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October 16, 2023

Chaquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 314G
Washington, D.C. 20201

Re: Request to Amend Massachusetts' Section 1115 Demonstration: MassHealth (11-W-00030/1)

Dear Administrator Brooks-LaSure:

In my capacity as Secretary of the Executive Office of Health and Human Services (EOHHS) for the Commonwealth of Massachusetts, I am submitting to the Centers for Medicare and Medicaid Services (CMS) a request to amend the Massachusetts Section 1115 Demonstration Project (11-W-00030/1).

This request to amend the demonstration includes a number of policy changes that support Massachusetts' ongoing efforts to advance health equity, strengthen coverage for residents, and address members' health-related social needs. Specifically, this amendment request includes proposed authorities to:

- Preserve CommonHealth Members' Ability to Enroll in One Care Plans,
- Expand Marketplace (Health Connector) Subsidies to Additional Individuals,
- Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard and CommonHealth to the State Statutory Limit,
- Remove the Waiver of Three Months Retroactive Eligibility,
- Provide 12 Months Continuous Eligibility for Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness Who Are 65 and Over,
- Include Short-Term Post Hospitalization Housing (STPHH) and Temporary Housing to Pregnant Members and Families as allowable Health-Related Social Needs (HRSN) Services,

- Increase the Expenditure Authority for the Social Service Organization Integration Fund, and
- Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions.

EOHHS received comments from 30 organizations in response to the public posting of the draft request, all of which were supportive of the proposals included in the request.

Thank you for your consideration of this amendment request. We appreciate your continued partnership on our 1115 demonstration as we work to advance our shared goals for health care reform.

Sincerely,

[redacted]

Kathleen E. Walsh

cc: Mike Levine, Assistant Secretary for MassHealth and Medicaid Director
Mehreen Rashid, Director, State Demonstrations Group
Rabia Khan, Project Officer, State Demonstrations Group
Marie DiMartino, CMS, Division of Medicaid Field Operations East

COMMONWEALTH OF MASSACHUSETTS
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MassHealth Section 1115 Demonstration Amendment Request

October 16, 2023

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MassHealth Section 1115 Demonstration Request

Introduction

The Massachusetts 1115 demonstration, currently approved through December 31, 2027, has long supported the Commonwealth's commitment to universal health care coverage and, particularly during the prior and current demonstration periods, has provided federal waiver and expenditure authority to test innovations in payment and care delivery.

Since the initial implementation of the demonstration in 1997, working in partnership with the federal government, the Commonwealth has made significant progress toward the goal of ensuring health care coverage for all our residents. Over 99 percent of the Commonwealth's children and youth and more than 97 percent of all its residents have health insurance, the highest in the country.[1] MassHealth, the Massachusetts Medicaid and Children's Health Insurance Programs, currently covers approximately 2.4 million individuals, or nearly 33 percent of the Commonwealth's residents.

Although the 1115 demonstration was recently extended through December 31, 2027, we are proposing this amendment to further the overall goals of the demonstration.

MassHealth's amendment request includes:

1. Preserve CommonHealth Members' Ability to Enroll in One Care Plans
2. Expand Marketplace (Health Connector) Subsidies to Additional Individuals
3. Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard and CommonHealth to the State Statutory Limit
4. Remove the Waiver of Three Months Retroactive Eligibility
5. Provide 12 Months Continuous Eligibility for Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness Who Are 65 and Over
6. Include Short-Term Post Hospitalization Housing (STPHH) and Temporary Housing Assistance for Pregnant Members and Families as allowable Health-Related Social Needs (HRSN) Services
7. Increase the Expenditure Authority for the Social Service Organization Integration Fund

[1] 2021-MHIS-Report.pdf (chiamass.gov)

8. Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions

Proposed Changes to the Demonstration

1. Preserve CommonHealth Members' Ability to Enroll in One Care Plans

Background

One Care is the Commonwealth's Medicare-Medicaid Plan (MMP) program currently operating under the authority of an 1115A Duals Demonstration as a Financial Alignment Initiative (FAI) capitated model. Full benefit dual eligible individuals (MassHealth members with Medicare Parts A and B and eligible for Part D) who have MassHealth Standard or CommonHealth, and who meet other One Care participation requirements (e.g., age 21-64 at the time of enrollment, no other source of insurance, etc.) may enroll in One Care plans. In addition, individuals may remain enrolled in One Care when they turn 65 as long as they continue to meet all other participation requirements, including continued eligibility for MassHealth Standard or CommonHealth. Dual eligible individuals over the age of 21 eligible for MassHealth CommonHealth may access their Medicaid benefits through either One Care or through MassHealth Fee-for-Service.

Request

In accordance with federal requirements, MassHealth is preparing to transition One Care from its current Duals Demonstration authority and structure to a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) structure with aligned Medicaid managed care entities. In anticipation of this transition, which will be effective January 1, 2026, EOHHS seeks to clarify in its 1115(a) Demonstration that dual eligible individuals with MassHealth CommonHealth may enroll in One Care, when they otherwise meet One Care participation requirements. MassHealth believes this will not require any changes to existing waiver or expenditure authorities, but will require clarification to the Special Terms and Conditions to specify that, effective as of January 1, 2026:

- MassHealth CommonHealth members ages 21-64 may elect One Care as their delivery system for their Medicaid coverage;
- MassHealth CommonHealth members who are enrolled in One Care when they turn age 65 may continue to remain enrolled in One Care, with the usual One Care process of plan selection; and
- MassHealth CommonHealth members who are disenrolled from One Care due to a lapse or downgrade in their MassHealth eligibility for a period of 12 months or less and who were enrolled in One Care upon their lapse or downgrade in eligibility, may have their One Care enrollment reinstated upon regaining

MassHealth CommonHealth eligibility, including those CommonHealth members who are at or over age 65 or turn 65 during their lapse or downgrade in eligibility.

2. Expand Marketplace (Health Connector) Subsidies to Additional Individuals

Background

ConnectorCare (originally established in 2006 as Commonwealth Care) is a program for uninsured individuals who are not eligible for employer sponsored insurance, Medicare or Medicaid. ConnectorCare members enroll in certain Qualified Health Plans administered by the Health Connector, the Commonwealth's health insurance marketplace, and receive state subsidized assistance with plan premiums and cost sharing, in addition to receiving federal tax credits towards the purchase of the insurance. Through the 1115 demonstration, the state has expenditure authority for these marketplace state subsidies for premiums and cost sharing and for gap coverage for individuals up to 300% FPL who are determined eligible for Qualified Health Plan coverage through the Connector, for up to 100 days while they select, pay and enroll into a health plan. These subsidies play a key role in supporting near-universal health coverage within the Commonwealth, and especially in smoothing transitions within the Commonwealth's health insurance system.

Request

The Massachusetts Legislature has enacted statutory changes that would implement a pilot program to increase the income limit for individuals to receive assistance with ConnectorCare premiums and cost sharing from 300% FPL up to 500% FPL, effective January 1, 2024. Therefore, the Commonwealth is requesting an expansion of its existing 1115 demonstration expenditure authority for marketplace subsidies to include eligible individuals above 300%, up to 500% FPL. An expansion of expenditure authority above 300% FPL would enable more individuals to benefit from these supports and further mitigate cost "cliffs" among the Commonwealth's different insurance programs. This amendment would be effective the later of January 1, 2024 or the first day of the month following approval, and extend through the end of the demonstration period assuming continued state statutory authorization.

3. Increase the Income Limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard and CommonHealth to the State Statutory Limit

Background

The FY2023 state budget included language to expand the standard income limits for the three Medicare Savings Programs by disregarding 90% of the Federal Poverty Limit (FPL) from an applicant's gross income. In practice, this goal was achieved by raising income limits. The new income limits are therefore 190% FPL for the Qualified Medicare Beneficiary (QMB) program, 210% FPL for the Specified Low-Income Medicare Beneficiary (SLMB) program and 225% FPL for the Qualified Individual (QI) program. These increased FPL limits will significantly reduce health care costs for more older adults, promoting economic security and protecting many of the most vulnerable.

Under the currently approved 1115 demonstration, MassHealth Standard members with income up to 133% FPL, including those who are or may become enrolled as Medically Needy, are eligible for QMB benefits, and those with income up to 165% FPL, including those who are or may become enrolled as Medically Needy, are eligible for payment of the Medicare Part B premium. Standard members that did not have an asset test to determine their Standard eligibility are authorized to also receive MSP without an MSP asset test.

Request

This amendment proposes to increase the income limit for MSP benefits for Standard individuals to the state statutory limit, including for those members on a spenddown who may subsequently become eligible for another benefit, such as Standard. Accordingly, the Commonwealth is requesting an expansion of its expenditure authority for monthly Medicare Part A and Part B premiums and for deductibles and coinsurance for certain MassHealth Standard members who are eligible for Medicare with incomes up to the state statutory limit. The Massachusetts legislature enacted statutory changes to eliminate the MSP asset test. Massachusetts will be implementing this change in February 2024 and will submit a State Plan Amendment to request authority for this change. Therefore, Expenditure Authority to waive the MSP asset test will no longer be needed.

The Commonwealth has received approval for an amendment to the state's Medicaid State Plan to increase the MSP income limits to the state statutory limit for individuals who receive MSP coverage and whose coverage is eligible for FFP under said state plan. This amendment will allow higher income individuals with Standard (who are often spending down income to receive Standard) to also receive the benefit of the MSP expansions under the state budget. This amendment would be effective on the first day of the month following approval.

Pursuant to section 1905(p)(4) of the Social Security, which requires the Commonwealth to make MSP benefits available to individuals covered under this 1115 demonstration, and notwithstanding section 1843 of the Social Security Act, the

Commonwealth requests expenditure authority to provide MSP benefits up to the statutory income limits to those members enrolled in CommonHealth.
The new income limits are therefore 190% FPL for the Qualified Medicare Beneficiary (QMB) program, 210% FPL for the Specified Low-Income Medicare Beneficiary (SLMB) program and 225% FPL for the Qualified Individual (QI) program.

In the alternative, if authority to grant MSP benefits to CommonHealth members is not granted, the Commonwealth requests expenditure authority to pay Medicare part B premiums for all CommonHealth members up to 225% FPL as a benefit of the CommonHealth program separate from MSP.

Note, certain requirements of Title XIX will not apply to this expenditure authority, including:

1. **Prohibition on QI for members eligible for Medicaid under the State Plan** (Section 1902(a)(10)(E)(iv)): to allow QI for members eligible for Medicaid under the State Plan; and
2. **Medicare Part A and Part B premiums for Medically Needy** (Section 1902(a)(10)(C)): to enable expenditures for Medicare Part B premiums paid for members of the Commonwealth's Medically Needy coverage group or those spending down toward Medically Needy coverage.
3. **MSP to CommonHealth members up to the statutory maximum** (Section 1902(a)(10)(E), to the extent it incorporates by reference to Section 1905 Sections 1818 and 1843 of the Social Security Act.

4. Remove the Waiver of Three Months Retroactive Eligibility

Background

MassHealth has long had waiver authority from the requirement to provide three months retroactive coverage for new members. In the most recent 1115 extension, MassHealth exempted children up to age 19 and pregnant individuals from this waiver authority and now provides them with up to three months of retroactive coverage.

Request

Effective January 1, 2025 MassHealth is seeking to withdraw its waiver authority under the current 1115 demonstration and revert to federal rules under 42 CFR 435.915. This amendment would provide all eligible members retroactive coverage up to the first day of the third month before the month of application if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided. MassHealth had removed this waiver for pregnant individuals and children up to age 19 in the most recent 1115 extension and this amendment

removes the waiver for all remaining eligible members. This amendment will help support enrollment continuity, improve health status, and reduce beneficiary medical debt.

