February 3, 2022

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Massachusetts "MassHealth" Section 1115 Demonstration Project Extension

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Massachusetts's application to extend its "MassHealth" section 1115 demonstration, which is set to expire on June 30, 2022.

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

We support Massachusetts's request to provide continuous eligibility to targeted adult groups which would improve continuity of care for these populations at greater risk of losing coverage. We also applaud the state's focus on advancing health equity including its proposal to provide Medicaid coverage 30 days prior to release from incarceration for certain populations with increased health needs. However, the state's proposal needs additional details on the provision and implementation of services for these adults, and the proposal to provide coverage to youth during their entire detention should be revised to only provide services in the months immediately prior to release. The state is seeking to implement a number of provisions through separate authorities promoting maternal and child health as part of its efforts to improve health equity; though these are not part of the state's 1115 proposal, we strongly support these initiatives which would be complementary to those in the demonstration.

While we commend the state for removing children and pregnant women from its request to waive retroactive coverage, we strongly oppose continuing to limit retroactive coverage to ten days prior to application for almost all other enrollees. Finally, the proposed changes to managed care payments should be implemented with a robust oversight mechanism to ensure that funding is utilized appropriately. CMS should use this demonstration as an opportunity to set a high bar for the collection of actionable data that can truly help address disparities and be used to evaluate this demonstration.

Increased Support for People Experiencing or At Risk of Experiencing Homelessness Would Improve Stability and Coordination of Care

The state proposes a new Community Support Program for Homeless Individuals (CSP-HI) that would build on the existing CSP for Chronically Homeless Individuals, which provides pre-tenancy and tenancy-sustaining services to people with a behavioral health condition who are experiencing homelessness. CSP-HI would use a broader definition of homeless, to include people who do not meet the Department of Housing and Urban Development's definition of "chronically homeless" but who are high utilizers of health care services. Only about 8 percent of people experiencing homelessness in Massachusetts met the narrower definition in 2020.[1] Broadening the CSP to include people who may not meet this definition but are still experiencing housing instability and are high utilizers of health care services still appropriately targets Medicaid-funded housing-related supports to enrollees whose health would likely improve—and whose health care utilization would likely decline—after getting the supports they need to obtain stable housing.

The state also proposes to add a CSP for people facing eviction as a result of behavior related to a disability (such as a mental illness or substance use disorder). Providing tenancy-sustaining services to individuals facing housing instability can prevent homelessness, which can reduce health care costs. These CSPs would deliver targeted housing-related services to MassHealth members at the greatest risk of housing instability. Evidence supports the positive impact such services can have on health outcomes and health care costs.[2] This use of FFP is consistent with the objectives of the Medicaid program and we support it.

Provide Continuous Eligibility for People Experiencing Homelessness

We strongly support the state's proposal to extend 24 months of continuous eligibility to MassHealth enrollees with a confirmed status of homelessness for a specified amount of time. Medicaid enrollees experiencing homelessness are more likely to experience a disruption in benefits over the course of a single year.[3] Reducing administrative barriers to retaining coverage for this population—which tends to have complex health care needs and be at greater risk of missing paperwork deadlines —will increase the likelihood of continuous care and access to the pre-tenancy and tenancy-sustaining benefits available through the CSPs. We encourage CMS to work with the state to ensure the Medicaid agency has ease of access to the HMIS Data Warehouse and that enrollees and their service providers are aware of the duration of the coverage period. We believe this part of the demonstration will yield novel data on the impact of an extended period of continuous eligibility for people experiencing homelessness, providing useful insights for other states working to improve care coordination and access to permanent supportive housing for people experiencing homelessness.

We note that Massachusetts has delivered housing-related services to MassHealth members through its 1115 demonstration rather than the 1915(i) state plan option. State plan coverage is

---

[1] National Alliance to End Homelessness, "State of Homelessness: 2021 Edition," 2021, https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-2021/.
[2] Tim Aubry *et al.*, "Effectiveness of Permanent Supportive Housing and Income Assistance Interventions for Homeless Individuals in High-Income Countries: A Systematic Review," *The Lancet*, June 2020, https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667%2820%2930055-4/fulltext.
[3] Isaac Dapkins & Saul Blecker, "Homelessness and Medicaid Churn," Ethnicity & Disease, January 2021, https://pubmed.ncbi.nlm.nih.gov/33519159/

appropriate for these evidence-based services and gives service providers the confidence they need to continue expanding access to eligible enrollees. We encourage CMS to work with Massachusetts and other states to prepare to transition these important services from demonstration projects to state plan coverage.

