequities—in access and outcomes—have been apparent for a long time, they were brought into sharper focus by the disparate impacts of the COVID-19 pandemic. Government and health care leaders seized an opportunity to elevate health equity as a policy issue. A Health Equity Task Force, created by an act of the Legislature, issued its final report and recommendations in July 2021. In addition to strengthening public health infrastructure, diversifying the health care workforce, investing in community health centers and safety net providers, and expanding coverage to all immigrant children, among other policy recommendations, the Health Equity Task Force also envisioned a cabinet-level Executive Office of Equity and a Secretary of Equity to help lift up equity within state government.[76] Federal actions to address the impacts of the pandemic, including ARPA, also acknowledge the importance of reducing inequities.[77] In early 2023, the Health Equity Compact, a coalition to advance health equity in Massachusetts, filed legislation aimed at prioritizing health equity in state government, standardizing and reporting on health equity data, and improving access to and quality of care. Attention to equity is high, as are the stakes. Many residents of Massachusetts are looking for results in correcting the impacts of structural racism and other types of discrimination; health inequity is one of the most prominent.

By establishing a health equity goal, MassHealth can be an engine for moving the system towards greater equity, as it was (and still is) for health care coverage. The Demonstration's focus on social drivers of health—particularly housing stability and food security—is important because these (and other) social factors often have a greater influence on the health of populations than health care services.[78] The continuation and expansion of the FSP and CSP programs, which provide nutritional and housing supports, is therefore very significant.

Whether and how Flexible Services—and other Demonstration provisions such as services for people who are homeless or justice-involved, and others—reduce inequities needs to be measured, which is another important feature of the Demonstration. Hospitals and health plans will be partners with MassHealth in achieving the equity goal. The Demonstration ties incentive payments to improved collection of social risk factor data and to the measurement and reduction of inequities; equity is now an element of health system performance and part of what hospitals are accountable for. This is new ground and will be important to follow as the details of the implementation plan are rolled out.

IMPLICATIONS FOR MASSHEALTH MEMBERS

This Demonstration includes expansions of eligibility and services that have the potential to include more individuals in MassHealth coverage and more opportunities to access key BH and care coordination services and supports. Expanded coverage and services for individuals who have been incarcerated, people who are facing homelessness, and individuals experiencing health conditions related to unstable housing and food insecurity offer a targeted approach to addressing health inequity in the Commonwealth.

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

IMPLICATIONS FOR ACCOUNTABLE CARE ORGANIZATIONS

Five years ago, Massachusetts launched an ambitious delivery system reform project, with the launch of the ACO program at the center. As discussed above, early results on member satisfaction, quality, and cost metrics are promising. Massachusetts

will continue its ACO program for the next five years. A new slate of ACOs (which includes many of the ACOs that started up in 2018), with new requirements, began operating in April of 2023.

ACOs that contract with MassHealth face new options and requirements. ACOs will be asked to operate new models of care, including new approaches to care coordination, new approaches to paying CPs, and operating a primary care sub-capitation program. These changes will require effort and infrastructure to build the required administrative process. As DSRIP ends, there may be some adjustments that ACOs will have to make to line up funding and new administrative functions.

IMPLICATIONS FOR PRIMARY CARE PROVIDERS

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

IMPLICATIONS FOR BEHAVIORAL HEALTH PROVIDERS

Beyond the MassHealth Demonstration, Massachusetts is redesigning its BH system, across all payers; these changes include a crisis response call/text option, expanded access to treatment, more BH services available in primary care offices, and community-based alternatives to the emergency department for BH crises.[79] The Demonstration includes several items related to the state's broader BH redesign, including workforce initiatives such as student loan repayment (described in Section VII) and expanded access to diversionary BH services (described in Section IV). For BH providers, additional covered services and workforce initiatives may mean better care for their clients, more payment for services they deliver, and debt relief that could increase the viability of remaining in practice.