5. Provide 12 Months Continuous Eligibility to Adults and 24 Months Continuous Eligibility for Members Experiencing Homelessness who are 65 and Over

Background

The Massachusetts 1115 demonstration, currently approved through December 31, 2027, has long supported the Commonwealth's commitment to universal health care coverage. This waiver currently includes continuous eligibility flexibilities for various populations such as justice-involved members, and those considered to be chronically homeless, allowing continuous coverage of comprehensive benefits for 12 or 24 months, dependent on the population. Additionally, the Consolidated Appropriations Act, 2023 provides 12 months continuous eligibility for individuals under the age of 19 beginning in January 2024.

Request

MassHealth is requesting an amendment to the demonstration, effective January 1, 2025, to include 12 months of continuous eligibility for all adults age 19 and over whose Medicaid eligibility is based on both Modified Adjusted Gross Income (MAGI) and non-MAGI eligibility criteria.

Additionally, MassHealth is requesting authority, upon approval, for 24 months of continuous eligibility for members experiencing homelessness for 6 months or longer who are aged 65 or over. Currently MassHealth has authority to provide 24 months of continuous eligibility for members experiencing homelessness for 6 months or longer under age 65. Members experiencing homelessness will be those reported as homeless (e.g., in emergency shelter, safe haven, transitional housing, day program, or unsheltered) in Homeless Management Information System (HMIS) and included in the state data warehouse known as the Rehousing Data Collective (RDC). By expanding this policy to older members as well, MassHealth will be better able to ensure coverage and access to services for an extremely vulnerable population.

The continuous eligibility initiative is meant to support consistent coverage and continuity of care by keeping beneficiaries enrolled for 12 months, or 24 months for members experiencing homelessness, regardless of changes in circumstances that would affect eligibility (except for death, voluntary termination, ceasing to be a resident of Massachusetts, or eligibility for an upgrade in coverage). This continuous eligibility policy is likely to assist in promoting the objectives of MassHealth by minimizing

coverage gaps and helping to maintain continuity of access to program benefits for the populations of focus, thereby improving health outcomes. Continuous coverage will also further reduce the rate of uninsured and underinsured individuals in the state.

6. Include Short-Term Post Hospitalization Housing and Temporary Housing Assistance For Pregnant Members and Families as allowable Health-Related Social Needs Services

Massachusetts proposes to expand the housing supports under the Demonstration to include Short-Term Post-Hospitalization Housing (STPHH) and short-term, temporary housing assistance and related supports for pregnant members and families. Each aspect of this request for expanded housing authority is discussed below.

Short-Term Post Hospitalization Housing

This addition would be effective January 1, 2025[2]. Through the addition of coverage for Short-Term Post-Hospitalization Housing (STPHH), MassHealth seeks to improve members' health and avert further intensive medical interventions, reduce health disparities, and reduce the total cost of care for members experiencing homelessness. This addition would be effective January 1, 2025[3].

Background

The Commonwealth has undertaken a number of efforts to ensure that MassHealth members experiencing homelessness are discharged from hospitals to a safe space instead of to the street. Despite these efforts, there are very few discharge options available for individuals without housing who no longer need hospital level of care and are not appropriate for discharge to a skilled nursing facility. As a result, individuals experiencing homelessness have an average hospital length of stay that is 4.6 days longer[4] as compared to individuals with stable housing.

Members experiencing homelessness face numerous barriers to hospital discharge, with the primary barrier being the lack of a safe and appropriate location where the individual can rest, recuperate, and receive needed ongoing outpatient medical care.

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[3] The Commonwealth has received approval from CMS to use funding from the enhanced FMAP under Section 9817 of the American Rescue Plan Act (ARPA) for a Medical Respite Pilot Program Grant. This pilot program will be aligned with the Short-Term Post Hospitalization Housing Program model and operate until December 2024. ARPA funds have been directed to thoroughly evaluate the grant program and the outcomes and lessons learned will inform and refine eligibility, and other requirements of this Short-Term Post Hospitalization Housing Program.

[4] Buchanan, David, et al. "The Effects of Respite Care for Homeless Patients: A Cohort Study." *American Journal of Public Health*, 2006, https://doi.org/10.2105/AJPH.2005.067850. Accessed 22 Oct. 2022.

Many homeless shelters require guests to leave during the day, do not allow beds to be reserved, and lack private bedrooms and bathrooms. In addition, most homeless shelters do not have onsite clinical staff to help triage medical issues or help with medication reminders or administration. Therefore, shelters are often not the most appropriate setting for individuals experiencing homelessness that have recently been hospitalized for a medical concern or procedure.

Providing a safe hospital discharge location to individuals experiencing homelessness advances MassHealth's 1115 demonstration goal of promoting health equity. In 2022 approximately 38% of those in Massachusetts experiencing homelessness identified as Black or African American[5]. In the same year, according to the US Census, Black or African Americans comprised only 9.3% of the Massachusetts population[6].

In addition to advancing our health equity goals, MassHealth is proposing using STPHH programs as a lever to improve health outcomes and reduce the total cost of care. The STPHH model (also called Medical Respite[7]) has been used across the country to address the clinical needs of individuals experiencing homelessness, including those that are being discharged from an acute inpatient hospital. STPHH provides a safe space for people experiencing homelessness who are being discharged from the hospital to continue their recovery for up to six months with services that are integrated with clinically oriented rehabilitative services and supports to mitigate the risk of future acute hospitalization or institutionalization. In addition to clinical improvement, one of STPHH's primary goals is to connect members to more permanent housing upon discharge from the STPHH.

STPHH will also improve flow throughout the Massachusetts hospital system by creating safe discharge options for members who no longer need a hospital level of care but who do not have safe or appropriate housing to support their medical needs after discharge. STPHH will facilitate timely discharge for members experiencing homelessness, allowing for inpatient hospital beds to be utilized by those who require hospital-level supports. This will help to alleviate wait times for inpatient beds and allow MassHealth to ensure more timely access to acute inpatient hospital services for those needing such services, including members awaiting care in emergency rooms. In

[5] "The Rehousing Data Collective Public Dashboard,." *Mass.Gov*, 13 Jul. 2022, www.mass.gov/info-details/the-rehousing-data-collective-public-dashboard. Accessed 10 Dec. 2022.
[6] "QuickFacts Massachusetts." *United States Census Bureau*, 1 Jul. 2022, www.census.gov/quickfacts/MA. Accessed 10 Dec. 2022.
[7] STPHH/ Medical Respite is similar to the Safe Haven model of housing for people experiencing homelessness; Massachusetts also uses the term "Medical Safe Haven" for this model to distinguish it from transitional housing programs.

addition, STPHH can reduce ED usage and readmissions,[8] representing further opportunities to reduce total cost of care.

Similar programs to the Commonwealth's proposed STPHH have demonstrated significant success. As compared to individuals who do not receive STPHH or STPHH-like services, those who do experience fewer future days experiencing homelessness[9]; significantly improve their odds of remaining stably housed[10]; and have improved long term health outcomes[11].

Request

Like other states with similar approved or pending models[12], the Commonwealth's proposal includes up to six months of post-hospitalization housing and supportive services for eligible MassHealth members, including those enrolled in managed care and those in fee-for-service, who meet the following risk-based and clinical criteria:

1. Currently experiencing homelessness; and
2. Being discharged from a hospital after an inpatient stay or from an emergency department visit; and
3. Has a primary acute medical issue that is not yet resolved, but no longer requires or does not require hospital level of care and does not meet skilled nursing facility level of care.

Services delivered to members in the STPHH program will include, but are not limited to, monitoring of vital signs, assessments, wound care, and medication monitoring and reminders as well as 24-hour on call medical support. Clinical services rendered will be tailored to the needs of each individual enrolled. Programs will provide transportation to and from medical appointments and support in coordinating needed clinical services. In addition to medical services, these programs will have robust housing navigation

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[8] Shetler, Dan, and Donald Shepard. "Medical Respite for People Experiencing Homelessness: Financial Impacts with Alternative Levels of Medicaid Coverage." *Journal of Health Care for Poor and Underserved*, 2018, http://muse.jhu.edu/article/694367/pdf. Accessed 22 Oct. 2022.

[9] Basu, Anirban, et al. "Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care." *Health Services Research*, 2011, https://doi.org/10.1111/j.1475-6773.2011.01350. Accessed 22 Oct. 2022.

[10] Meschede, Tatjana. "Accessing Housing: Exploring the Impact of Medical and Substance Abuse Services on Housing Attainment for Chronically Homeless Street Dweller*s." Journal of Human Behavior in the Social Environmen*t, 2008, https://doi.org/10.1080/10911350903269880. Accessed 22 Oct. 2022.

[11] Buchanan, David, et al. "The Health Impact of Supportive Housing for HIV-positive Homeless Patients: A Randomized Controlled Trial." *American Journal of Public Health*, 2009, https://doi.org/10.2105/AJPH.2008.137810.

[12] California: Short-Term Post Hospitalization Housing and Recuperative Care (*approved* 2021). New Mexico: Medical Respite for individuals experiencing homelessness (*pending* 2023) Rhode Island: Restorative and Recuperative Care Pilot (*pending 2023)*

services available to assist members with the goal of identifying permanent housing options once they have recuperated. Housing settings will be capable of providing the specifically enumerated care set forth above.[13] Members who meet the criteria may receive STPHH, regardless of prior receipt of STPHH. Each stay in STPHH will last no more than 6 months.

In addition, the Commonwealth proposes allowing members experiencing homelessness in the community who do not have consistent access to a private bathroom to utilize STPHH services for up to two days to prepare for colonoscopies. After the procedure, the member would not be eligible to continue to receive STPHH services unless they met the risk-based and clinical criteria outlined above. Given the importance of screening for early detection of colorectal cancer and that non-Hispanic Black people have the highest rate of new cancer cases and death[14], this use of STPHH will allow the Commonwealth to improve utilization of services targeted at reducing deaths related to colorectal cancer, improve health outcomes, and further our goal of improving health equity.

Temporary Housing Assistance and Related Supports for Pregnant Members and Families

Background

The Commonwealth, like other states, has faced a recent influx of immigrants, including recent arrivals with an immigration status that entitles them to full Medicaid benefits. These new arrivals include, but are not limited to, Cuban/Haitian entrants, refugees, asylum seekers, and individuals granted parole into the United States for at least one year. These individuals are (or may be) enrolled in the full MassHealth benefit, yet they face significant challenges in obtaining housing while they await the issuance of work authorizations and related documentation. Additionally, in the absence of alternative housing solutions, some newly arrived immigrant MassHealth members have sought shelter in emergency departments, placing strain on health care providers.

The lack of available, safe accommodations has inhibited many pregnant individuals and families from connecting to necessary healthcare resources and services – including services for pregnant individuals and children. A prior analysis of healthcare cost and utilization of families enrolled in MassHealth demonstrated the significant healthcare needs of the family shelter population. For example, adult MassHealth members in family shelter had significantly higher rates of alcohol, opioid, and nonopioid

[13] STPHH will therefore be exempt from the exclusion on room and board under STC 15.4.b.

[14] Tong, M., Hill, L., Artiga, S. Racial Disparities in Cancer Outcomes, Screening and Treatment. February 3, 2022. Racial Disparities in Cancer Outcomes, Screening, and Treatment | KFF

drug use disorders; adjustment, anxiety, and depressive disorders; injuries due to external causes; and complications during pregnancy and birth than a comparison group. The same analysis found that homeless families in shelter who were enrolled in MassHealth had higher healthcare expenditures and more visits to the emergency room than other MassHealth families.[15] Additionally, 2022 data from a major Massachusetts hospital showed that 80% of families experiencing homelessness in the hospital's pediatric emergency department were Haitian asylum-seekers, and 42% of all families presenting to the emergency department, including Haitian families and others, came to the ED within 30 days of arriving to the U.S.[16]

In response to the rapidly rising numbers of migrant families arriving in Massachusetts in need of shelter and services and a severe lack of shelter availability in the state, Governor Healey declared a state of emergency in the Commonwealth.[17] In response to the emergency, the Commonwealth has been working to expand the availability of shelter and other accommodations (including hotels) to provide temporary housing to families and pregnant individuals, including many newly arrived immigrants.

