MLRI MASSACHUSETTS LAW REFORM INSTITUTE

September 9, 2023

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

Submitted by email to 1115WaiverComments@mass.gov

Re: Comments on MassHealth 1115 Demonstration Amendment Request

Dear Assistant Secretary Levine,

Thank you for the opportunity to submit comments on MassHealth's proposed Section 1115 waiver amendment released for public comment on August 2, 2023. These comments are submitted on behalf of the Massachusetts Law Reform Institute, on behalf of our clients.

We strongly support MassHealth's waiver amendment requests, which will expand coverage and services, and improve continuity of care. We make the following additional recommendations in furtherance of those shared goals.

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

We appreciate the agency's foresight in using 1115 authority now to facilitate the transition of One Care to a Medicare + Medicaid plan that will be operating under a different legal authority in January 2026. MLRI has endorsed the comments of Health Care for All concerning the 1115 amendments including its recommendation to allow for more flexibility for One Care beneficiaries to remain enrolled in One Care after age 65 than currently proposed. We look forward to continuing to work with the agency along with others in the disability community to identify what other uses of 1115 authority may be needed to preserve successful features of the One Care program in 2026.

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

We support the state's efforts to expand affordable coverage to more people through the ConnectorCare program. However, we hope EOHHS and the Health Connector will also revisit the burden of cost-sharing at the lower end of the income scale in ConnectorCare where someone with income $1 over 100% FPL or $1 over 200% FPL now faces a steep increase in out of pocket costs relative to income. The burden of cost-sharing on the low end of the income scale deters enrollment in ConnectorCare and, for those who do enroll, studies show even modest cost sharing at low-income levels deters the use of needed services.

3. **Increase income limit for Medicare Savings Program (MSP) Benefits for Members on MassHealth Standard to the State Statutory Limit**.

The Medicare Saving Program (MSP) is an important benefit for Medicare-eligible beneficiaries who do not qualify for full Medicaid coverage as well as those who do. We support the agency amending the demonstration to raise the MSP income limits to the statutory standards as proposed but urge it to go further as discussed in more detail below.

The current demonstration authorizes MassHealth to provide MSP to people eligible for Standard (without an asset test) but only up to 133% FPL for QMB and 165% FPL for SLMB/QI. Effective January 1, 2023, the state statutory limit for MSP raised the income standard to 190% FPL for QMB and 225% for SLMB/QI. Because MSP has been subject to an asset test, 1115 authority has been needed to extend MSP to certain individuals eligible for MassHealth Standard without an asset test without also obtaining asset information not needed under the MAGI rules. However, there is no reason why the 2023 MSP standards need to await an amendment to the demonstration to be applied to people on MassHealth Standard who *do* have an asset test and who are eligible for MSP, and we urge the agency to implement the 2023 MSP income limits for all non-MAGI individuals eligible for MassHealth Standard.[1]

<u>The agency should also request demonstration authority to increase the MSP benefits to people on CommonHealth to the state statutory limit</u>.

We were disappointed that EOHHS has not taken this opportunity to address MSP for people enrolled in CommonHealth and urge it to do so. In June 2021 EOHHS requested an amendment to provide MSP to individuals in both Standard and CommonHealth with income up to 165% FPL. CMS approved the request for Standard but took no action with respect to the request for CommonHealth. In September 2022 when CMS approved a 5-year extension of the waiver, this is what it said about the MSP waiver for people on CommonHealth:

> For CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth may pay the cost of the monthly Medicare Part B premium until June 30, 2026 ….Effective July 1, 2026, the Commonwealth must either discontinue the program, or have submitted and received approval of an amendment to the demonstration for a Part B premium subsidy design that is consistent with all applicable federal legal requirements.

According to the Medicaid director, the federal legal requirement CMS referred to was Section 1843 of the Social Security Act, (42 U.S.C. 1395v). This section authorizes states and the Secretary of HHS to enter into "buy in " agreements whereby "eligible individuals" may be enrolled in Medicare by the state and for whom the state may pay Medicare premium. Section

[1] MassHealth Standard members with an asset test are currently eligible for MSP with income up to 210% FPL. To be eligible at the QI income level of 210-225% FPL, individuals cannot also be eligible for a state plan benefit like MassHealth Standard. The current demonstration waives this QI limitation for people receiving a state plan benefit with income up to 165% FPL. Therefore, implementation of the 2023 standards for people eligible for Standard will not be able to include people at the new QI level at 210-225% FPL until an amendment of the waiver is granted.