The Proposal Would Support Coverage and Continuity of Care for Adults and Youth Who Are Incarcerated

We strongly support the state's proposal to extend 12 months of continuous eligibility to all MassHealth enrollees who leave juvenile or adult correctional facilities. The Affordable Care Act greatly expanded access to health coverage for people who have a history of incarceration or conviction. However, people who have been impacted by the criminal legal system face additional barriers to maintaining health coverage, which can disrupt access to care. For example, formerly incarcerated people experience homelessness at nearly ten times the rate of the general public.[4] Homelessness or frequent moves caused by housing instability can interfere with a person's ability to complete paperwork on time, which can cause eligible people to lose coverage.

Continuous coverage would build on steps Massachusetts has already taken to improve Medicaid enrollment for eligible people leaving jail and prison, including by suspending instead of terminating Medicaid coverage while people are incarcerated and taking steps to process new Medicaid applications prior to reentry.

We encourage CMS to work with the state to ensure the Medicaid agency has ease of access to the data from county and state correctional facilities and that enrollees and their service providers are aware of the duration of the coverage period. This will facilitate effective implementation of continuous coverage for people exiting incarceration and yield useful insights about strategies for enrolling and coordinating care for this population.

Cover Medicaid Services During the Last 30 Days of Incarceration for Certain Adults

Massachusetts requests authority to cover services delivered during the last 30 days of incarceration for adults with chronic conditions, mental health conditions, or substance use disorders with the goal of strengthening continuity of care and addressing health disparities. We strongly support the state's goal of addressing barriers to care as adults transition to community-based care, though additional details are needed to understand whether the proposal would have the intended impact.

Medicaid coverage "for certain services" during the last 30 days of incarceration alone would not be sufficient to improve care transitions and connection to community-based care upon reentry. Without clarity on which services would be covered and which providers would deliver them, Medicaid coverage could allow for the reimbursement of *existing* services delivered by correctional health providers during the last 30 days of incarceration, shifting the cost of the status quo without improving care, coordination, or health outcomes. We recommend that the state agency, with input from community-based providers and people with lived expertise in the state, identify and specify to

[4] Lucius Couloute, "Nowhere to Go: Homelessness Among Formerly Incarcerated People," Prison Policy Initiative, August 2018, https://www.prisonpolicy.org/reports/housing.html.

CMS the services that will be provided during the last 30 days of incarceration, and how the state will ensure continuity of care.

Provide Medicaid Coverage During the Duration of Youth Detention

Massachusetts requests authority to cover services delivered to all otherwise-eligible youth during the duration of their detention. Medicaid can play an important role in ending the incarceration of young people and supporting the healing of youth who were previously incarcerated, but only if used as part of a comprehensive approach to preventing the incarceration of children and young adults, mitigating the harm for those who are incarcerated, and ensuring access to high quality and comprehensive health and social services for those who were formerly incarcerated. Without a commitment to minimizing the incarceration of children and young adults, Medicaid funding could be used perpetuate the harm the juvenile carceral system causes, instead of ending it.

Like many states, Massachusetts has made strides to reduce the incarceration of young people in recent decades. For example, the number of youths arrested or detained declined by 75 percent and 78 percent, respectively, between 2008 and 2019.[5] However, the state still has significant progress to make. In 2020, the Department of Youth Services (DYS) served 510 committed youth and maintained 40 secure residential facilities.[6]

We recommend that CMS work with the state to modify its youth proposal to focus on services during the last 60-90 days of commitment — a critical period for preparing youth to transition to community-based care — instead of covering services for the duration of commitment (if longer than 60-90 days). This would help to mitigate the risk that Medicaid coverage of services during commitment would displace the use of community-based services for youth involved in the justice system or incentivize the use of longer-term detainment, while still allowing the state to better coordinate coverage and services for MassHealth enrollees under the care of the Department of Youth Services.