The Commonwealth has also been working to establish robust services to assist newly arrived immigrant families in connecting to necessary healthcare and social services, such as linkages to prenatal and pediatric care, behavioral health supports, educational supports, and community and social service organizations. State agencies and community-based organizations are providing a range of services in the temporary housing including connection to public benefits (including, but not limited to, SNAP, WIC, Transitional Aid to Families with Dependent Children (TAFDC), and Medicaid/CHIP services), health assessments, vaccinations, immigration and housing related case management services, employment and education services, and basic necessities including safe sleep options for infants.

In June 2023, the Commonwealth established a new resource, called Family Welcome Centers, to assist newly arriving immigrant families, among others, with connections to critical services. The Family Welcome Centers are run by community-based organizations and serve as a culturally competent connection point to assist homeless families in identifying and applying for state and federal benefits, identifying shelter and other housing opportunities, connecting to social and educational resources, and obtaining referrals to medical and behavioral health providers. Similarly, other providers

[15] Clark, R., Weinreb, L., Flahive, J., Seifert, R., "Homelessness Contributes to Pregnancy Complications", *Health Affairs* 38 No. 1 (2019): 139-146, available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05156

[16] Bovell-Ammon, A., et. al, "Haitian Migrants Face Unique Challenges Finding U.S. Housing" (Jan. 17, 2023), available at https://healthcity.bmc.org/population-health/haitian-migrants-face-unique-challenges-finding-us-housing

[17] Emergency Declaration Letter_0.pdf (mass.gov)

supporting these individuals, such as Resettlement Agencies, identify and determine individual needs and then proactively connect individuals to the services necessary to support families in achieving self-sufficiency and exiting temporary accommodations.

Request

The Commonwealth seeks expenditure authority, effective upon approval of the amendment, for up to six months of temporary housing assistance and related support for families and pregnant individuals, including newly arrived immigrants, who are enrolled as MassHealth members. Through this authority, the Commonwealth would provide temporary housing assistance to eligible members. Eligible members include homeless pregnant individuals and homeless families who are determined eligible for temporary housing assistance under the Massachusetts Emergency Assistance family shelter program[18] and who are eligible for full MassHealth benefits, including those with lawful immigration statuses, such as Cuban/Haitian entrants, refugees, asylum seekers, and individuals granted parole into the United States for at least one year.[19] Members would also be eligible to receive supportive services, including outreach, case management, and referrals to medical, social, and educational services, from community-based providers qualified to meet the specialized needs of this population. The state may utilize Certified Public Expenditures to directly provide these temporary housing and related services to members.

7. Increase the Expenditure Authority for the Social Service Organization Integration Fund

Background

The Social Service Organization (SSO) Integration Fund is an $8M program authorized under the 1115 demonstration that allows SSOs to receive funding to support infrastructure needs associated with the implementation of the Flexible Services Program (FSP). Funding may be spent in the following categories: (1) Technology; (2) Developing business and operational practices to support delivery of Flexible Services; (3) Workforce development; and (4) Outreach and education. Additionally, the state may utilize the funds to provide technical assistance to SSOs in the form of one-on-one support, trainings, or learning communities.

The Commonwealth's initial design and corresponding demonstration request for the SSO Integration Fund was based on the premise that the FSP would continue to operate as it had in the prior demonstration. However, the final 1115 demonstration approval created a new Health Related Social Needs (HRSN) services construct that

[18] Pregnant individuals and families with children may be eligible for temporary housing assistance under the Massachusetts emergency assistance family shelter program.

[19] The state will work with CMS to identify the needs-based criteria and risk factors for this population, as required.

included both the legacy FSP and Specialized Community Support Program services. The new HRSN framework also includes new expectations on the Commonwealth and HRSN providers regarding managed care participation and electronic referral platforms.

In light of these changes to the delivery model for FSP and the combined HRSN framework contemplated in the demonstration, the Commonwealth seeks to amend the SSO Integration Fund authority to increase the funding and include Specialized CSP providers.

Request

Upon approval, the Commonwealth will transition the FSP into the managed care framework, and will combine certain legacy FSP services with the Specialized CSP program to create a unified Health-Related Social Needs Services framework. Additionally, the Commonwealth will be implementing a statewide HRSN electronic referral platform, which will be used by the HRSN providers. These exciting changes require HRSN providers, including Specialized CSP providers, to take on additional projects at added costs. Such projects may include, but are not limited to:

1. Enrolling as and meeting qualifications to be a MassHealth provider (e.g., undergoing enrollment and credentialling processes, submitting claims);
2. Workflow updates (e.g., changing invoicing and reporting practices); and
3. Acquiring and integrating electronic referral platforms

Additionally, the state expects the need for:

4. Broader technical assistance (e.g., support in becoming MassHealth provider); and
5. Additional partnerships

These projects are similar to those initially contemplated and approved for the SSO Integration Fund and thus can fit within the currently approved categories within the STCs.

In light of the approved demonstration, the state is requesting an additional $17M in expenditure authority for the SSO Integration Fund, for a total of $25M.

8. Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions

Background

The federal Medicaid "Inmate Exclusion Policy" (MIEP) generally excludes individuals in certain public institutions from Medicaid coverage.[20] For the purposes of this request, "individuals in certain public institutions" means:

- Individuals in County Correctional Facilities (CCFs) and state Department of Corrections (DOC) facilities, including individuals who are sentenced; detained prior to arraignment, trial or sentencing; or held pursuant to a civil commitment order; and
- Youth committed to the care and custody of the state Department of Youth Services (DYS) who are in DYS juvenile justice facilities and currently excluded under MIEP.

Strengthening continuity of care for this population, particularly for individuals from historically marginalized and underserved groups, is a high priority for Massachusetts. When comparing sentencing trends, Black and Hispanic individuals are disproportionately represented at higher rates than white individuals: 7.4 times and 4.1 times respectively, underscoring the health equity implications of this proposal.[21] People who identify as LGBTQIA+, particularly transgender and gender-nonconforming individuals, also experience disproportionate rates of incarceration, and face unique challenges pre- and post-incarceration.[22][23]

To inform the development of this proposal, MassHealth convened an interagency Coordinating Council that began in January 2021. The Coordinating Council includes representatives from DOC, the Massachusetts Sheriffs' Association, the fourteen Massachusetts Sheriffs' Offices (of which thirteen have correctional facilities), DYS, Parole and Probation Units, and the state Executive Office of Public Safety and Security (EOPSS). To inform planning and implementation, MassHealth will continue to identify opportunities to engage with stakeholders, including people with lived and living experience.

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[20] With the exception of services for patients in medical institutions, in accordance with federal law and guidance.
[21] Nellis, Ashley. " The Color of Justice: Racial and Ethnic Disparity in State Prisons." The Sentencing Project, October 2021. https://www.sentencingproject.org/reports/the-color-of-justice-racial-and-ethnic-disparity-in-state-prisons-the-sentencing-project/.
[22] Jones, Alex. "Visualizing the unequal treatment of LGBTQ people in the criminal justice system." Prison Policy Initiative, March 2021. https://www.prisonpolicy.org/blog/2021/03/02/lgbtq/.
[23] Ghandnoosh, Nazgol and Emma Tammen. "Incarcerated LGBTQ+ Adults and Youth." The Sentencing Project, June 2022. https://www.sentencingproject.org/policy-brief/incarcerated-lgbtq-adults-and-youth/.

Health Disparities in Justice-Involved Populations

As displayed in Table 1, research from across the country shows that individuals held in carceral settings face numerous health disparities in comparison to the general public relating to hypertension, asthma, substance use disorder, oral health, and particularly mental health conditions.

Furthermore, individuals leaving carceral settings have increased risks of hospitalization and mortality.[24] Compared to the general population, individuals reentering the community after incarceration have 12.7 times the chance of death within two weeks of release, and they are over 120 times more likely to die of a drug overdose within two weeks of release.[25] While progress has been made addressing the opioid epidemic in Massachusetts and nationwide, given the societal upheaval of the COVID-19 pandemic, rates of overdose continue to rise.[26,27] Massachusetts trends in opioid overdose deaths are particularly stark among non-Hispanic Black men (where the rate jumped 41% from 2021 to 2022) and non-Hispanic Black women (where the rate jumped 47% from 2021 to 2022), both of which experienced the highest opioid-related overdose death rate increase among their respective groups in all race/ethnicity groups.[28]

Table 1: Individuals with justice involvement face health disparities when compared to the general public

Condition	Health Disparities in Justice-Involved Populations
Substance Use Disorder (SUD)	Over half of incarcerated adults have SUD, and there are elevated rates of SUD among incarcerated youth. At the MA Middlesex County Jail & House of Correction, 75% of incarcerated individuals have a substance use condition.[29] Individuals recently released from incarceration face 120 times higher risk of fatal overdose than the

[24] Frank, J.W., J.A. Linder, W.C. Becker, et al. "Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: Results of a national survey." Journal of General Internal Medicine (2014) 29, no. 9: 1226–1233. https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC4139534/.
[25] "An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 - 2015)." The Commonwealth of Massachusetts Executive Office of Health and Human Services, August 2017. https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-august-2017/download.
[26] "Current Opioid Statistics." Massachusetts Department of Public Health, May 2021. https://www.mass.gov/lists/current-opioid-statistics#updated-data-%E2%80%93-as-of-may-2021.
[27] Provisional Drug Overdose Death Counts." United States National Center for Health Statistics, 2021. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.
[28] "Opioid-Related Overdose Deaths, All Intents, MA Residents – Demographic Data Highlights." Massachusetts Department of Public Health, June 2023. https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-june-2023/download.
[29] Middlesex County Restoration Center Commission (2019). "Year One Findings and Recommendations". Accessible at https://www.mamh.org/library/middlesex-county- restoration-center-commission-year-one-findings-and-recommendations.

Condition	Health Disparities in Justice-Involved Populations
	general population. Moreover, over one quarter of MassHealth members who had a fatal overdose over a five-year period had been recently released from incarceration.[30]
Mental Health	Nationally, approximately 50% to 75% of justice-involved youth meet criteria for a mental health disorder. Additionally, more than half of incarcerated male adults and three-quarters of incarcerated female adults across the country have a mental health condition.[31] In Massachusetts, 36% of male and 81% of female individuals incarcerated in DOC facilities have a mental health condition, while 28% and 75% respectively have a serious mental health condition.[32] Between 60% and 70% of Massachusetts youth in the care and custody of the DYS have been found to have at least one mental health condition.[33] Nearly 50% of incarcerated individuals at the Middlesex Jail & House of Correction have a mental health condition – 80% of whom have a co-occurring substance use condition.[34]
HIV/AIDS	A Connecticut study found that people living with HIV who were released from incarceration had a mortality rate that was 8.47 times higher than the general Connecticut population. Among deaths with reported causes, HIV/AIDS was the most common cause of death (45.9%). Individuals who were subsequently re-incarcerated for 1 year or longer had *lower* mortality from HIV/AIDS, suggesting they had greater access to treatment while incarcerated than in the community upon their reentry.[35]Additionally, a study conducted in Middlesex County found that people with HIV and substance use

[30] Massachusetts Department of Public Health. "An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts" (2011-2015) (published August 2017).
[31] James, Doris J., and Lauren E. Glaze, "Mental Health Problems of Prison and Jail Inmates," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. September, 2006.
[32] Massachusetts Department of Correction Research and Planning Division (2020). "Prison Population Trends 2019". Accessible at https://www.mass.gov/doc/prison-population-trends- 2019/download.
[33] Grisso, Thomas & Davis, Maryann & Vincent, Gina. (2004). "Mental Health and Juvenile Justice Systems: Responding to the Needs of Youth with Mental Health Conditions and Delinquency".
[34] Middlesex County Restoration Center Commission (2019). "Year One Findings and Recommendations". Accessible at https://www.mamh.org/library/middlesex-county- restoration-center-commission-year-one-findings-and-recommendations.
[35] Loeliger KB, Altice FL, Ciarleglio MM, et al. All-cause mortality among people with HIV released from an integrated system of jails and prisons in Connecticut, USA, 2007-14: a retrospective observational cohort study. Lancet HIV. 2018;5(11):e617-e628.

