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April 15, 2021

Daniel Tsai, Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to daniel.tsai@state.ma.us and MassHealth.Innovations@mass.gov

Re: MassHealth 1115 Demonstration Renewal

Dear Assistant Secretary Tsai,

As MassHealth considers submission of the renewal of the Section 1115 demonstration, our three legal advocacy organizations urge the agency to consider the following recommendations relating to initial and continuing eligibility, the process for applying for coverage, resolving disputes, and eliminating barriers to coverage and care for vulnerable populations. The recommendations on these topics set out below are based on our experience working with low-income MassHealth applicants and members and informed by flexibilities in place during the COVID-19 public health emergency. These reforms related to eligibility, enrollment, dispute resolution, and access to coverage will support and enhance payment and delivery system reforms and should be included as part of the plan for improving MassHealth over the next five years.

Retain Three Month Retroactive Coverage

The original 1997 MassHealth Section 1115 demonstration and each renewal since then has included a waiver of the three calendar months of retroactive eligibility that federal law requires states to make available to applicants. 42 USC §1396(a)(34). MassHealth should not seek to continue this limitation on coverage. As far as we have been able to determine, in the 23 years this waiver has been in effect, the waiver of three month retroactive coverage has never been

evaluated to determine whether it "assists in promoting the objectives" of the Medicaid Act as required by Section 1115. It does not.

It has always been true that waivers of Medicaid Act protections must have a valid research value and cannot be instituted only to save money. See, *Newton Nations v. Betlach*, 660 F. 3d. 370 (2011). Today, we have the benefit of several court decisions striking down the federal Health and Human Services (HHS) Secretary's approval of the waiver of three month's retroactive coverage as arbitrary and capricious. See e.g., *Gresham v. Azar*, 950 F. 3d. 93, 102-103 (2020) (Overturning HHS Secretary's approval of work requirements and reduction in retroactive coverage to 30 days for failure to account for "critical issue of loss of coverage") cert. granted 141 S. Ct. 890 (Dec. 2020).

Retroactive eligibility is an important feature of the Medicaid program that was added to the statute in 1972 to protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying. H.Rep. No. 231, 92d Cong. 2d Sess., reprinted in 1972 U.S.Code Cong. & Ad.News 4989, 5008, 5099. See also, *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States* MaryBeth Musumeci and Robin Rudowitz Published: Nov 10, 2017 KFF https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/.

Full retroactive eligibility strongly fosters the purposes of the Medicaid Act, the Affordable Care Act and Massachusetts health reform by reducing the number of months that a household is uninsured. It reduces the burden of medical debt suffered by the poor, and we know the existence of medical debt often deters patients from seeking follow-up care, and contributes to a cascade of financial problems that adversely affect health. Retroactive coverage also fairly compensates safety net providers that provide care to patients uninsured at the time of their visit, and accommodates the practical barriers that may interfere with the ability of individuals dealing with many other pressing problems or limitations that delay completion of an application.

During the COVID-19 public health emergency, MassHealth reinstated three-month retroactive coverage for those under age 65. Few people know about this, but for those who do, it has been an important protection. Here are two examples, one from a hospital-based Certified Application Counselor (CAC) and one from HLA:

> Patient was admitted to the hospital for substance use treatment. Patient and hospital staff believed they still had private coverage through their parent because it ran as active coverage. Patient later learned (well after the 10-day retro period had passed) that the policy had been terminated at the time of their admission, and the insurance company had been slow in updating their enrollment records. This resulted in the patient receiving a bill for$4,000 for the cost of their admission. The patient ended up being MassHealth

eligible, and was able to have the admission and bill covered because of the 3-month retro flexibility allowed during the COVID pandemic.

Client had a 23-day MassHealth coverage gap and incurred $2,575 in debt to a hospital for emergency services without realizing that she was uninsured. By the time she realized she was uninsured and re-enrolled in MassHealth, the 10-day retroactive period did not cover the dates of service. After MassHealth implemented the 90-day retroactive coverage policy for the duration of the Public Health Emergency, HLA helped this client obtain 90-day retroactive coverage, which fully covered the debt.

Whatever justification there may have been for waiver of three months of retroactive coverage in 1997, there is no justification for seeking renewal of this feature of the waiver in 2022. Retroactive coverage serves a valuable purpose and should be available to Medicaid members under age 65 in Massachusetts as it is in almost all other states.