Eliminating Retroactive Coverage Does Not Promote the Objectives of Medicaid and is No Longer an Experiment

Massachusetts currently limits Medicaid reimbursement for medical costs incurred by most individuals with MassHealth coverage, including pregnant women and children, to only ten days prior to the date of application and has done so since the inception of the demonstration. The state is seeking to reinstate three-month retroactive coverage to pregnant women and children under age 19. We strongly support this request.

However, the state is requesting to extend its waiver of retroactive coverage for almost all other enrollees, exposing them to medical debt and financial harm. Under the law, Medicaid payments are

---

[5] Emerging Adult Justice Project, "Massachusetts' Youth Justice System: Data Trends and Three Key Indicators," Columbia Justice Lab, November 2020, https://static1.squarespace.com/static/5c6458c07788975dfd586d90/t/5faaa2bd6d2510345eb5b450/1605018301477/MA+Youth+Justice+Caseloads+Updated+Nov+2020.pdf

[6] Massachusetts Department of Youth Services, "Briefing Fact Sheet," Mach 2021, https://www.mass.gov/doc/dys-fact-sheet-march-2021-edited/download.

available for these expenses for a full three months prior to the month of application, if the beneficiary was eligible for Medicaid during this period. The purpose of retroactive coverage is the same today as it was almost 50 years ago when the benefit was first established: to protect low-income Medicaid beneficiaries from the financial burden of medical debt resulting from the costs of care they need during the three months prior to applying for Medicaid. Data from Indiana show how important retroactive coverage is for low-income parents in that state – a group that wouldn't be expected to have large medical costs, but in fact incurred significant medical costs prior to enrollment. Medicaid paid $1,561 on average on behalf of parents in Indiana who incurred medical costs prior to enrolling in Medicaid.[7] Waiving retroactive coverage does not promote the central objective of the Medicaid program, to provide coverage, and in fact, by definition takes coverage away from these enrollees.

Furthermore, the state has had a waiver of retroactive coverage as part of its "MassHealth" demonstration for *over two decades*. The purpose of a section 1115 demonstration is to test *new* approaches to delivering services that have the potential to improve Medicaid coverage for beneficiaries. The state does not provide a research hypothesis or experimental purpose for waiving retroactive coverage in its application. While we do not believe that there was ever a legitimate research purpose for waiving three-month retroactive coverage, Massachusetts's waiver is well past the point of being an experiment. *We urge you to deny the state's request.*

However, if you do choose to allow the state to continue waiving retroactive coverage, a rigorous evaluation of the effect of the waiver is necessary, which should include the incidence and amount of medical debt incurred by MassHealth beneficiaries with breakdowns by race and ethnicity. This is particularly important since waiving retroactive coverage is more likely to affect people of color who have greater levels of medical debt.[8]

CMS Should Strengthen Oversight and Accountability Mechanisms for Massachusetts's Proposed Changes to Managed Care

The MassHealth demonstration would continue and expand upon existing flexibilities in Medicaid managed care in Massachusetts. We are supportive of the intent of the state's initiatives aiming to expand access to care coordination and services addressing health-related social needs (HRSN). However, we urge CMS to increase safeguards for consumers and review policies related to managed care and provider payment in several areas.

Ensure that Providers Are Prepared to Take on Risk and that Consumers Are Protected from Potential Pressures to Stint on Care

The state has requested authority to shift risk onto providers through sub-capitation. Before approving such payment systems, we urge CMS to ensure that providers are prepared and supported

[7] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[8] Leonardo Cuello, "Retroactive Coverage Waivers: Coverage Lost and Nothing Learned" Georgetown University Center for Children and Families, October 4, 2021, https://ccf.georgetown.edu/2021/10/04/retroactive-coverage-waivers-coverage-lost-and-nothing-learned/.

to handle the associated risk and that sufficient protections are in place to prevent cherry-picking of patients and stinting on care. While we believe that quality metrics are valuable, and we are supportive of the state's effort to expand data collection and reporting related to health equity, we are concerned that quality-based payment alone is insufficient to protect the diverse populations enrolled in Medicaid (including individuals of varying functional status, age, etc.), especially when paired with "total cost of care" metrics. CMS should consider requiring detailed and public reporting on service utilization and panel composition patterns, complaints and grievances, and other information to provide a complete picture of the impact on enrollees.