Condition	Health Disparities in Justice-Involved Populations
	disorder experienced difficulties in connecting with care following release from jail.[36]
Prenatal care	Justice-involved youth have higher incidence of reproductive health needs, including pregnancy.[37,38]
Hypertension	Incarcerated adults are approximately 1.2 times more likely to have hypertension.[39]
Asthma	Incarcerated adults are more than 1.3 times more likely to have asthma.[40]

Individuals leaving carceral settings tend to experience difficulties accessing the care they need, largely due to challenges in establishing or reestablishing Medicaid coverage, making appointments before coverage is established, and planning around uncertain release dates.[41] They are also more likely to lack health insurance.[42] Other barriers include trouble navigating the health care system, lack of transportation, interruption in medication, and unmet health-related social needs (HRSN) such as food

[36] Dong, Kimberly, Denise Daudelilin, Peter Koutoujian, et al. "Lessons Learned from the Pathways to Community Health Study to Evaluate the Transition of Care from Jail to Community for Men with HIV." AIDS Patient Care STDS. 2021 Sep;35(9):360-369. doi: 10.1089/apc.2021.0060.
[37] Albertson, Elaine M., Christopher Scannell, Neda Ashtari, and Elizabeth Barnert. "Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration". American Journal of Public Health, Vol. 110, No. 3 (March 2020).
[38] Barnert, Elizabeth S., Raymond Perry, and Robert E. Morris. "Juvenile Incarceration and Health". Academic Pediatrics 16:2 (March 1, 2016).
[39] Binswanger, Ingrid A et. al. "Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population". J Epidemiol Community Health. 63(11):912–919. (January 11, 2007).
[40] Binswanger, Ingrid A et. al. "Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population". J Epidemiol Community Health. 63(11):912–919. (January 11, 2007).
[41] Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP." June 2023. https://www.macpac.gov/wp-content/uploads/2023/06/MACPAC_June-2023-WEB-508.pdf.
[42] Winkelman, Tyler N., Edith C. Kieffer, Susan D. Goold, Jeffrey D. Morenoff, Kristen Cross, and John Z. Ayanian. "Health Insurance Trends and Access to Behavioral Healthcare Among Justice- Involved Individuals." Journal of General Internal Medicine 31, no. 12 (December 31, 2016): 1523–29. https://doi.org/10.1007/s11606-016-3845-5.

insecurity or homelessness.[43,44,45] Individuals reentering the community after incarceration are 10 times more likely to be unhoused than the general public; experience unemployment rates 5 times greater than that of the general public, with Black women and men experiencing the highest unemployment rates; are very likely to face food insecurity, as 91% of adults recently released from state prisons report they were food insecure; and have lower levels of education and literacy, among other needs.[46,47] Allowing for coverage 90 days prior to expected release would help to smooth the transition from carceral setting to the community by building meaningful transition plans, establishing trusting relationships with community providers in the pre-release period, and improving access to health care services in the post-release period. As wait times for physical and behavioral health appointments continue to grow, pre-release coverage for 90 days would allow for a greater proportion of returning members to schedule post-release appointments within a shorter timeframe after their release.[48,49]

Youth Committed to the Care or Custody of DYS

DYS programs strive to address the unique educational, psychological, and health needs of youth in their care and custody across a continuum of supervision and services. To that end, DYS works with a variety of other state agencies, including MassHealth, to develop partnerships with health care providers in the community to which youth are connected during and after their release from DYS' care (detained youth) or discharge from DYS' custody (committed youth). Together with these agencies, DYS focuses on transition planning and continuing supportive partnerships for committed youth in the community. The goal of these efforts is to ensure youth

[43] Golzari, Mana, and Anda Kuo. "Healthcare Utilization and Barriers for Youth Post-Detention." International Journal of Adolescent Medicine and Health 25, no. 1 (2013): 65–67.
[44] Couloute, Lucius. "Nowhere to go: Homelessness among formerly incarcerated people." Prison Policy Initiative, August 2018. https://www.prisonpolicy.org/reports/housing.html.
[45] Wang, E.A., G.A. Zhu, L. Evans, et al. "A pilot study examining food insecurity and HIV risk behaviors among individuals recently released from prison." AIDS Education and Prevention 25, no. 2 (2013). https://guilfordjournals.com/ doi/10.1521/aeap.2013.25.2.112.
[46] "Prison And Jail Reentry And Health." Health Affairs Health Policy Brief, October 28, 2021.DOI: 10.1377/hpb20210928.343531.
[47] Couloute, Lucius. "Nowhere to go: Homelessness among formerly incarcerated people." Prison Policy Initiative, August 2018. https://www.prisonpolicy.org/reports/housing.html.
[48] Hopkin G. et al., "Interventions at the Transition from Prison to the Community for Prisoners with Mental Illness: A Systematic Review." Administration and Policy in Mental Health and Mental Health Services Research 45 (2018): 623-634. https://doi.org/10.1007/s10488-018-0848-z.
[49] Matsumoto, A et al., "Jail-based reentry programming to support continued treatment with medications for opioid use disorder: Qualitative perspectives and experiences among jail staff in Massachusetts." International Journal of Drug Policy 109 (2022) https://doi.org/10.1016/j.drugpo.2022.103823.

receive the treatment and care they need while also sustaining the gains they made while in DYS residential programming once they return to the community.

Reentry services for committed youth begin during residential confinement and continue through community supervision. These services are designed to include a seamless continuum of programming, support, and aftercare. For example, while youth are committed to DYS custody, DYS staff work with them and their families to connect with a primary care provider and mental health provider for the youth in the community. Upon release under supervision and at discharge, youth are offered connections to case management and additional clinical services as well as other transitional supports such as housing, continued education, and job training. These types of supports encourage continuity of care and help reduce recidivism.

Massachusetts is committed to providing health care coverage for justice-involved youth committed to the care and custody of DYS. Eligible youth in DYS' care and custody are currently covered by MassHealth; even those excluded under MIEP are covered at state cost.[50] Extending certain federal Medicaid covered services to DYS youth for 90 days pre-release will result in further strengthened relationships with community providers for youth incarcerated in DYS facilities and build on current efforts to facilitate a smooth transition back into the community.

Massachusetts has worked across agencies to address challenges caused by MIEP

Massachusetts has taken many steps to optimize continuity of care and promote equitable health outcomes for justice-involved populations. Massachusetts was one of the first states to suspend, rather than terminate, coverage for incarcerated adults, reactivating coverage upon their release.

In addition, MassHealth and its partners have:

- Covered youth while they are committed to the care and custody of DYS at state cost;
- Engaged in reentry planning and connections to community providers for incarcerated individuals;
- Worked with facilities to process new MassHealth applications for individuals who were previously uninsured prior to incarceration;
- Piloted a program with the Massachusetts Probation Service in participating courts to assist individuals on probation with applying for MassHealth coverage;
- Entered into data sharing agreements with the DOC and the 13 Sheriffs' Offices that have correctional facilities;
- Established a dedicated phone line and team to process eligibility updates for incarcerated individuals;

[50] Massachusetts does not currently claim FFP for DYS youth excluded under MIEP.

- Continued to re-activate community Medicaid benefits for individuals upon release;
- Supported a number of grant- and state-funded reentry initiatives, including the Justice Community Opioid Innovation Network[51]; and
- Implemented 12 months continuous eligibility for individuals upon release from a carceral setting to reduce administrative eligibility churn during the post-release period.

Massachusetts also developed the MassHealth Behavioral Health Supports for Justice Involved Individuals (BH-JI) program, which launched in two counties in 2019 and expanded statewide across all 14 counties in 2022. BH-JI offers (1) in-reach activities that take place in correctional facilities prior to a participant's release; (2) coordination with community providers, organizations, and criminal justice agencies; and (3) community supports provided to participants after release from incarceration and to individuals on probation or parole. BH-JI provides supports that include navigators to help develop personalized treatment plans, linkages to health care providers immediately after release, and connections to social services like housing and employment to address HSRN.

Additionally, in 2022, MassHealth received authority from CMS through the demonstration for the Community Support Program for Individuals with Justice Involvement (CSP-JI) which complements the BH-JI program by providing community supports to eligible members after release from incarceration or detention and for individuals on probation or parole. CMS approval of the most recent demonstration extension aligned CSP-JI within MassHealth's framework for addressing HRSN and extended authority for CSP-JI to MassHealth fee-for-service members.

Since statewide rollout of BH-JI in February 2022, more than 2,100 people have been enrolled in BH-JI or CSP-JI. Preliminary results from Massachusetts' BH-JI program indicate a decrease in inpatient and emergency room utilization, and increased connection to more appropriate outpatient behavioral health services. The average cost per member per month for inpatient services decreased by 47% and for outpatient services increased by 39%. The BH-JI program also showed increased housing stability and employment, decreased legal violations, and increased use of behavioral health outpatient services compared to their use before enrollment in the program. Enrollees in BH-JI have experienced measurable improvements in housing and employment status—after six months the number of individuals owning or renting a residence

[51] The National Institutes of Health, through its HEAL Initiative (Helping End Addiction Long Term), created the Justice Community Opioid Innovation Network. The Massachusetts Justice Community Opioid Innovation Network Hub is led by investigators at Baystate Health and the University of Massachusetts Amherst in collaboration with the Massachusetts Department of Public Health, seven Sheriff's Offices, and community treatment providers.

increased from 14% to 29% and individuals who were employed increased from 36% to 45%.

In addition to the direct support for members, BH-JI led to extensive partnerships between community behavioral health providers and state and local entities, including criminal justice agencies. MassHealth has convened statewide BH-JI meetings since the summer of 2021, and the individual BH-JI providers began organizing regional coordinating meetings in Fall 2022.

However, despite all these efforts, the health disparities for justice-involved populations described above persist, leading MassHealth to propose this reentry demonstration to strengthen access to quality health care and continuity of care by providing Medicaid coverage to vulnerable populations, including youth, prior to their release from carceral settings.

Request

Building upon Massachusetts' December 2021 demonstration request and guided by the State Medicaid Directors Letter issued on April 17, 2023, MassHealth's amended demonstration request proposes providing certain Medicaid covered services (including medical, behavioral health, and pharmacy services) for up to 90 days prior to expected release to "qualified individuals", that is, individuals in certain public institutions who, but for MIEP, would otherwise be eligible for MassHealth, including:

1. All individuals in County Correctional Facilities (CCFs) and state Department of Corrections (DOC) facilities, including individuals held pursuant to a civil commitment order; and
2. Eligible youth committed to the care and custody of the state Department of Youth Services (DYS) who are currently excluded under MIEP.

These qualified individuals would receive certain pre-release/pre-discharge covered services that are included in the benefit plan for which they would be eligible but for MIEP (e.g., MassHealth Standard or MassHealth Limited). Qualified individuals must meet other MassHealth eligibility criteria, including the criteria that they must be Massachusetts residents and must be U.S. Citizens or qualified aliens (unless otherwise eligible for MassHealth Limited under 42 CFR 435.139). Enrollment in MassHealth would be voluntary for the qualified individuals.