Retain Extension of the 30-Day Appeal Period

MassHealth allows its applicants and members 30 days to request a fair hearing after receiving an appealable notice. 130 CMR 610.015(B). However, federal law permits states to give Medicaid applicants and members up to 90 days. 42 CFR 431.221(d). As of 2018, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that at least 25 other states had longer appeal periods than Massachusetts.[1] A 30-day appeal period is too short to account for the complications of everyday life, particularly for people living with low incomes. As Medicaid advocates in Massachusetts, we frequently encounter clients who are blocked from having their meritorious appeals heard because of MassHealth's short appeal period. The following are a few examples:

A MassHealth member with intellectual disabilities had his request for PCA hours denied. This member's 81-year-old father and legal guardian requested a fair hearing 41 days after the date of the denial notice, because he mistakenly thought that he needed to obtain and submit medical documentation with the appeal. The Board of Hearings dismissed the appeal for being untimely, and then denied the father's request to vacate the dismissal. GBLS then got involved, filed a 30A complaint, and settled the matter. The member's PCA hours were ultimately approved. If GBLS had not intervened, this member would not have received the PCA hours he needed and for which he was eligible, simply because his legal guardian submitted his appeal 11 days (6 days, accounting for mail) late.

[1] Medicaid and CHIP Payment and Access Commission, *Elements of the Medicaid Appeals Process under Fee for Service, by State*, April, 2018. https://www.macpac.gov/publication/elements-of-the-medicaid-appeals-process-under-fee-for-service-by-state/

> A MassHealth member's coverage was wrongly terminated, based on incorrect information about her residency. The member was hospitalized at the time, and didn't return home until 10 days after the termination notice was mailed. She then submitted her request for fair hearing 28 days after returning from the hospital, and 38 days after the notice of decision was mailed. The Board of Hearings dismissed the member's appeal for being untimely. The member requested the dismissal be vacated. GBLS then got involved and got the dismissal vacated by showing that the member had appealed within 30 days of receiving the notice (after she returned from the hospital). The member prevailed at the hearing and her coverage was reinstated retroactive to the date of termination. All this could have been avoided with a longer appeal period.

A longer appeal period would allow more appeals to be decided on the merits, ensuring that those who are eligible for MassHealth benefits and services are able to receive them. MassHealth could extend its appeal period to 90 days without a waiver, just by amending its state plan. However, during the COVID-19 emergency, Massachusetts used section 1135 waiver authority to temporarily extend its appeal period to 120 days. While a 90-day appeal period would be a significant improvement, we propose that Massachusetts make the 120 day appeal period permanent by including it in its Section 1115 waiver renewal.

Extend the Deadline to Request Aid Pending Appeal

Federal law requires states to maintain services (i.e. aid pending appeal) if the member requests a hearing before the date of action, and to reinstate and continue services if a member requests a hearing within 10 days of receiving an appealable notice. 42 CFR 431.230(a) and 431.231(c)(2). MassHealth's fair hearing regulations likewise allow members just 10 days after receiving an appealable notice to request aid pending appeal. 130 CMR 610.036(A).

Our experience as Medicaid advocates has demonstrated that ten days after receiving an appealable notice is not a reasonable amount of time to request aid pending appeal. Mail delays, lack of regular access to fax machines, the post office, or phones, and the complications of everyday life when living in poverty or with complex medical needs all make this 10-day timeline difficult for many to meet. While MassHealth and its partners do their best to avoid incorrect determinations, with nearly 2 million members in a complex system, mistakes are inevitable. MassHealth's services are critical to the health and wellbeing of its members. If a member misses the 10-day opportunity to request aid pending appeal, then they could miss months of essential services, such as PCA hours or prescriptions, before the Board of Hearings reinstates their coverage.