More specifically, we are concerned that providers will have no choice but to take on high levels of risk. Many providers may be unprepared for the risk and/or payments may diverge widely from utilization. While the state's proposal includes some discussion of mitigation strategies, "especially in the first years of the program," we believe this is a long-term sustainability question that could lead to failures from a wide range of factors, such as budget constraints. CMS needs to specifically review the mitigation strategies prior to approving the demonstration *and* develop contingencies including stop-loss mechanisms or other circuit breakers (including circuit breakers for problems with utilization or provider participation, discussed below). Such policies are required for managed care by section 1903(m)(A)(2)(x) of the Medicaid Act, a non-waivable provision of the statute requiring, among other things, "stop-loss protection" in the case of payment arrangements that "directly or indirectly have the effect of reducing or limiting services."

Carefully Review the State's Sub-Capitation Arrangements

CMS must also review how the sub-capitation arrangements will work – or fail – based on utilization and payment data for specific subpopulations, including children, pregnant, and post-partum individuals. Different populations will require different sub-capitation levels, and thus have varying margins of error within the capitation arrangements. As the state notes in its proposal, "children and youth populations access health care services differently than adult populations."

Do Not Approve the Proposed Waiver of Medicaid Payment Standards

Aggressively forcing risk onto providers may lead to provider participation problems, either because providers lack the capacity to handle risk or refuse to participate. This concern is exacerbated by state's requested waiver of Medicaid payment standards at section 1902(a)(30)(A) of the Social Security Act. CMS should not simultaneously approve a provider access barrier and waive provider access standards. It is not clear that a waiver of section 1902(a)(30) is even necessary, and the state should be required to explain more about it. Such a waiver is not needed to "vary" the payment made to a provider (i.e., different payments could each be consistent with section 1902(a)(30)), and thus the request appears extraneous or overbroad. And in any case, a waiver of the requirement to pay an adequate rate (or such expenditure authority) does not promote the objectives of Medicaid. We believe that CMS should not approve such a waiver or expenditure.

If CMS does approve the policy, CMS should clearly identify what standard will ensure adequacy of rates and access. For example, it is unclear from the proposal whether the state believes their sub-capitation payments must be actuarially sound. We note that we do not believe CMS has the authority to waive actuarial soundness requirements in section 1903(m)(2)(A)(iii) or the 42 C.F.R. Part 438 managed care regulations.

Work With the State to Establish Care Coordination Standards for All Delivery Systems

We commend the state for increasing investments in care coordination for medically complex children and individuals with high-risk pregnancies, and for proposing to make improved care coordination a sustainable and core MCO/ACO function. We urge CMS to work with the state to help it establish care coordination requirements and directly finance such care coordination supports, regardless of the delivery systems used (i.e., MCO, ACO, sub-capitation, etc.). Such care coordination supports directly address gaps in care and will help reduce health disparities. CMS should not rely on indirect and vague incentives flowing from global budgets in the hope that care coordination will materialize. Instead, CMS should work with states to ensure that the supports are *required* and *reimbursed* for providers, and that these services are adequately included in capitation rates. This is true for care coordination as well as expanded services to address HRSNs.

Move Demonstration Funding Toward Sustainable and Adequate Base Provider Payments

Finally, we believe a sustainably-funded safety net is critical for Medicaid enrollees and other underserved populations. As such, we are supportive of the intent to support the safety net through the current DSRIP program and the newly proposed demonstration. However, we believe that CMS should develop policies to ensure true sustainability, and make two broad recommendations. First, to the extent a state wishes to make a valuable *investment* in state infrastructure – for example, designing and implementing new IT systems – such an investment might be funded through a demonstration but only with the clear understanding that it is a short-term investment. Such investment demonstrations should not be endless or conflated with on-going provider support. Second, CMS should continue to work to shift on-going provider payment streams *away* from bulk demonstration financing (e.g., Uncompensated Care pools) which are less transparent, less aligned with the actual provision of services and value, and may have harmful unintended policy consequences, and *towards* truly sustainable and adequate base payment rates for services.

Conclusion

Thank you for your willingness to consider our comments. We support many features of Massachusetts's extension of its section 1115 demonstration, but urge you to reject the state's request to continue waiving retroactive coverage for many MassHealth beneficiaries as well as ensure the state has mechanisms in place to provide oversight over its new ACO payment structures.

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).