Delivery of pre-release/pre-discharge covered services under this proposal are expected to be implemented using a phased approach based on the readiness of each facility. These services will be provided through a combination of in-person and telehealth modalities as determined by each facility and participating community-based providers. Facilities participating in the demonstration may choose to leverage

community-based providers to offer “in reach” pre-release/pre-discharge covered services and/or carceral health care providers for the delivery of some or all the pre-release/pre-discharge covered services. All participating facilities will demonstrate readiness, as determined by MassHealth (in collaboration with the DOC, DYS, and Sheriffs’ Offices), which will be based in part on a facility-submitted assessment. This process will be described in detail in the implementation plan that Massachusetts will submit after approval of this request.

During the pre-release/pre-discharge timeframe, qualified individuals will receive certain MassHealth covered services included in the benefit plan for which they would otherwise be eligible, which may include:

- Pre-release case management, post-release treatment plan, and discharge planning to assess and address physical and behavioral health needs and HRSN;
- Physical and behavioral health clinical consultation services provided in-person, via telehealth, or combination;
- Laboratory and radiology services;
- Medications and medication administration;
- Medication Assisted Treatment (MAT) with FDA approved medications and accompanying counseling for all types of SUD, to include SUD withdrawal management, with accompanying counseling;
- MassHealth covered services provided by health workers such as BH-JI navigators, Community Support Program (CSP) workers, recovery coaches, recovery support navigators, peer support specialists, community health workers, and doulas;
- A minimum of 30 days of medications, including MAT, upon release, and when clinically appropriate, up to 90 days of medications; and
- Necessary durable medical equipment (DME) upon release.

Massachusetts will continue the practice of suspending MassHealth enrollment upon entry into a carceral facility. Staff in facilities participating in the demonstration will conduct pre-release outreach, along with eligibility and enrollment support, well in advance of the 90-day pre-release timeframe for all individuals. Then, during the pre-release timeframe (up to 90 days before the scheduled release date), a care coordinator will assist with reentry care facilitation and initiate pre-release/pre-discharge planning activities with each qualified individual.

Participating providers in the reentry demonstration will be a combination of facility-based health providers as well as community-based providers. Massachusetts plans to enhance current staffing resources both within public institutions and in the community, using capacity-building funds for the reentry demonstration. Massachusetts envisions

that additional staffing resources would include facility-based care coordinators from community-based providers, assigned based on facility needs and census. These staff would need to demonstrate experience and competence in providing effective care coordination for justice-involved members, expertise concerning the health and HRSN of these members, and strong networks of medical and behavioral health providers and social service organizations. They would also build on and/or align with existing MassHealth programs such as the Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Community Partners, BH-JI, and CSP-JI. Leveraging community providers advances the goals of Massachusetts' reentry demonstration request by creating a bridge to community-based care and supporting HRSN transitions for the qualified individuals upon reentry.

Facility-based care coordinators will work with the relevant public institutions to assist with the provision of pre-release covered services, including developing a care plan, facilitating the services upon release, leading efforts on many of the new services, working with the aforementioned programs to address HRSNs, and partnering and communicating with local service agencies to enhance access to programs that address HRSN. Facility-based care coordinators may also serve as a resource to MassHealth to help MassHealth support the readiness goals of carceral facilities and carceral health care providers who may provide and bill for the pre-release covered services as applicable.

Massachusetts also requests authority to use presumptive eligibility for individuals who are anticipated to have short-term stays, such as those who are detained short-term prior to trial or sentencing or are sentenced for a period shorter than 31 days, in order to enroll individuals who are likely eligible under the Commonwealth's Medicaid eligibility guidelines for a temporary period of time.

MassHealth intends to implement a fee-for-service model for pre-release services for qualified individuals. Prior to release, facility-based care coordinators would assist qualified individuals in selecting a post-release MassHealth primary care provider and, where appropriate, an accountable care organization (ACO) or managed care plan, as well as facilitating connections to community providers included in the applicable MassHealth plan. Covered services would include providing the qualified individual, upon release from a carceral setting to the community, with a minimum of 30 days of medications and durable medical equipment as applicable.[52] When clinically appropriate, up to 90 days of medications would be provided upon release, including MAT. The carceral facility, MassHealth ACO or managed care plan, and other post-release care coordinators would work together to ensure appropriate follow-up and continuity of care following release and reentry.

[52] MassHealth anticipates that these medications will be reimbursed through MassHealth Fee-for-Service.

In addition, during the 90 days prior to a committed youth's release from a DYS facility, DYS would coordinate with MassHealth to ensure that youth receive covered services, including —and in particular—behavioral health services to support any mental health and/or substance use recovery needs. While youth are committed to DYS care and custody, DYS staff would work with them and their families to connect with a community primary care provider, community behavioral health provider, and resources to address food and housing insecurity as needed.

Implementation Plan

MassHealth will submit an implementation plan that describes the activities and associated timelines for achieving the demonstration milestones. For each milestone, MassHealth will identify key implementation challenges and a specific plan to address the challenges. MassHealth will submit a draft implementation plan no later than 180 days after approval of this request.

The implementation plan will outline readiness activities the relevant public facilities and health care providers must conduct in order to begin implementation at each site. MassHealth anticipates a phased approach for implementing the reentry demonstration at such facilities. MassHealth plans to learn from the challenges and successes of implementation at initial sites to improve implementation at later sites. The implementation plan will also describe MassHealth's plan for using capacity-building funds to support the readiness needs of each facility, as well as plans to ensure new MassHealth providers comply with Medicaid provider participation policies.

Reinvestment Plan

As part of the implementation plan, MassHealth will submit a reinvestment plan that outlines the state's approach to reinvest federal matching funds received for the eligible services under the reentry demonstration. Available funds will be reinvested into critical activities and initiatives that strengthen access and quality of health care services for individuals who are incarcerated or were recently released from incarceration, or for health-related social services that help divert people from criminal justice involvement.

MassHealth will develop a plan to reinvest funds into four categories: (1) administrative/infrastructure costs of the relevant public institutions related to the delivery of Medicaid services, (2) new or enhanced health care services within these settings, (3) HRSN services within facilities to support reentry and/or divert individuals from criminal justice involvement, and (4) community-based investments in services to support healthy transitions and/or diversion from criminal justice involvement. New federal funds will not supplant existing state or local spending on such services and resources. MassHealth will submit a draft reinvestment plan no later than 120 days after approval of the demonstration initiative.

Transitional, Non-Service Expenditures

Massachusetts requests expenditure authority for new expenditures to support capacity building for information technology and capital investments such as:

- Development of new business and operational practices related to coordination of pre- and post-release services;
- Data sharing regarding eligibility for MassHealth covered services;
- Establishment or upgrading of Electronic Health Records to meet criteria within the Office of the National Coordinator for Health Information Technology Certification Program;
- Implementation of claiming systems;
- Hiring and training of staff to implement the reentry initiative; and
- Outreach, education, and stakeholder convening to advance collaboration between facilities, state agencies, and other organizations involved in supporting and planning for the reentry demonstration.

Demonstration Implementation

Massachusetts is seeking to begin implementing the demonstration initiative to provide pre-release covered services to qualified individuals 90-days pre-release by July 1, 2025, with the assumption that there will be a phased-in approach and a ramp up of qualified individuals receiving covered services over the course of the demonstration.

Impact on Members

Massachusetts anticipates that this expenditure authority will improve health care outcomes for newly released MassHealth members by increasing coverage and continuity of care, therefore improving transitions from the relevant public institutions to the community. Specifically, Massachusetts anticipates that this expenditure authority would increase access to and engagement in primary and behavioral health care in these settings and in the community following reentry; improve identification of HRSN and improve connection to providers with the capacity to meet those needs in the community; decrease avoidable hospitalizations and emergency department visits; improve health outcomes and reduce all-cause deaths; and decrease disparities in health outcomes. Preliminary results from Massachusetts' BH-JI demonstration, described above, support these anticipated outcomes. There is also a growing body of evidence demonstrating that access to health care coverage could also reduce recidivism.[53]

[53] Badaracco, Nico, Marguerite Burns, and Laura Daugue. "The Effects of Medicaid Coverage on Post-Incarceration Employment and Recidivism." Health Services Research, Vol 56, S2 (September 2021). https://doi.org/10.1111/1475-6773.13752.

Finally, the proposal to provide certain MassHealth covered services to youth committed to the care and custody of DYS during the 90 days pre-release would support progress made in the therapeutic environment provided by DYS in order to improve the juveniles' near-term and long-term health and other life outcomes. As youth re-enter the community, the services authorized by this demonstration initiative will strengthen relationships with providers in the community, improve access to needed services, and improve overall health outcomes.

Note, certain Title XIX and XXI requirements would not apply to this requested expenditure authority, including:

1. **Statewideness** (Section 1902(a)(1)): to allow for phased implementation of this policy on a geographically limited basis for different public institutions across the Commonwealth;
2. **Amount, duration, scope of services, and comparability** (Section 1902(a)(10)(B) and 1902(a)(17): to account for differences in service delivery in various types of public institutions (e.g., security requirements), and enable the Commonwealth to provide a limited set of pre-release services to qualified individuals in these settings that is different than services available to all other beneficiaries in the same eligibility groups authorized under the state plan or the demonstration;
3. **Freedom of choice** (Section 1902(a)(23)(A)): to allow pre-release services to be delivered to qualified individuals by designated health providers within the various types of public institutions subject to this authority;
4. **Cost-sharing requirements**: to enable the Commonwealth to not require certain cost-sharing requirements to ensure qualified individuals in these settings do not pay more than they are currently charged;
5. **Eligibility requirements**: to enable the Commonwealth to not require certain eligibility requirements and implement a streamlined eligibility process for qualified individuals;
6. **Requirements for Providers under the State Plan** (Sections 1902(a)(27) and 1902(a)(78)): to enable the Commonwealth to not require designated health care providers in these settings to enroll as Medicaid providers in order to provide, order, refer, or prescribe pre-release services as authorized under this authority; and
7. **Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority Above, Requirements for Providers under the State Plan** (Section 2107(e)(1)(D)): To enable the Commonwealth to not require designated health

care providers to enroll as Medicaid providers in order to provide, order, refer, or prescribe pre-release services as authorized under this authority.

Summary of Waiver and Expenditure Authorities Requested

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

Table 2.