We propose that MassHealth request an extension of the 10-day timeline for requesting aid pending appeal in its Section 1115 waiver renewal. During the COVID-19 pandemic, CMS set a precedent of approving extensions of the aid pending appeal timeline for the duration of the public health emergency. Seven states have received approval under section 1135 waiver

authority to extend the timeframe from 10 days to the same amount of time the state allows to request a fair hearing.[2] A permanent waiver of this 10-day limitation can also be requested under section 1115 waiver authority. Section 1115 of the Social Security Act provides that CMS "may waive compliance with any of the requirements of … section 1902", which covers a state's fair hearing process. 42 USC §§ 1315, 1396a. We propose that MassHealth include in its Section 1115 waiver renewal a request to extend the 10-day time limit to request aid pending appeal. We propose an extension to a minimum of 20 days, or another amount proportionate to the time to request a fair hearing: 30 days if the timeline to request a fair hearing is extended to 90 days, or 40 days if the timeline to request a fair hearing is extended to 120 days.

Retain the flexibilities for member authorization by means other than an in-person ("wet") signature

During the COVID pandemic, MassHealth instituted flexibilities to accept authorization from members through means other than an in-person ("wet") signature, which has greatly facilitated the submission of benefits applications, Permission to Share Information (PSI) forms, and other documentation to MassHealth. These flexibilities have been particularly important for Certified Application Counselors ("CACs"), legal services attorneys, and other representatives who help members to access the benefits for which they are eligible. We strongly urge MassHealth to adopt these alternative authorization flexibilities beyond the end of the public health emergency.

Permitting alternative means of authorization – including e-signatures, wet signatures based on verbal consent, and verbal signatures – has ensured access to benefits for many eligible members who would otherwise face difficulties with completing forms and applications for the MassHealth agency. Problems such as delayed mail, unavailable or unreliable internet, and lack of access to a fax machine have been exacerbated by the pandemic, but many members regularly experienced these problems prior to the health emergency. Prior to COVID, the wet signature requirement regularly caused delays in completing key documentation, often due to time-lags in obtaining the signatures. Even "minor" delays of a few days have resulted in uncovered, unaffordable medical debt due to the unfairly short 10-day retroactive period available to MassHealth applicants. Moreover, the wet signature requirement unfairly privileged members with access to technology such as computers, printers, and scanners, because these members were able to quickly send signed documents to CACs, advocates, or directly to the MassHealth agency. The most vulnerable members – those who are homeless, without Internet, or lacking disposable income to purchase technological access – are the most disadvantaged by the pre-COVID wet signature rule and have the most to gain from continuing these flexibilities.

[2] Kaiser Family Foundation, *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19,* Apr 5, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/#Table4

The goal of wet signatures is to ensure *bona fide* authorization by MassHealth members, but in today's digital world, the COVID flexibilities have already demonstrated there are multiple ways to ensure valid and genuine authorization of necessary documentation. The value and effectiveness of these member authorization modalities will remain undiminished after the pandemic, particularly for the most disadvantaged MassHealth members who lack access to reliable mail or technology.

Restore Provisional Income Eligibility

We recommend that the waiver proposal include a provision restoring the 90-day provisional eligibility period for income for all eligibility groups covered by the waiver. Provisional eligibility allows for receipt of MassHealth benefits pending submission of income verification. If self-attested income would establish eligibility, but can not be electronically verified, then the applicant is provided benefits for up to 90 days pending submission of corroborative information.

Massachusetts' Section 1115 waiver accepted self-attestation of all eligibility factors except for citizenship and immigration status and provided 90 days of provisional eligibility based on this self-attestation in order to align eligibility rules of MassHealth applicants with the rules for advance premium tax credits pursuant to the Affordable Care Act. On December 14, 2017, CMS approved a request by Massachusetts to amend its waiver so that this provisional eligibility was limited to children under age 21, pregnant women, HIV+ adults and adults with breast and cervical cancer. All other adults were not provided benefits unless their income attestation could be confirmed electronically or unless they submitted corroborating information. The justification used by CMS for approving this change was program integrity. However, this overlooks harm caused by the resulting delay in provision of benefits to many eligible individuals, the potential for confusion caused by a rule that differs from the rules used by the Health Connector, and the inefficiency of incentives to continue submitting paper documentation with an application. It also assumes that individuals who lose benefits due to missing verification deadlines are in fact financially ineligible, which we know from evidence of "churning" may not be the case. Many individuals lose coverage, not because they are financially ineligible, but simply for missing filing deadlines.