IMPLICATIONS FOR COMMUNITY PARTNERS

In the rollout of MassHealth delivery system reforms, the CP program was successful in reaching populations historically not fully engaged in the health care system, but many CPs and ACOs also struggled with the complexity and rigidity of the program design.[80] MassHealth made changes to the structure of the CP program in response to these concerns, including increases to the CP payment rate.

Massachusetts is transitioning funding for CPs from DSRIP to be part of the ACO and MCO payment, with ACOs and MCOs paying CPs directly for services. Alongside this change, Massachusetts is giving CPs more responsibility in the care planning process (this change is especially significant for LTSS CPs). In addition, BH CPs will be required either to be designated as a CBHC, a new type of entity that will deliver behavioral health care for MassHealth members and other Massachusetts residents, or to have formalized processes for communication and referral with the CBHC in each of their service areas.

These changes mean that CPs will have many new processes, activities, and partnerships to build over the coming months and years. They have already shown success in the implementation of reforms, engaging members who might otherwise have been unable to access care coordination and management.[81]

IMPLICATIONS FOR COMMUNITY-BASED SOCIAL SERVICE ORGANIZATIONS

When the FSP started in 2020, there was hope that ACOs would partner with social service agencies to provide housing and nutrition supports, bolstering social service organizations (SSOs) that have been at this work for decades. This hope has been borne out, with 40 social service providers in partnerships with ACOs to run FSPs beginning April 1, 2023. In an analysis

of the rollout of the ACO program, organizations noted a desire for more structure in the FSP and better approaches to affordable housing.[82] Another analysis found a strong need for resources and technical assistance to improve data-sharing systems, to allow ACOs and SSOs to exchange referrals and other necessary information for serving members.[83] With the extension of the FSP and continued funding for infrastructure, capacity building, and technical assistance for SSOs, relationships between ACOs and SSOs will have the chance to grow stronger over the course of the next five years to meet these challenges.

IMPLICATIONS FOR MASSHEALTH AND MASSACHUSETTS

By refining the delivery reform models, and encouraged by interim evaluation findings, Massachusetts is signaling its commitment to moving ahead with its transformation of the MassHealth delivery system, and to accountable, value-based care.[84] These innovations mirror similar trends in the broader health care system. The elevation of health equity as an explicit goal of the Demonstration is a notable new feature of MassHealth policy and, because MassHealth is an important engine of state health policy overall, the structure, process, and outcomes of the new financial incentives to improve equity has the potential to influence payers and providers beyond MassHealth.

X. CONCLUSION

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

Looking ahead, Massachusetts aims to build on the foundation of expanded access and accountable care and to explicitly address and improve health equity. Using the MassHealth Demonstration as its vehicle, Massachusetts continues its efforts to improve MassHealth eligibility and services for populations that experience health inequities, to make adjustments to core features of the Demonstration (ACOs, CPs, and the FSP), to introduce new accountability for ACOs and hospitals to address health equity, and to support continued investment in primary care and BH.

ENDNOTES

1 Department of Health and Human Services, Centers for Medicare & Medicaid Services, “MassHealth Extension Approval,” approved September 28, 2022, accessed at https://www.mass.gov/doc/masshealth-extension-approval/download.

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

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

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

5 Gershon, Grenier, & Seifert, “The MassHealth Waiver 2016–2022: Delivering Reform.” Blue Cross Blue Shield of Massachusetts Foundation (January 2017).

6 “Draft Independent Evaluation Interim Report Massachusetts Medicaid 1115 Demonstration Extension 2017–2022,” released for public comment August 2021, accessed at https://www.mass.gov/doc/1115-demonstration-interim-evaluation-report/download. (hereinafter “Draft Independent Evaluation Interim Report”)

7 Draft Independent Evaluation Interim Report p. 23.

8 Demonstration Request, p. 18.

9 Demonstration Request.

10 Executive Office of Health & Human Services, “MassHealth 1115 Demonstration Extension, 2022–2027.” Slide deck, October 2022.