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
Preserve CommonHealth Members' Ability to Enroll in One Care	Clarify delivery system enrollment options for CommonHealth Adults in the STCs under existing expenditure authority #1 for expenditures for CommonHealth Adults	
Marketplace Subsidies	Additional expenditure authority to provide premium and cost sharing subsidies for individuals with incomes at or below 500 percent of the FPL who purchase health insurance through the Massachusetts Health Insurance Connector Authority and gap coverage for up to 100 days while they select, pay, and enroll into a QHP	
Provide MSP, including Qualifying Individual benefits, for individuals on Standard (including those over 65) with income up to the state statutory limit for MSP,	Additional expenditure authority to provide MSP benefits to MassHealth members eligible for Medicare cost sharing assistance through the Commonwealth's MSP income limit expansion,	Certain Title XIX and XXI requirements would not apply, including: Section 1902(a)(10)(C), 1902(a)(10)(E)(i), 1902(a)(10)(E)(iv), and certain implementing regulations of 1902(a)(10)

who are otherwise eligible under the State Plan	without applying an asset test	
Provide MSP to CommonHealth members up to the state statutory maximum Or, alternatively, to pay Medicare Part B premiums to all CommonHealth members up to 225%	Additional expenditure authority to provide MSP benefits to CommonHealth members up to the Commonwealth's MSP income limit expansion Additional expenditure authority to pay Part B premiums as a benefit to CommonHealth members up to 225% separate from MSP	1902(a)(10)(E) to the extent its reference to section 1905 incorporates sections 1818 and 1843
12 Month Continuous Eligibility for adults age 19 and over and 24 Month Continuous Eligibility for members experiencing homelessness who are age 65 and over	Waive redetermination of eligibility regardless of changes in circumstances for 12 months (or for 24 months for those experiencing homelessness and are age 65 or over)	Section 1902(a) to the extent it incorporates 42 CFR 435.916
Expanded Housing Authority (i.e., Short-Term Post-Hospitalization Housing (STPHH) and Temporary Housing Assistance for pregnant members and families and related services)	Include expanded housing authorities for STPHH and temporary housing assistance for pregnant members and families and related services as Health-Related Social Needs services under existing expenditure authority 22 and STC 15, including all related waivers applicable to HRSN services in the current demonstration	

Social Service Organization (SSO) Integration Fund	Increase expenditure authority in the amount of $17M (increase from $8M to $25M) under existing expenditure authority 23 and STC 15, including all related waivers applicable to HRSN services in the current demonstration	
Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions	Expenditure authority to provide certain MassHealth covered services to otherwise eligible individuals held in certain public institutions 90 days prior to their release from those settings; expenditure authority to support related capacity building	Certain Title XIX and XXI requirements would not apply, including: Sections 1902(a)(1), 1902(a)(10)(B), 1902(a)(17), 1902(a)(27), 1902(a)(78), and 2107(e)(1)(D).

Budget Neutrality

Budget neutrality prior to amendment

The Commonwealth's projected budget neutrality cushion as of the quarterly report for the quarter ending June 30, 2022,[54] is approximately $28.2 billion total, of which $6.2 billion is attributable to the SFY 2018-2022 waiver period.[55] This estimate incorporates projected expenditures and member months through SFY 2022 as reported through the quarter ending September 30, 2022. This budget neutrality calculation reflects significant realized and anticipated savings.

Effect of amendment

As reflected in the accompanying budget neutrality workbook, this amendment results in $6.1 billion in costs to the MassHealth program and would increase the total populations and expenditures over the 2022-2027 waiver period. The combined effect of these two

[54] The budget neutrality cushion as of the quarterly report for the quarter ending July 30, 2022 includes member month and actual expenditure data as reported in the CMS-64 report for the corresponding time period. Safety Net Care Pool spending included in the calculation reflects figures as reported in the budget neutrality agreement approved by CMS on November 4, 2016.

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

dynamics would decrease the Commonwealth's budget neutrality cushion by approximately $273.6 million for the 2022-2027 waiver period. For the calculation of the budget neutrality impact, the expenditures for following proposed amendments will fall under hypothetical MEGs: STPHH, Marketplace Subsidies, Enrollment in One Care, Pre-Release MassHealth Services to Individuals in Certain Public Institutions, 12 Month Continuous Eligibility for MAGI Adults, provide MSP to CommonHealth members, and temporary housing assistance for pregnant members and families and related services. The expenditures for hypothetical MEGs have no impact on budget neutrality. Overall, after integrating the proposed amendments, the Commonwealth and the federal government would continue to realize savings on the demonstration.

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

Evaluation

The currently approved demonstration seeks to advance five goals:

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

The Evaluation Design Document for the current waiver period is still under review by CMS but the general impact of the amendment on the evaluation of the waiver is described below:

Amendment request #1 (Preserve CommonHealth Members' Ability to Enroll in One Care Plans) seeks to advance Goal #2 by preserving access for CommonHealth members to elect One Care as an alternative to MassHealth FFS for their Medicaid coverage.

Amendment request #2 (Expand Marketplace Subsidies to Additional Individuals) seeks to advance Goal 5 to maintain near-universal coverage and supports hypotheses that enrollment in programs funded with demonstration investments supports near-universal coverage in Massachusetts and results in improved health outcomes.

Amendment request #3 (Increase the Income Limit for MSP Benefits for Members on MassHealth Standard and CommonHealth to the State Statutory Limit) seeks to advance Goal #5, to maintain near-universal coverage and supports hypotheses that enrollment in programs funded with demonstration investments supports near-universal coverage in Massachusetts and results in improved health outcomes.

Providing MSP benefits to additional individuals to comply with the expansion under state law supports the state's goal of maintaining near-universal coverage. The MSP amendment would also help to ensure the long-term financial sustainability of the state's health coverage programs by requiring enrollment in Medicare as the Medicare coverage would no longer come at a cost to the member.

Amendment #4 (Remove the Waiver of Three Months Retroactive Eligibility) seeks to advance Goal #5, to maintain near-universal coverage and supports hypotheses that this amendment will increase enrollment continuity, improve health status, and reduce beneficiary medical debt.

Amendment request #5 (Provide 12 Months Continuous Eligibility for Adults and 24 months Continuous Eligibility for Members Experiencing Homelessness Who Are Age 65 and Over) seeks to advance Goal #5, to maintain near-universal coverage and supports hypotheses that enrollment in programs funded with demonstration investments supports near-universal coverage in Massachusetts and results in improved health outcomes. Providing 12 months continuous eligibility for adults age 19 and over (and 24 months continuous eligibility for members experiencing homelessness who are age 65 or older) whose Medicaid eligibility is based on both MAGI and non-MAGI eligibility criteria expands upon the prior and current demonstration periods which provide federal waiver and expenditure authority to allow for continuous eligibility flexibilities for various populations such as children up to age 19, justice-involved

members, and those considered to be chronically homeless, allowing continuous coverage of comprehensive benefits for 12 or 24 months, dependent on the population.

Amendment request #6 (expanding housing authority through STPHH and temporary housing assistance for pregnant members and families) seeks to advance Goal # 3. The evaluation of STPHH will include an analysis of how the services affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. Additionally, the evaluation will include a cost analysis to support developing comprehensive and accurate cost estimates of providing services and an assessment of the potential improvements in the quality and effectiveness and utilization of outpatient services.

As noted in Footnote #2, the Commonwealth has received approval from CMS to use funding from Section 9817 of the American Rescue Plan Act (ARPA) for a Medical Respite Pilot Program Grant. This pilot program will operate until December 2024 and will be aligned with the Short-Term Post Hospitalization Housing Program model. The evaluation of STPHH will build on the evaluation of the ARPA-funded Medical Respite Grant Program.

Similar to the evaluation of STPHH, the evaluation of temporary housing assistance and support services for pregnant members and families will include analysis of the impact housing has on utilization of preventive care as well as costs associated with potentially avoidable, high-acuity health care. Additionally, the analysis will include monitoring the ability to link pregnant members and families with other services, including SNAP and WIC, as well as more stable housing.

Amendment request #7 (Increase the Expenditure Authority for the SSO Integration Fund) seeks to advance Goal # 3 to continue to improve access to and quality and equity of care, with a focus on initiatives addressing health-related social needs. The evaluation of the SSO Integration Fund will continue as proposed in the Evaluation Design Document.

Amendment request #8 (Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions) seeks to advance Goal #3 to continue to access to and equity of care, with a focus on initiatives addressing health-related social needs and specific improvement areas relating to health quality and equity, including maternal health and health care for justice-involved individuals who are in the community.

For evaluation of the provision of MassHealth services to individuals in certain public institutions, evaluation metrics may include:

- Provision of physical and behavioral health services prior to release;
- Provision of medication-assisted treatment prior to release;

- Hospitalizations and use of emergency services post-release;
- All cause deaths post-release, particularly opioid-related;
- Provision of physical, behavioral health, and HRSN services post-release;
- Completion of Hepatitis C treatment after release for individuals who initiated Hepatitis C treatment while incarcerated;
- Individuals with substance use disorder maintaining medication-assisted treatment after incarceration; and
- Community tenure after incarceration.

These goals are consistent with the directives from Section 5032 of the SUPPORT Act as well as the guidance provided by CMS in its SMD# 23-003. Additionally, Massachusetts will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of the extended full 90-day period for covered services before the beneficiary's expected date of release on achieving the articulated goals of the initiative, including whether returning members will be more likely to establish connections with community providers prior to release and have appointments scheduled soon after release. Further evaluation will include mixed-method measurement of cross-system communication and collaboration and connections between carceral settings and community services. MassHealth intends to collect data to support analyses by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, geography, and sexual orientation and gender identity), which will provide an understanding of disparities in access to and quality of care and health outcomes.

Public Process

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

Public Notice

The Commonwealth released the amendment for public comment starting on August 2, 2023. The Public Notice, the Amendment Request, which includes the Budget Neutrality

Impact section, and a Fact Sheet about the Amendment (including the instructions for submitting comments) are on the MassHealth website https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver, and the public notice with a link to the MassHealth website was published in the *Boston Globe*, *Worcester Telegram & Gazette* and the *Springfield Republican*.

Tribal Consultation

The Commonwealth provided a summary of the Amendment through an email to all Tribal leaders or their designees and additional Tribal health contacts on August 2, 2023. The summary included links to the documents and instructions for providing comment.

Public Meetings

The Commonwealth hosted a virtual listening session on August 17, 2023 to seek input regarding the amendment. The session included a presentation on the proposed changes and an opportunity for public testimony. 155 people attended the session. During the public testimony portion of the meeting commenters expressed support for the amendment and asked questions about the STPHH request including criteria for homelessness and the intersection with current pilot program; as well as the request to Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions including several suggestions to expand the advisory committee to include a broader network of stakeholders.

Public Comment Letters

The Commonwealth received 29 comment letters from consumer and legal advocates, health care provider organizations, social service providers and individuals on or before the September 9, 2023 deadline, including one letter co-signed by 36 other organizations* (noted with an asterisk below) and one letter co-signed by 30 other organizations# (noted with a hashtag below). The Commonwealth also received one comment letter after September 9 which is included in the summaries below. All of the comment letters expressed overall support for the amendment.

11* of the comment letters expressed support for the request to Preserve CommonHealth Members' Ability to Enroll in One Care Plans. Two commenters requested clarification regarding reinstatement of members under the age of 65, in addition to members over 65. The Commonwealth appreciates these comments and has made clarifying edits to the request.

17* comment letters expressed support for the request to expand Marketplace (Health Connector) subsidies to additional individuals. One comment letter asked that MassHealth consider further cost supports for individuals with lower incomes who rely

on ConnectorCare. The Commonwealth appreciates this comment and will continue to consider a multi-pronged approach to supporting affordable health care.

7* comment letters expressed support for the request to increase the income limit for MSP benefits for Members on MassHealth Standard to the State Statutory Limit. 1 comment letter urged the agency to implement 2023 MSP income limits for all non-MAGI individuals eligible for MassHealth Standard without waiting for further expenditure authority, and to request expenditure authority for members on CommonHealth to receive MSP up to the state statutory limit. The letter also urged the agency to submit an amendment for Part B premium subsidy design. In response, the Commonwealth has updated the amendment to request expenditure authority for members on CommonHealth to receive MSP up to the state statutory limit and for a Part B premium subsidy design. Expenditure authority is needed to provide MSP to medically needy non-MAGI members over 165% FPL and to provide QI to non-MAGI members on Standard so EOHHS has not made changes to those requests.

17* comment letters expressed support for the request to remove the wavier of three months retroactive eligibility. Six comment letters asked for an earlier effective date than January 1, 2025. In the absence of an earlier effective date, one comment letter urged the agency to consider alternative approaches to support coverage for individuals between approval of the amendment and the planned 1/1/25 system implementation date. Due to needed system updates the Commonwealth is not able to implement this change or develop alternative approaches earlier than January 1, 2025.