1843 defines eligible individuals via specific cross-references to certain Medicaid eligibility categories but then gives states a broad option to include as eligible individuals anyone eligible under the Medicaid state plan or as "qualified Medicare beneficiaries" under MSP. CommonHealth is not an eligibility category described in the Massachusetts state plan (although it is related to an optional federal program for covering working people with disabilities).[2] Rather, it is a program operating under the 1115 "expenditure" authority. We assume CMS is taking the view that an "eligible individual" under 1843 cannot include an individual in a coverage group that is only under the 1115 expenditure authority and not in the state plan.

We urge the agency to take up CMS's invitation to submit an amendment for a Part B premium subsidy design consistent with all legal requirements. If we are right about the basis for CMS's 2022 objections, we offer three ideas for a Part B premium subsidy design consistent with Section 1843 that we urge the agency to consider and to include in its amendment request:

1). Section 1843 does recognize that individuals eligible under 1115 authority may be "eligible individuals" defined through a series of cross-references. CMS was taking too narrow a view of who may be an "eligible individual" for purposes of Section 1843 in September 2022 particularly in light of the federal regulatory update which took effect in January 2023.

a. Section 1843 defines "eligible individuals" who states may include in a "buy-in" agreement with the Secretary as including "qualified Medicare beneficiaries" and it cross-references to both Sections 1905p and 1902(a)(10)(E) to further define "qualified Medicare beneficiaries."[3] The section of 1902 cross-referenced in 1843(h) includes a further cross-reference to 1905p.[4] The cross-reference to 1905p (4) includes this provision which brings in eligible groups under an 1115 demonstration:

> In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the

[2] See. 42 U.S.C. § § 1396a (a)(10)(A)(ii)(XV), (XVI); 1396o (g).

[3] Section 1843(h) provides in pertinent part:

> (1) The Secretary shall, at the request of a State … enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include (A) individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX, or (B) qualified Medicare beneficiaries (as defined in section 1905(p)(1))….
>
> (3) In this subsection, the term "qualified Medicare beneficiary" also includes an individual described in section 1902(a)(10)(E)(iii).

[4] Section 1902(a)(10)(E)(iii) cross-referenced in 1843(h)(3) above provides in pertinent part:

> (iii) for making medical assistance available for Medicare cost sharing described in section 1905(p)(3)(A)(ii) ***subject to section 1905(p)(4)***, for individuals who would be qualified Medicare beneficiaries described in section 1905(p)(1) … (emphasis supplied).

same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

Thus, Section 1902(a)(10)(E) requires state plans to make assistance available for Medicare cost sharing for "qualified Medicare beneficiaries" under QMB, SLMB and QI as defined in 1905(p). In order to meet this requirement "in the same manner as if the State had in effect an approved state plan" the statute must be giving states authority to include people eligible under the 1115 expenditure authority as "eligible individuals" for purposes of Section 1843.

b. Recently effective federal regulations also support this reading of Section 1843 as giving a state the option to include all state Medicaid beneficiaries not just those in its state plan in its buy in agreement with the Secretary. Final rules modernizing Medicaid payment of Medicare premiums took effect on Jan. 1, 2023.[5] The regulations now provide for three groups of individuals eligible to be included in a state's buy-in agreement: Group 1 includes individuals who are categorically eligible for Medicaid and receive or are deemed to receive cash assistance; Group 2 includes individuals described in Group 1 and the three MSP eligibility groups (QMB, SLMB, and QI), and, in "Group 3: All Medicaid Eligibility Groups: This buy-in group includes all individuals eligible for Medicaid." 42 CFR 407.42. This definition of Group 3 is consistent with reading Section 1843 as including people eligible under an 1115 in addition to those eligible under the state plan as "eligible individuals" under Section 1843.