11 “17 Health Care Organizations Selected to Participate in the Accountable Care Organization Program”, released by The Massachusetts Executive Office of Health and Human Services on November 04, 2022. Accessed at https://www.einnews.com/pr_news/599530270/17-health-care-organizations-selected-to-participate-in-the-accountable-care-organization-program.

12 Commonwealth of Massachusetts, Executive Office of Health and Human Services. “Request for Responses for Accountable Care Organizations.” April 13, 2022.

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

14 EOHHS, “Massachusetts Delivery System Restructuring: 2020 Update Report,” https://www.mass.gov/doc/masshealth-restructuring-2020-update-report/download, accessed February 17, 2023.

15 EOHHS, “Massachusetts Delivery System Restructuring: 2020 Update Report.”

16 “List of MassHealth Community Partners.” https://www.mass.gov/info-details/list-of-masshealth-community-partners. Accessed February 20, 2023.

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

18 Centers for Medicare & Medicaid Services, “MassHealth Flexible Services Program Protocol,” accessed at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-appvd-flex-services-protocol-05112020.pdf.

19 Demonstration Request, pp. 55–56.

20 MassHealth Demonstration Special Terms and Conditions 5.11.

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

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

23 130 CMR, §505.004; 130 CMR, §519.012.

24 42 CFR 935. States are required to extend Medicaid eligibility retroactively if a person received a Medicaid-covered service during that time and would have been eligible for Medicaid if an application had been submitted.

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

26 Ibid.

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

28 Executive Office of Health and Human Services, Office of Medicaid. "Three-Month Retroactive Eligibility for Certain MassHealth Applicants." Eligibility Operations Memo 22-18, December, 2022. https://www.mass.gov/doc/eom-22-18-three-month-retroactive-eligibility-for-certain-masshealth-applicants/download. Accessed May 12, 2023

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

30 Demonstration Request, p. 75.

31 Demonstration Request, p. 68.

32 Fourteen other states have asked for waivers of the inmate exclusion policy to allow Medicaid to take effect at least 30 days prior to release from incarceration. CMS approved California's request on January 26, 2023. (Sweta Haldar and Maeline Guth, "Section 1115 Waiver Watch: How California Will Expand Medicaid Pre-Release Services for Incarcerated Populations." Kaiser Family Foundation, February 7, 2023. https://www.kff.org/policy-watch/section-1115-waiver-watch-how-california-will-expand-medicaid-pre-release-services-for-incarcerated-populations/, accessed February 21, 2023.

33 Demonstration Request, p. 68.

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

35 Boozang, P., & Ferguson, M., "MassHealth's Role Promoting Coverage and Access," Blue Cross Blue Shield of Massachusetts Foundation (June 2021), accessed at https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2021-06/MH_Impact_MH-Matters_brief_FINAL.pdf.

36 EOHHS, "Three-Month Retroactive Eligibility for Certain MassHealth Applicants." Eligibility Operations Memo, December 2022. Accessed at https://www.mass.gov/doc/eom-22-12-extension-of-postpartum-coverage-for-eligible-individuals-revised-eligibility-criteria-0/download#:~:text=Effective%20April%201%2C%202022%2C%20MassHealth,in%20the%20period%20after%20childbirth.

37 EOHHS, "MassHealth Behavioral Health Supports for Justice Involved Individuals", accessed at https://www.mass.gov/masshealth-behavioral-health-supports-for-justice-involved-individuals-bh-ji; Bishop, E. T., Hopkins, B., Obiofuma, C., & Owusu, F., "Racial Disparities in the Massachusetts Criminal System," Harvard Law School Criminal Justice Policy Program (September 2020), accessed at http://cjpp.law.harvard.edu/assets/Massachusetts-Racial-Disparity-Report-FINAL.pdf.