19* comment letters expressed support for the request to provide 12 months continuous eligibility for adults and 24 months continuous eligibility for members experiencing homelessness who are 65 and over. Five comment letters asked for an earlier effective date than January 1, 2025. Three comment letters asked for the request to include multi-year CE for children. One comment letter suggested some consideration for addressing HIV needs, tackling homelessness, and working with the Ryan White program. One comment letter asked for clearer definitions for homelessness and that those individuals at risk of homelessness be included, as well as requesting consideration of a grace period prior to members turning 65 to allow for continuity of care and engagement in needed services. Lastly, one comment letter asked that the agency consider alignment with current continuous eligibility policies for justice-involved and postpartum populations, so that an individual eligible for the more than one CE period has the benefit of the longest available period of CE. In line with CMS guidance, the Commonwealth will be implementing 12-months continuous eligibility for children in January 2024, however, due to needed system updates, the Commonwealth is not able to implement these additional changes earlier than January 1, 2025. The Commonwealth will continue to collaborate with Ryan White HIV/AIDS program grantees including the Massachusetts Department of Public Health and the Boston Public Health Commission. Members experiencing homelessness will be those reported as homeless in Homeless Management Information System (HMIS) and included in the

state data warehouse known as the Rehousing Data Collective (RDC) and this clarification has been added to the request. Federal regulations do not allow for grace period coverage of an individual who has not been determined eligible for MassHealth within their appropriate population (i.e., MAGI versus non-MAGI). Individuals who turn 65 must be redetermined in order to ensure eligibility.

15* comment letters expressed support for the request to include STPHH as an allowable HRSN service noting that this service will improve health equity, reduce hospital congestion and provide necessary care for members experiencing homelessness.

Five comment letters asked that the program expand beyond members in ACOs. After reviewing and considering these comments, the Commonwealth has updated the amendment request to expand the proposed STPHH service to all eligible managed care and fee-for-service MassHealth members except for those on Limited.

Other comments on the STPHH request include one comment letter which encouraged the state to work with state housing officials. The Commonwealth agrees with this comment and intends to continue its regular collaboration with state housing officials. One comment letter asked for further clarification and details around how the proposal will be implemented, emphasized the importance of behavioral health, and recommended that the state work with organizations that have the capacity to expand existing services. One comment letter encouraged the state to consider opportunities for collaboration between providers. MassHealth agrees that this collaboration is important and anticipates requiring a partnership between a healthcare agency and a homeless provider, similar to the recent MassHealth Medical Respite Pilot Grant program established with ARPA funding.

Two comment letters encouraged the state to expand the criteria beyond inpatient stays or ED visits, suggesting that that was too limiting. The Commonwealth notes in response that it is requesting that STPHH be available to individuals experiencing homelessness in the community if they have an upcoming medical procedure and need a safe place to prepare (e.g., preparing for a colonoscopy) and has included this clarification in the amendment request. Additionally, two comment letters expressed concern about the 6-month limitation. The Commonwealth notes in response that the 6 months limit is a per-stay limit, and not an annual or lifetime limit. The Commonwealth intends to allow eligible individuals to have multiple STPHH stays, as necessary, after hospital stays and has included this clarification in the amendment request.

Additionally, to recognize the emergent need for housing and related support services for newly arrived immigrants enrolled in MassHealth, and to align with strong support for increasing resources for housing-related services throughout the Commonwealth voiced in multiple comment letters, the state has updated its amendment to include a request for federal funding to support up to six months of temporary housing assistance and related support services for pregnant members and families who are receiving or may

be eligible to receive services under the Massachusetts Emergency Assistance family shelter program.

The Commonwealth appreciates all of the comments on STPHH and the importance of improving the housing situation for newly arrived immigrants and will continue to take them into consideration as further details around implementation are developed.

12* comment letters expressed support for the request to increase the expenditure authority for the social service organization integration fund. One comment letter included specific suggestions for how to allocate the funding increase, including encouraging new ventures; prioritizing building health care workforce; supporting training and TA; encouraging building flexible, responsive systems; and paying for technical system implementation. One comment letter requested that the state increase the expenditure authority request to $25M and asked that the agency provide adequate lead-time for SSOs and ACOs to implement changes and establish an advisory group for nutrition SSOs participating in FSP. One comment letter encouraged use of outcomes-based metrics to measure success and asked for clarification about what will be expected of HRSN providers. Three comment letters suggested establishing a stakeholder advisory group. One comment letter asked that MassHealth ensure a transparent transition to managed care; allocate sufficient funds for reimbursement of nutrition services as well as data exchange between ACOs and other involved entities; remove the 6-month limit on nutrition services; develop a comprehensive budget, pricing, and payment strategy for HRSN services; and require ACOs to include nutrition support services as a mandatory covered benefit. Finally, one comment letter asked the state to consider expanding participation in the SSO Integration Fund to Community Partners (CPs). The Commonwealth appreciates these comments and will take them into consideration as it finalizes design of the SSO Integration Fund.

18*# comment letters expressed support for the request to provide pre-release MassHealth services to Individuals in certain public institutions. One comment letter* encouraged the state to enlarge the Coordinating Council and to include more community in planning. One comment letter encouraged adding the following targeted interventions: HIV testing and caseworker services that aid in transition to the community. One comment letter had questions about the reinvestment plan described on p.23 and encouraged the use of correctional officers in reentry. One comment letter encouraged including a requirement that all 3 FDA approved medications for opioid use disorder (methadone, buprenorphine, and naltrexone) be available to incarcerated individuals as they prepare for release, and encouraged MassHealth to include a requirement around partnering with community providers. One comment letter suggested adding specific language around the importance of SUD intervention prior to release. One comment letter# suggested 1) including a provision for an advisory council of consisting of a broader group of stakeholders with lived experience; 2) including incentives to involve managed care plans and community organizations; 3) including an

explicit commitment to screen for and treat the Hepatitis C virus in the justice-involved population; 3) establishing reinvestment plan services that reduce future incarceration; 4) adopting accountability and oversight measures; and 5) adding provisions and funding for improving the suspension of coverage process.

In response to these comments, the Commonwealth has added language to the request confirming its intention to work with stakeholders, including those with lived and living experience, to inform planning and implementation. The Commonwealth appreciates all of the comments received on this proposal and will take them into consideration as it finalizes the design of providing pre-release MassHealth services to individuals.

After reviewing and considering the comments received by letter and during public testimony at the virtual listening session, the Commonwealth has modified the requests as originally posted for public comment as described above.

Conclusion

The proposed flexibilities described in the demonstration amendment request build on the Commonwealth's current efforts to advance health equity by further strengthening coverage for Massachusetts residents and addressing MassHealth members' health-related social needs.

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

State Contact

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	CY 2023 DY 28	CY 2024 DY 29	CY 2025 DY 30	CY 2026 DY 31	CY 2027 DY 32	7th Extension Total
	Projected	Projected	Projected	Projected	Projected	
With Waiver Expenditures						
Base Populations						
Base Families	$ 3,333,241,369	$ 3,435,348,745	$ 3,546,319,995	$ 3,652,791,174	$ 3,762,601,290	$ 18,629,755,919
Base Disabled	$ 2,889,797,067	$ 2,978,518,103	$ 3,073,601,925	$ 3,168,089,548	$ 3,265,509,719	$ 16,078,057,923
1902 (r) 2 Children	$ 134,838,094	$ 139,232,890	$ 143,035,801	$ 146,805,698	$ 150,703,890	$ 745,205,288
1902 (r) 2 Disabled	$ 66,049,592	$ 68,085,867	$ 70,519,675	$ 72,700,877	$ 74,950,013	$ 371,009,332
1902 (r) 2 BCCDP	$ 12,293,143	$ 12,668,010	$ 13,076,108	$ 13,474,578	$ 13,887,615	$ 68,815,062
Hypothetical Populations						
CommonHealth	$ 132,387,266	$ 164,917,288	$ 195,694,271	$ 270,241,064	$ 278,992,703	$ 1,074,451,469
FFCY	$ 443,031	$ 456,765	$ 470,924	$ 485,523	$ 500,574	$ 2,482,122
New Adult	$ 2,652,712,221	$ 2,736,786,180	$ 2,903,822,233	$ 3,014,810,658	$ 3,108,503,751	$ 15,199,524,813
SMI IMD Services	$ 94,956,224	$ 100,273,772	$ 105,889,104	$ 111,818,893	$ 118,080,752	$ 553,962,975
SUD					$	-
Marketplace Subsidies	$ 370,143,897	$ 656,063,987	$ 825,688,873	$ 889,366,095	$ 957,954,003	$ 3,788,654,562
HRSN Services	$ 71,903,277	$ 124,899,764	$ 163,699,764	$ 163,699,764	$ 163,699,764	$ 687,902,334
HRSN Infrastructure	$ -	$ 12,500,000	$ 12,500,000	$ -	$ -	$ 25,000,000
HRSN - Temporary Housing Assistance for pregnant members		$ 960,311,558	$ 659,463,750	$ 791,356,500	$ 949,627,800	$ 3,360,759,608
STPHH for non-ACO members			$ 2,007,500	$ 2,586,938	$ 3,621,713	$ 8,216,150
CE Formerly Incarcerated/Base Families	$ 79,079	$ 82,875	$ 86,853	$ 91,022	$ 95,391	$ 435,221
CE Formerly Incarcerated/Base Disabled	$ 88,039	$ 92,265	$ 96,694	$ 101,335	$ 106,199	$ 484,534
CE Homeless/Base Families	$ 1,529,023	$ 3,205,320	$ 3,359,175	$ 3,520,416	$ 3,689,396	$ 15,303,330
CE Homeless/Base Disabled	$ 1,684,939	$ 3,533,052	$ 3,702,638	$ 3,880,365	$ 4,066,622	$ 16,867,617
CE Homeless/1902 (r) 2 Children	$ 110,125	$ 230,822	$ 241,902	$ 253,513	$ 265,682	$ 1,102,044
CE Homeless/1902 (r) 2 Disabled	$ 14,500	$ 31,025	$ 32,514	$ 34,074	$ 35,710	$ 147,823
CE Homeless/1902 (r) 2 BCCDP	$ 28,569	$ 62,598	$ 66,041	$ 69,673	$ 73,505	$ 300,386
CE Adults/Base Families			96,279,888	186,279,366	195,220,775	$ 477,780,029
CE Adults/ Base Disabled			118,311,941	228,906,302	239,893,805	$ 587,112,047
CE Adults/1902 (r) 2 Children			2,238,500	4,330,982	4,538,869	$ 11,108,351
CE Adults/1902 (r) 2 Disabled			4,921,012	9,521,022	9,978,031	$ 24,420,065
CE Adults/1902 (r) 2 BCCDP			1,196,185	2,329,801	2,457,940	$ 5,983,926
CE Adults/ e-HIV			455,300	360,287	360,287	$ 1,175,873
CE No Waiver			70,120,013	136,701,662	144,356,955	$ 351,178,629
CE Homeless 65+/Base Families		72,343	157,664	94,209	17,672	$ 341,889
CE Homeless 65+/No Waiver		3,723,145	8,114,250	4,848,514	909,508	$ 17,595,417
Pre-Release MassHealth Services to Individuals in Certain Put			$ 21,489,897	$ 67,693,175	$ 118,463,056	$ 207,646,127
Pre-Release Infrastructure			$ 17,500,000	$ 35,000,000	$ 17,500,000	$ 70,000,000
With Waiver Only						
e-HIV/FA	$ 12,058,866	$ 12,430,437	$ 12,833,082	$ 13,227,010	$ 13,633,170	$ 67,509,999
EAEDC	$ 59,093	$ 60,925	$ 62,814	$ 64,761	$ 66,769	$ 333,388
e-Family Assistance	$ 8,091,913	$ 8,342,763	$ 8,601,388	$ 8,868,031	$ 9,142,940	$ 45,070,015
End of Month Coverage	$ 22,005,416	$ 30,338,891	$ 31,850,459	$ 33,437,186	$ 35,102,795	$ 158,236,101
Provisional Eligibility	$ 425,862,402	$ 439,064,136	$ 452,675,124	$ 466,708,053	$ 481,176,003	$ 2,371,951,318
CSP	$ 15,135,431	$ 15,135,431	$ 15,135,431	$ 15,135,431	$ 15,135,431	$ 79,461,013
Diversionary BH	$ 237,548,982	$ 244,974,363	$ 252,629,931	$ 260,522,822	$ 268,660,393	$ 1,323,723,737
MSP Expansion	$ 11,568,311	$ 50,640,940.70	$ 86,746,480.08	$ 90,894,837.36	$ 95,245,630.07	$ 337,988,277
Flexible Services Transportation	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 75,000
Flexible Services Cooking Supplies	$ 3,076,288	$ 3,167,034	$ 3,348,526	$ 3,439,272	$ 3,257,780	$ 16,288,900
Hospital Quality and Equity Intitiative	$ 410,000,000	$ 490,000,000	$ 490,000,000	$ 490,000,000	$ 490,000,000	$ 2,472,500,000
Workforce Initiatives	$ 6,010,000	$ 10,810,000	$ 10,810,000	$ 10,810,000	$ 4,800,000	$ 43,240,000
SNCP	$ 911,100,131	$ 936,499,944	$ 902,380,944	$ 850,502,625	$ 850,000,000	$ 4,679,683,952
LTSS CP Care Coordination	$ 4,000,000	$ 4,000,000	$ 4,000,000	$ 4,000,000	$ 4,000,000	$ 20,000,000
						7th Extension BN Room
BN Room	$ 2,844,344,935	$ 3,090,935,999	$ 3,447,112,802	$ 3,713,978,087	$ 3,997,166,320	$ 17,891,975,289