The potential for delay in receiving health benefits is evident. The delay is particularly egregious for people who apply on their own using a paper application. These individuals first must wait for their application to be received and processed. Then, they have to wait to receive the Request for Information Notice that MassHealth mails when it cannot electronically verify eligibility factors. This notice provides a 90=day period to submit verifications. MassHealth then has to process these verifications before eligibility is established. While COVID rules are largely avoiding delays in determining eligibility at the present, eligibility determinations often exceeded the 45 days authorized by the Medicaid statute.

While individuals are provided eligibility retroactive to the period 10 days prior to date of application upon an eligibility determination, this is not a substitute for provisional eligibility. Retroactive eligibility is not a solution for someone who has been unable to fill a prescription, obtain home health services, start a request for PCA services or DME, or see a specialist. These are all situations where treatment can be denied without current active health insurance. Similarly, retroactive coverage does not retroactively enroll you in managed care. The consequences resulting from the inability to fill a prescription can be particularly dire. A 2003 study found an association between interruptions in Medicaid coverage among individuals with schizophrenia and increased inpatient hospitalization.[3]. Similarly, a lack of access to asthma medications can result in avoidable emergency room visits.

Pursuant to the requirements of the ACA regulations, the Health Connector accepts self-attestation of income pending verification during a so-called inconsistency period that operates in the same way as provisional eligibility. Without provisional eligibility, MassHealth rules leave individuals who are unquestionably eligible for either MassHealth or Advance Premium Tax Credits without any coverage. For example, an applicant who is a citizen self-attests to income under 100% FPL, but the data match shows income of 140% FPL. This individual cannot be approved for Health Connector coverage because of self-attested income under 100%. However, this individual will not be approved for MassHealth either because the income attestation was not verifiable electronically. An individual who by income is clearly eligible for some category of state subsidized insurance is denied all coverage until income is verified. Provisional eligibility in this situation would ensure there is access to health care while the ultimate eligibility category is determined.

The ACA established additional systems for verifying data electronically in order to simplify and streamline the eligibility determination system. Provisional eligibility furthered that goal by no longer requiring applicants to gather and submit paper documentation of income, and no longer requiring MassHealth workers to process the resulting paperwork. In many cases, attested income could be verified through the federal data services hub and other data sources with no need for added paper processing, and in some cases an inconsistency could be readily resolved by an explanation such as the loss of employment. Now, applicants are all well-advised to submit income verification just in case electronic verification is not reasonably compatible, thus offsetting much of the benefit of data matching.

[3]Psychiatry online, *Association Between Interruptions in Medicaid Coverage and Use of Inpatient Psychiatric Services*, July 1, 2003, *https://doi.org/10.1176/appi.ps.54.7.999*

Adopt Continuous Eligibility

We strongly urge MassHealth to seek Section 1115 Waiver approval of 12-month continuous Medicaid and CHIP eligibility for both adults and children. Continuous eligibility would facilitate ACO plan stability, prevent unnecessary acute and emergency care costs, and promote better health outcomes for MassHealth members. Since March 2020, MassHealth members have benefited from the Families First Coronavirus Response Act ("FFCRA") continuous coverage condition for enhanced FMAP to Massachusetts. FFCRA § 6008(a)-(b). Prior to the pandemic, many states already provided twelve months of continuous coverage for certain Medicaid recipients, particularly children, as a means to prevent churn, improve health outcomes, and facilitate continuity of care. We urge you to extend the benefits of continuous coverage after the public health emergency ends. See, ASPE Issue Brief, Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pande*mic, April 12, 2021, https://aspe.hhs.gov/system/files/pdf/265366/medicaid-churning-ib.pdf*.

States have the option to provide continuous Medicaid and CHIP coverage to children without a waiver. Thirty-four states offer 12-month continuous coverage to children through Medicaid and/or CHIP.[4] States also can provide continuous coverage to adults through a Section 1115 waiver, as New York and Montana have done.[5] [6]

Providing continuous coverage would help stabilize membership in ACO plans, which is crucial to ensure the success of the accountable care model. Volatility in ACO plan enrollment remains a primary concern for the MassHealth administration because it undermines the financial viability of MassHealth's accountable care system. Unfortunately, coverage churn is common in the MassHealth program. In 2017, 34% of those terminating their Health Connector coverage were individuals transitioning to MassHealth, and 31% of new Health Connector enrollees were transitioning from MassHealth.[7] Churn also creates greater administrative burden, as MassHealth must disenroll and re-enroll members as their income fluctuates from month to month.