38 Prison Policy Initiative, "Massachusetts State Profile," available at https://www.prisonpolicy.org/profiles/MA.html; Bishop, Hopkins, Obiofuma, & Owusu, "Racial Disparities."

39 Massachusetts Senate Committee on Reimagining Massachusetts Post-Pandemic Resiliency, "Reimagining the Future of Massachusetts" (October 2021), accessed at https://malegislature.gov/Reports/12010/SD2782_Senate_Reimagining_the_Future_of_Massachusetts.pdf. Greater Boston Food Bank, "Gaps in Food Access During the COVID-19 Pandemic in Massachusetts" (May 2021), accessed at https://www.gbfb.org/wp-content/uploads/2021/04/GBFB_Gaps_in_Food_Access_Report_Final_May_2021.pdf.

40 Demonstration Request, p. 20.

41 Chiquita Brooks-LaSure, CMS Administrator, letter to Assistant Secretary Amanda Cassel Kraft approving MassHealth Demonstration, September 28, 2022.

42 Anne Smithey, Amanda Bank, and Diana Crumley. "Testing One, Two, Three: CMS' New Demonstration Opportunity to Address Health-Related Social Needs." Center for Health Care Strategies. https://www.chcs.org/testing-one-two-three-cms-new-demonstration-opportunity-to-address-health-related-social-needs/. Accessed February 22, 2023.

43 Massachusetts Senate Committee on Reimagining Massachusetts Post-Pandemic Resiliency, "Reimagining the Future of Massachusetts" (October 2021), accessed at https://malegislature.gov/Reports/12010/SD2782_Senate_Reimagining_the_Future_of_Massachusetts.pdf. Greater Boston Food Bank, "Gaps in Food Access During the COVID-19 Pandemic in Massachusetts" (May 2021), accessed at https://www.gbfb.org/wp-content/uploads/2021/04/GBFB_Gaps_in_Food_Access_Report_Final_May_2021.pdf.

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

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

46 Wagner, P., & Sawyer, W., "States of Incarceration: The Global Context," Prison Policy Initiative (June 2018), accessed at https://www.prisonpolicy.org/global/2018.html#methodology.

47 Bishop, Hopkins, Obiofuma, & Owusu, "Racial Disparities in the Massachusetts Criminal System." Harvard Law School Criminal Justice Policy Program, September 2020 (Requested by Chief Justice Ralph D. Gants, Supreme Judicial Court of Massachusetts). Available at https://hls.harvard.edu/content/uploads/2020/11/Massachusetts-Racial-Disparity-Report-FINAL.pdf.

48 Prison Policy Initiative, "Massachusetts State Profile." Available at https://www.prisonpolicy.org/profiles/MA.html; Bishop, Hopkins, Obiofuma, & Owusu, "Racial Disparities in the Massachusetts Criminal System." Harvard Law School Criminal Justice Policy Program, September 2020 (Requested by Chief Justice Ralph D. Gants, Supreme Judicial Court of Massachusetts). Available at https://hls.harvard.edu/content/uploads/2020/11/Massachusetts-Racial-Disparity-Report-FINAL.pdf.

49 Kaiser Family Foundation State Health Facts, "Infant Mortality Rate by Race/Ethnicity" (2019).

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

51 Approved as a State Plan Amendment July 28, 2022.

52 MassHealth, Managed Care Entity Bulletin 65, August 2021. Available at https://www.mass.gov/doc/managed-care-entity-bulletin-65-preventive-behavioral-health-services-for-members-younger-than-21-0/download.

53 Demonstration Approval, STC #14.

54 Demonstration Request, p. 54.

55 Demonstration Approval, Expenditure Authority #25.

56 Demonstration Approval, STC #14.2–14.5.

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

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

59 Model Accountable Care Partnership Plan Contract. Appendix K – Primary Care Sub-Capitation Program.

60 Demonstration Approval, STC #13.

61 Anthony, S., Boozang, P., Chu, B., & Striar, A., "Ready for Reform: Behavioral Health Care in Massachusetts," Blue Cross Blue Shield of Massachusetts Foundation (January 2019), pp. 1–2, available at https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2020-09/Model_BH_ExecSummary_January2019_Final.pdf.