2). If CMS does not agree with that reading of the statute, there is another approach that may not require an 1115 amendment. Instead, the MassHealth agency simply needs to determine eligibility for MSP based on the MSP eligibility rules and allow individuals who are eligible for both CommonHealth and MSP to receive both. For dually eligible individuals under 65 on CommonHealth this would require supplementing the ACA-3 application with questions about assets.[6] For people 65 and older, the SACA-2 already asks for asset information and uses it in ruling out eligibility for Standard which is one of the eligibility criteria for CommonHealth.

Currently, MassHealth takes the position that disabled individuals enrolled in CommonHealth who demonstrate their eligibility for MSP by also completing the separate MSP application and supplying asset information or who are 65 or older and have supplied asset information as part of their CommonHealth application must choose between the two programs but cannot have both unless their income is under 135% FPL and they are covered under the current demonstration. However, CMS

[5] 87 Fed. Reg. 66454 (Nov. 3, 2022).

[6] This is consistent with the requirement of 42 CFR 435.911(c)(2) that the agency collect such additional information as may be needed to determine whether an individual is eligible for Medicaid on any basis other than the applicable modified adjusted gross income standard and furnish Medicaid on such basis.

guidance to states is clear that if individuals qualify for full Medicaid and for MSP, they should receive both:

> Individuals eligible as a QMB may also meet the separate requirements for another Medicaid eligibility group. In such cases, the individual is eligible for both groups, and therefore eligible for coverage of Medicare cost-sharing and any other state plan services available under the non-QMB group. [7]

MassHealth representatives have told us that despite this CMS guidance, they think CMS prohibits them from taking this approach. The 1115 amendment process is an opportunity for the state to clarify the applicable federal requirements for providing both benefits and seek a waiver if CMS deems it necessary. Clearly, there will be no problem with Section 1843 for CommonHealth members who have separately demonstrated their eligibility for MSP and are therefore unquestionably "eligible individuals" under that section of the Social Security Act.

3). Finally, the 2024 GAA directs the agency to disregard all assets in determining eligibility for MSP subject to federal approval. Section 47, Ch. 28, Act of 2023. Assuming the agency submits its request for a state plan amendment promptly, CMS is likely to approve it long before it acts on the 1115 amendment request. Once this amendment has been approved, there should be no impediment to individuals who qualify for CommonHealth without an asset test, as well as those who qualify for MassHealth Standard without an asset test, to also qualify for MSP. To the extent there is any doubt about that or if additional 1115 authority would facilitate system changes needed to implement the expansion, the agency should expressly ask for any 1115 amendment that it will need when there is no longer an asset test for MSP.

4. Remove the Waiver of Three Months Retroactive Eligibility

We applaud MassHealth's choice to come into alignment with almost all other states by ending its decades-long waiver of three-month retroactive eligibility. We understand that MassHealth plans to wait until a long-term system upgrade before implementing this change. We agree that it is better to have a full system upgrade than to rely on manual processing as a long term strategy. However, while the system upgrade is in development, we urge MassHealth to fill in the gap by implementing this change now as a manual process.

MassHealth has three years of experience implementing three-month retroactive coverage during the COVID public health emergency. Thus, MassHealth enrollment workers are already familiar with how to apply three months retroactive coverage manually. In terms of the CMS authority required to reinstate retroactive coverage, the other lesson from that period is that the state simply needed to notify CMS that it was not choosing to use its waiver authority, it did not need CMS to authorize it to refrain from waiving federal law.

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[7] CMS, Medicaid Program Implementation Guide, Qualified Medicare Beneficiaries, p. 2 (Jan 2020) https://www.hhs.gov/guidance/document/implementation-guide-qualified-medicare-medicare-beneficiaries

The benefits of restoring three-month retroactive eligibility are too great to delay implementation. It reduces the number of months that households are uninsured. It also reduces the burden of medical debt suffered by the poor. 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.

In addition to urging MassHealth to implement three-month retroactive coverage without delay, we also welcome the opportunity to learn more about how MassHealth intends to program three-month retroactive coverage into the system long-term. Ideally, the coverage date will be based on information gathered upon application and renewal (if the renewal is establishing new Medicaid eligibility), and the system will apply three months retroactive coverage without requiring further action by the applicant or MEC worker.