Medicaid recipients with chronic health conditions who undergo churn experience higher emergency department utilization, increased acute care costs, increased uncompensated care

[4] *Continuous Eligibility for Medicaid and CHIP Coverage*, Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html

[5] *GIS 15 MA/022: Continuous Coverage for MAGI Individuals*, New York State Department of Health, Dec. 2015. https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma022.htm

[6] Section 1115 Waiver for Additional Services and Populations (WASP). Montana State Department of Public Health and Human Services. https://dphhs.mt.gov/montanahealthcareprograms/medicaid/medicaid1115waiver

[7] D. Nelson and J. Rushakoff. *Massachusetts' remaining uninsured*, Harvard Kennedy School, (2019), at 26. https://www.hks.harvard.edu/sites/default/files/degree%20programs/MPP/files/PAE%20Final%20-%20Nelson%20Rushakoff%20NO%20LOGO%20NO%20NAME.pdf

costs, and overall worse health outcomes.[8] [9] As Medicaid advocates, we have worked with many clients with fluctuating incomes who experience gaps in coverage due to difficulty understanding and keeping track of their fluctuating insurance eligibility, leading to medical debt and poor health outcomes. Not only are these care outcomes bad for individual patients, but preventable medical problems also increase costs across the MassHealth system while making it harder to ensure plan accountability for patients cycling in-and-out of coverage.

MassHealth members with lower incomes tend to experience greater rates of income volatility,[10] which creates more opportunity for churn. Moreover, larger trends in the labor market have shifted more workers into the so-called "gig" economy with irregular earning patterns. Contract work and income fluctuation among workers has increased in recent years: one in five jobs is now held by a contract worker, and 49% of contract workers report fluctuating incomes.[11] Workers with fluctuating incomes disproportionately rely on government-sponsored health insurance as their primary insurance: 54% of individuals with income that changes from month to month or seasonally are not offered employer-sponsored health insurance.[12] As the COVID-19 pandemic has caused widespread income loss, the number of individuals covered by MassHealth as primary insurance has grown by 10%.[13] Although unemployment numbers improved during the summer of 2020 as the economy reopened, such progress has since stagnated, and many job losses have become permanent.[14]

Given the high churn in ACO plan enrollment, increase in job and income instability, and the well-documented health and fiscal outcomes of continuous coverage, MassHealth should provide twelve-month continuous Medicaid and CHIP coverage to adult and child populations past the COVID-19 public health emergency.

Waive Estate Recovery for Home and Community-Based Services

MassHealth should seek a waiver of Medicaid estate recovery for home and community-based services (HCBS). This reform would go hand-in-hand with longstanding efforts to provide the elderly and individuals with disabilities with care in the least restrictive setting. Further, it is in

[8] X. Ji et al. *Discontinuity of Medicaid Coverage: Impact on Cost and Utilization among Adult Medicaid Beneficiaries with Major Depression*, 55(8) Med. Care 735 (2017). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6684341/

[9] J.C. Rusley et al. *Discontinuity of Medicaid Coverage Among Young Adults with HIV*, 33(3) AIDS Patient Care and STDs 89 (2019). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6442235/

[10] *How Income Volatility Interacts with Americans Families' Financial Security*, Pew Charitable Trusts (2017). https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security

[11] NPR/Marist Poll (2017). http://maristpoll.marist.edu/wp-content/misc/usapolls/us171204_KoC/NPR/NPR_Marist%20Poll_National%20Nature%20of%20the%20Sample%20and%20Tables_January%202018.pdf#page=3

[12] *Id*.

[13] *Id.*

[14] *Employment recovery in the wake of the COVID-19 pandemic*, U.S. Bureau of Labor Statistics (2020). https://www.bls.gov/opub/mlr/2020/article/employment-recovery.htm

keeping with a growing recognition at the federal and state level of the extent to which Medicaid estate recovery unfairly burdens low income extended families and reinforces historical patterns of wealth inequality among poor and marginalized groups. It was based on considerations like these that, just last month, a federal commission recommended to Congress that it amend the statute to make Medicaid estate recovery entirely optional for the states. Medicaid and CHIP Payment and Access Commission (MACPAC), Report To Congress on Medicaid and CHIP, Chapter 3, Medicaid Estate Recovery: Improving Policy and Promoting Equity, (March 2021) *available at* https://www.macpac.gov/publication/medicaid-estate-recovery-improvingpolicy-and-promoting-equity/.