62 Baskin, M., "As Mental Health Crises Rise, Shortage Of Psychiatric Beds Leaves Patients Stranded In ER," GBH News (March 29, 2021), available at https://www.wgbh.org/news/local-news/2021/03/29/as-mental-health-crises-rise-shortage-of-psychiatric-beds-leaves-patients-stranded-in-er.

63 Kenney Walsh, K., Gottsegen, J., Long, S. K., Sirkin, J. T., Rasky, R., Newberry, M., Horstman, C., & Figueroa, A., "Behavioral Health During the First Year of the COVID-19 Pandemic: An Update on Need and Access in Massachusetts 2020/2021," Blue Cross Blue Shield of Massachusetts Foundation (February 8, 2022), accessed at https://www.bluecrossmafoundation.org/publication/behavioral-health-during-first-year-covid-19-pandemic-update-need-and-access-0.

64 Sirkin, J., Sheedy, K., Hunt, M., Hoffman, C., Pfefferle, S., Kogan, A., & Olsho, L., "Navigating the Outpatient Mental Health System in Massachusetts: Consumer and Stakeholder Perspectives," Blue Cross Blue Shield of Massachusetts Foundation (October 2017), pp. 1–17, accessed at https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2020-09/Outpatient_MH_Navigating_REPORT_v05_Final.pdf.

65 Ibid.

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

67 Demonstration Approval, STC #13.

68 Demonstration Approval STC #10.

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

70 Demonstration Approval STC #11.

71 Because of a federal restriction, most Institutions for Mental Disease (IMD) services provided under a state's Medicaid program cannot be reimbursed by the federal government (unless a state receives an IMD waiver).

72 Certain expenditures have different match rates, but 50 percent is by far the predominant rate and the one that applies to DSH payments. The federal share in the numbers cited here does not appear to be exactly 50 percent of the total because of rounding.

73 MACPAC, Report to Congress on Medicaid and CHIP, Chapter 3: Annual Analysis of Disproportionate Share Hospital Allotments to States. March 2022.

74 Demonstration Approval, Expenditure Authority #20.

75 Demonstration Approval, STC #19.4, Table 20.

76 Health Equity Task Force, "A Blueprint for Health Equity: Health Equity Task Force Final Report," accessed at https://malegislature.gov/Reports/11522/Final%20Health%20Equity%20Task%20Force%20Final%20Report-%20A%20Blueprint%20for%20Health%20Equity%207.1.21.pdf.

77 Seifert, R. W., & Schiff, M., "Impact of the American Rescue Plan Act on the Massachusetts Health Care System," Blue Cross Blue Shield of Massachusetts Foundation (October 2021).

78 Artiga, S., & Hinton, E. (2016). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. KFF. Retrieved 8 October 2021.

79 EOHHS, Roadmap for Behavioral Health Reform, accessed at https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform.

80 Blue Cross Blue Shield of Massachusetts Foundation, "The MassHealth Accountable Care Organization Program: Uncovering Opportunities to Drive Future Success" (May 2021), accessed at https://www.bluecrossmafoundation.org/publication/masshealth-accountable-care-organization-program-uncovering-opportunities-drive-future.

81 EOHHS, Draft Independent Evaluation Interim Report.

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

83 Mullarkey, C., Ear, S., Ribble, M., & Sheff, A., "LIFT OFF: Partnerships to Address Health-Related Social Needs," available at https://hcfama.org/wp-content/uploads/2021/12/Lift-Off_Partnerships-to-Address-Health-Related-Social-Needs-Y3-Report-11.23.21.pdf.

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

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