7th Extension BN room	$ 17,891,975,289
Carry forward savings (DY16 - DY 25)	28,167,993,575
(A) Total Savings	$ 46,059,968,864
(B) 15% of Medicaid Expenditures	$ 18,699,799,972
Total Available Savings MIN(A,B)	$ 18,699,799,972
Total CNOM	$ 11,616,061,700
TOTAL VARIANCE	**$ 7,357,361,957**

Medicare Savings Program (MSP) Eligibility

Projections based on 7/1/2024 effective date

	DY27	DY28	DY29	DY30	DY31
MSP Expansion - Standard	$ -	$ -	$ 38,714,011.89	$ 74,449,816.47	$ 78,216,977.18
MSP Expansion - CommonHealth			$ 28,350,710.95	$ 54,513,285.16	$ 57,271,657.39

Short-term Post-Hospitalization Housing (STPHH) - Hypothetical

This amendment has no impact on budget neutrality.

The STPHH expenditures will be reported under HRSN Services. This amendment does not increase the hypothetical cap for HRSN services.

Short-term Post-Hospitalization Housing (STPHH) for non-ACO Members- Hypothetical

	DY29	DY30	DY31
Beds utilized per day		22	27
Total Bed Days		8,030	9,855
Per diem rate		$ 250.00	$ 262.50
Total Gross Cost		$ 2,007,500.00	$ 2,586,937.50

HRSN - Temporary Housing Assistance for pregnant members and families and related services - Hypothetical

	DY29	DY30	DY31
Total	$ 960,311,558.20	$ 659,463,750.00	$ 791,356,500.00

Marketplace (Health Connector) Subsidies - Hypothetical

Projections based on 7/1/2024 effective date

		DY27	DY28	DY29	DY30	DY31
Current BN Workbook	Member Months	523,157	2,092,627	2,982,376	3,088,383	3,150,151
	Hypothetical PMPM	$ 170.96	$ 176.88	$ 186.79	$ 197.25	$ 208.29
	Expenditures	$ 89,437,706	$ 370,143,897	$ 557,063,987	$ 609,168,950	$ 656,148,130
300% to 500% FPL	Member Months			360,000	745,592	760,504
	PMPM			$ 275.00	$ 290.40	$ 306.66
	Expenditures			$ 99,000,000.00	$ 216,519,923.95	$ 233,217,965.65
Full Marketplace Subsidies Population with Waiver Amendment	Total Member Months			3,342,376	3,833,975	3,910,655
	Total Expenditures			$ 656,063,986.55	$ 825,688,873.45	$ 889,366,095.36
	Updated Hypothetical PMPM individuals up to 500% FPL			$ 196.29	$ 215.36	$ 227.42

SSO Integration Fund - Capped Hypothetical

	DY27	DY28	DY29	DY30	DY31
Current Waiver SSO Expenditures	$ -	$ -	$ 8,000,000	$ -	$ -
Expenditures with SSO amendment	$ -	$ -	$ 12,500,000	$ 12,500,000	$ -
Net New SSO Expenditures	$ -	$ -	$ 4,500,000	$ 12,500,000	$ -

One Care Eligibility for CommonHealth Members - Hypothetical

Effective 1/1/2026

hypothetical	DY27	DY28	DY29	DY30	DY31
One Care for CommonHealth Members	$ -	$ -	$ -	$ -	$ 67,419,532

Pre-Release MassHealth Services to Individuals in Certain Public Institutions - Hypothetical -

Data is preliminary and subject to change

7/1/2025 effective date

	DY27	DY28	DY29	DY30	DY31
Pre-release services PMPM*				$1,662.79	$1,745.93
Member Months				$8,616.01	$25,848.04
Existing Services				$14,326,597.80	$45,128,783.06
New Services				$7,163,298.90	$22,564,391.53
Existing + New Services PMPM				$2,494.18	$2,618.89
Infrastructure Costs				$17,500,000.00	$35,000,000.00
Total Cost		$ -	$ -	$38,989,896.70	$102,693,174.59

*DY30 PMPM was trended from the base year at 5%

12-month Continuous Eligibility for Adults - Hypothetical

	DY27	DY28	DY29	DY30	DY31
Member Months					
Base Families	-	-	-	188,451	347,910
Base Disabled	-	-	-	79,532	146,828
1902(R)2, Children	-	-	-	4,294	7,927
1902(R)2, Disabled	-	-	-	7,416	13,691
1902(R)2, BCCTP	-	-	-	489	903
e-HIV	-	-	-	318	587
CommonHealth	-	-	-	2,276	4,201
New Adult	-	-	-	171,147	315,964
No Waiver	-	-	-	67,618	124,833
Expenditures					
Base Families	-	-	-	115,481,084	223,855,641
Base Disabled	-	-	-	48,832,679	94,660,271
1902(R)2, Children	-	-	-	2,636,359	5,110,480
1902(R)2, Disabled	-	-	-	4,553,558	8,826,898
1902(R)2, BCCTP	-	-	-	300,274	582,069
e-HIV	-	-	-	195,155	378,301
CommonHealth	-	-	-	1,313,245	2,545,675
New Adult	-	-	-	105,084,444	203,702,153
No Waiver	-	-	-	65,269,977	126,523,340
Total				**343,666,775**	**666,184,826**

24 months Continuous Eligibility for Adult 65+ Experiencing Homelessness - Effective 7/1/24

Member Months	DY27	DY28	DY29	DY30	DY31
CE Homeless 65+/Base Families			148	309	176
CommonHealth			153	318	181

CE Homeless 65+/No Waiver			3,770	7,840	4,470

Expenditures

CE Homeless 65+/Base Families			72,343	157,664	94,209
CommonHealth			84,127	183,347	109,556
CE Homeless 65+/No Waiver			3,723,145	8,114,250	4,848,514
Total			**3,879,615**	**8,455,262**	**5,052,279**

3 Months Retro Eliigibility

	DY27	DY28	DY29	DY30	DY31
Member Months					
Base Families	-	-	-	100,289	100,289
Base Disabled	-	-	-	44,598	44,598
1902(R)2, Children	-	-	-	2,033	2,033
1902(R)2, Disabled	-	-	-	4,128	4,128
1902(R)2, BCCTP	-	-	-	267	267
e-HIV	-	-	-	175	175
CommonHealth	-	-	-	5,930	5,930
New Adult	-	-	-	89,494	89,494

Expenditures

Base Families	$ -	$ -	$ -	$ 8,123,408	$ 8,529,579
Base Disabled	$ -	$ -	$ -	$ 3,612,434	$ 3,793,056
1902(R)2, Children	$ -	$ -	$ -	$ 164,667	$ 172,900
1902(R)2, Disabled	$ -	$ -	$ -	$ 334,408	$ 351,129
1902(R)2, BCCTP	$ -	$ -	$ -	$ 21,609	$ 22,690
e-HIV	$ -	$ -	$ -	$ 14,144	$ 14,851
CommonHealth	$ -	$ -	$ -	$ 480,333	$ 504,350
New Adult	$ -	$ -	$ -	$ 7,249,030	$ 7,611,481

DY32	Total
$ 82,174,756.22	$ 273,555,561.76

$ 60,169,603.25	$ 200,305,256.75

DY32	Total
36	
13,140	
$ 275.63	
$ 3,621,712.50	$ 8,216,150.00

DY32	Total
$ 949,627,800.00	$ 3,360,759,608.20

DY32
3,213,154
$ 219.96
$ 706,750,269

775,714
$ 323.84
$ 251,203,733.60

3,988,868
$ 957,954,002.68
$ 240.16

DY32	Total
$ -	$ 8,000,000
$ -	$ 25,000,000
$ -	$ 17,000,000

DY32	Total	Trend
$ 68,767,922.22	$ 136,187,454	2%

DY32	Total	Trend
$1,833.22		5%
$43,080.06		
$78,975,370.36		
$39,487,685.18		
$2,749.83		
$17,500,000.00		
$135,963,055.54	$277,646,126.83	

DY32	DY27	DY28	DY29	DY30	DY31	DY32
	Member Months after offsets					
347,910	-	-	-	137,714	173,765	173,808
146,828	-	-	-	58,120	73,414	73,414
7,927	-	-	-	3,138	3,963	3,963
13,691	-	-	-	5,420	6,846	6,846
903	-	-	-	357	451	451
587	-	-	-	232	293	293
4,201	-	-	-	1,663	1,906	1,950
315,964	-	-	-	125,069	157,982	157,982
124,833	-	-	-	49,413	57,601	58,689
	Expenditures after offsets					
235,048,423	-	-	-	84,390,023	111,826,133	117,441,549
99,393,284	-	-	-	35,685,420	47,330,135	49,696,642
5,366,004	-	-	-	1,926,570	2,555,240	2,683,002
9,268,243	-	-	-	3,327,600	4,413,449	4,634,121
611,172	-	-	-	219,431	291,034	305,586
397,216	-	-	-	142,614	189,151	198,608
2,672,958	-	-	-	656,622	1,154,585	1,240,351
213,887,260	-	-	-	76,792,478	101,851,076	106,943,630
132,849,507	-	-	-	34,259,605	58,018,286	62,162,390
699,494,068				**237,400,363**	**327,629,089**	**345,305,880**

DY32	**Member Months after offsets**	DY29	DY30	DY31	DY32
31		148	8	8	8
32		153	8	8	8

		3,770	200	200	200

Expenditures after offsets

		72,343	4,023	4,216	4,418
		84,127	4,678	4,902	5,138
		3,723,145	207,026	216,963	227,377
		3,879,615	**215,726**	**226,081**	**236,933**

800
17,672
20,551
909,508
947,731

DY32 Total

100,289
44,598
2,033
4,128
267
175
5,930
89,494

$ 8,956,058	$ 25,609,045
$ 3,982,709	$ 11,388,199
$ 181,545	$ 519,112
$ 368,685	$ 1,054,222
$ 23,824	$ 68,123
$ 15,594	$ 44,590
$ 529,568	$ 1,514,251
$ 7,992,055	$ 22,852,566