To the extent current state law may require amendment to implement a waiver of recovery for the costs of HCBS, this likely can be accomplished in the current legislative session with the Administration's support. There are already bills pending in the current legislative session to limit estate recovery to federally mandated costs, to prohibit recovery of capitated managed care payments that exceed the costs of services received by the member, to exempt spending for CommonHealth members from estate recovery, and to seek such plan amendments or waivers as necessary to implement the Act. See, *An Act protecting the homes of seniors and disabled people on MassHealth*, SD 1031 and HD 1408 (2021).

A waiver of estate recovery of HCBS would also address any uncertainty in the scope of mandatory estate recovery. Currently, mandatory Medicaid estate recovery extends to nursing home costs, the costs of "home and community-based services" and related costs. 42 USC 1396p. The estate recovery section of the statute does not define home and community-based services. The 2001 State Medicaid Manual defines the term as applicable to the HCBS 1915c waiver programs, but according to the Office of Medicaid, CMS may no longer be following the Manual definition. While a broad definition of HCBS is in keeping with the compelling public policy goals of reducing facility-based care and promoting independence, mandatory estate recovery for a broad definition of HCBS has the opposite effect.

A waiver of estate recovery of HCBS would also support the Commonwealth's interest in the growth of the Senior Care Options program. Currently, only a small number of SCO members are nursing home residents, but a very high percentage are "nursing home certifiable," most of whom are likely enrolled in the frail elder waiver. If people deemed "nursing home certifiable" knew that they would be incurring an estate recovery debt on the order of $2500-3000 per month by enrolling in a SCO, only high cost users would have any reason to enroll. However, SCO enrollees are not notified that this is how their estate recovery debt will be calculated. If they were notified, and only high cost users enrolled, the SCO model might not be sustainable. One way to solve this conundrum is by waiving estate recovery for HCBS. If HCBS were not recoverable, this would reduce estate recovery to only the portion of the capitated monthly payment to the SCO that represents recoverable costs.

Finally, Medicaid estate recovery is subject to the Secretary's Section 1115 waiver authority which extends to all provisions in section 1902 of the Social Security Act. Section 1902(a)(18) (42 USC 1396a(a)(18)) requires compliance with Section 1917 (42 USC 1396p) regarding Medicaid estate recovery, thus bringing that section of the statute under Section 1115. This waiver should extend to the 65 and over population as well as those under age 65.

Extend Medicaid Before Release for Criminal Justice-involved Individuals

We applaud the expansion of the Behavior Health Supports for Individuals who are Justice-Involved ("BH-JI") program to address the needs of individuals re-entering society. However, the efficacy of this program is diminished by the inmate exclusion policy: when inmate coverage is terminated, it virtually guarantees a gap in continuity of care when a person leaves incarceration. Gaps in coverage can be extremely dangerous for newly released populations, who are estimated to have a risk of death 120 times higher[15] than the general population during the first two weeks of release.

These risks can be obviated, and the BH-JI program can be further enhanced, by seeking a waiver to permit reinstatement of MassHealth coverage for people who are within 30 days of release from jail or prison. This change would permit BH-JI staff conducting in-reach supports to fulfill some of the roles currently required of community supports post-release, and permit those community supports to focus more comprehensively and immediately on outpatient services. It would also permit more immediate prescription of Medication Assisted Treatment (MAT) and other behavioral health supports, since therapeutic interventions often cannot be scheduled until insurance coverage is in place. All these factors would further reduce the great risk of overdose during that critical initial two-week period and enhance the BH-JI program. This approach has been requested by six states already to date,[16] and was similarly contemplated by Congress in

[15] *See* An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015), *obtained at* https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-august-2017/download.

[16] *See* California Request For Section 1115 Demonstration Authority Related To The COVID-19 Public Health Emergency, *obtained at* https://www.dhcs.ca.gov/Documents/COVID-19/CMS-Ltr-and-CA-COVID-19-1115-Waiver-040320.pdf; Illinois COVID-19 Section 1115(a) Demonstration Application, *obtained at* https://www.illinois.gov/hfs/SiteCollectionDocuments/03262020IllinoisCOVID19Section1115DemonstrationProposalFinal.pdf; Kentucky Department of Medicaid Services 1115 SUD Demonstration Proposed Amendment Continuity of Care for Incarcerated Members, *obtained at* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ky-health-demo-pa4.pdf; New York State Department of Health Medicaid Redesign 1115 Demonstration Amendment Application, *obtained at* https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/docs/amendment_app.pdf; State of South Carolina's COVID-related 1115 Demonstration Waiver, *obtained at* https://msp.scdhhs.gov/covid19/sites/default/files/%282020-03-27%29%20SC%201115%20Inpatient%20COVID19.pdf; State of Utah's Special Terms and Conditions for the 1115 Primary Care Network Demonstration Waiver, *obtained at* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-care-network-pa10.pdf.

early versions of the American Rescue Plan Act.[17]

Reimburse providers for language access services

Providing interpretation and translation services is critical to ensure that clinicians and other healthcare staff communicate effectively with patients and their families, and lack of language access has been identified as a roadblock to delivery of care.[18] Interpretation and translation is particularly important because limited proficiency in English is associated with health disparities and leads to poor health outcomes.[19] Currently, Massachusetts does not adequately compensate providers for language access services and does not receive all available federal funding for such services. We strongly recommend that MassHealth attempt to maximize federal funding for interpretation and translation services through the Section 1115 Waiver.

Other states, including those that use global (or bundled) payment models or capitated managed care, have been able to receive federal matching funds for interpretation and translation services in provider settings by separating translation and interpretation services from the bundled provider payments to qualify for FMAP, including an enhanced FMAP for children's services.[20] MassHealth should take a lesson from these other states and restructure provider payments to ensure federal matching funds for interpreter and translation services. This would bring more federal money into the Commonwealth, adequately reimburse providers who serve limited English proficient patients, and ensure greater access to care for people who speak languages other than English.

Federal matching funds under Medicaid and CHIP are available to assist states in paying for translation and interpretation services. 2010 Guidance from CMS laid out the options available to states to obtain federal reimbursement to help states assure meaningful access to covered services for members with limited English proficiency.[21] These options are particularly

[17] H.R.1319 - American Rescue Plan Act of 2021, introduced to the House on February 21, 2021. Obtained from https://www.congress.gov/bill/117th-congress/house-bill/1319/text/rh#toc-H702C1569357D49679ED1F137853E666E.

[18] Elizabeth A. Jacobs, et.al., *Impact of Interpreter Services on Delivery of Health Care to Limited-English-Proficient Patients*, 16 J Gen Intern Med., 468 (2001)

[19] Jane W. Njeru, et.al., *Emergency department and inpatient health care utilization among patients who require interpreter services*, 214 BMC Health Services Research (2015).

[20] Id., 2009; Mara Youdelman, *Medicaid and CHIP Reimbursement Models for Language Services*, NHeLP, 2017, https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf (last accessed 4/14/21).

[21] CMS guidance July 1, 2010, https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho10007.pdf); 42 USC (1397ee (a)(1); Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3; State Children's Health Insurance Program [hereinafter CMS Guidance].

compelling for children for whom enhanced reimbursement is available for translation and interpreter services in provider settings. We urge MassHealth to work with providers, health plans, and advocates in developing a payment model that will take advantage of available federal reimbursement to pay the costs for adequate interpreter and translation services at the point of care.

Expand CommonHealth Eligibility

In keeping with the eligibility and coverage focus of these comments, we also enthusiastically endorse the proposal advanced and discussed at greater length in comments by Health Care for All. This proposal would remove the CommonHealth work requirement and deductible for people with disabilities of all ages – both under age 65 and over 65. The plan would allow anyone who meets MassHealth's disability criteria to enroll in CommonHealth and pay a premium based on income, just as the CommonHealth program currently works for children. Not only would this proposal eliminate a major obstacle to retirement for disabled working people – the asset test under Standard for the 65 and older population – but it would also ensure access to coverage for disabled people, including those with behavioral health or intellectual disabilities, who truly cannot work 40 hours per month.

Thank you for the opportunity to make these comments. We look forward to seeing the draft proposal for the 1115 renewal later this summer, and of course we will be happy to supply any additional information regarding these recommendations.

Yours truly,

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