5. **Provide 12 months Continuous Eligibility to Adults and 24 months Continuous Eligibility for Members Experiencing Homelessness who are 65 and over.**

We strongly support MassHealth's request to expand 12-month continuous eligibility to all age groups, and to expand 24-month continuous eligibility for members experiencing homelessness to members 65 and over. This is a momentous policy improvement that will significantly reduce churn, improving continuity of care and health outcomes for MassHealth members, reducing medical debt, and relieving MassHealth's administrative costs.

When implementing this change, we urge MassHealth to carefully consider how these new continuous coverage benefits will work in combination with existing 12-month continuous coverage for the justice-involved and postpartum populations. When 12-month continuous eligibility for all adults is implemented, and 24-month continuous eligibility for the homeless is implemented (late this year for under 65, and pending CMS approval for over 65), it will be important to assure that an individual eligible for more than one of the continuous eligibility provisions has the benefit of the longest available period of continuous eligibility.

We look forward to working with the agency further on other ways that continuous eligibility can relieve member burdens and make coverage easier for members to use and understand. For example, continuous coverage for all members may be an opportunity to make better use of MassHealth member cards. With continuous coverage, there will be more certainty about the member's coverage dates and coverage type- this may make it practical to issue annual MassHealth member cards. Members are often confused about their MassHealth coverage and rarely know what type of coverage they have. This would reduce member confusion and also serve as a reminder of when their continuous coverage period ends, and they need to renew. It would also help members verify their MassHealth coverage to prove their eligibility for other

programs such as fee waivers, utility discounts, and categorical eligibility for other means-tested programs.

6. Include Short-Term Post Hospitalization Housing as an Allowable Health-Related Social Needs Service

We welcome MassHealth's proposal to support and expand medical respite/short term post hospitalization housing (STPHH) services for homeless individuals through the 1115 amendment. This is a much-needed service that requires a more stable funding source. However, a more broadly defined benefit will better meet the needs of these MassHealth beneficiaries and achieve the goals of STPHH to advance health equity, promote better health outcomes and permanent housing, and reduce total costs of care.

The proposal limits eligibility for medical respite services to MassHealth members enrolled in one of the MassHealth Accountable Care Organizations (ACOs). This excludes disabled and homeless individuals who are not eligible for ACOs because they are dually eligible for MassHealth and Medicare, as well as disabled homeless individuals who may be enrolled in other forms of mandatory managed care that are not ACOs such as the PCC Plan or the MCOs. This appears to exclude a sizable portion of the homeless population with complex medical needs that most need the services. It also excludes any homeless individual age 65 or older.

We understand that the STPHH will be funded as a Health-Related Social Need (HRSN) under the existing demonstration authority as described in Expenditure Authority 22 and Section 15 of the Special Terms and Conditions. However, neither of those two sections appear to limit HRSN to ACOs. In fact, STC 15.7 describes the delivery systems for HRSN as including the fee for service delivery system as well as managed care. Even the general exclusion of the elderly from the demonstration has exceptions for certain services such as diversionary behavioral health services and perhaps could also include an exception for medical respite. See, STC 4.9 Eligibility Exclusions.

A second proposed eligibility criteria for the medical respite benefit that seems far too narrow is the requirement that a MassHealth member is "[b]being discharged from a hospital after an inpatient stay or from an emergency department visit." A clinical criterion less narrowly focused on a recent hospital stay or ED visit would better address the varied circumstances of unhoused people with complex medical and behavioral conditions and be more consistent with the recently approved waivers in California and Washington state.

CMS approved the renewal of Washington State's waiver in July and it included new programs of Recuperative Care and Short-Term Post Hospitalization Housing. See, STC 15.3. The terms are defined differently. Recuperative care is for a shorter period of 90 days but does not appear to be limited to one episode and is not limited to a recent discharge from a hospital or other institutional setting. It requires a medical assessment that the individual is at risk of needing covered services. Short-Term Post Hospitalization Housing is related to a discharge from an

institution, can be for a longer term of up to 6 months but only for one 6-month period. Similarly, California's waiver also includes different definitions for what it calls Short Term Post Hospitalization Housing and Medical Respite. The former is for up to 6 months after being discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care. Medical Respite is for unhoused people who need to heal from an illness or injury.

We urge MassHealth to take a closer look at the scope of the STPHH limitations and define the eligibility criteria more broadly with respect to ACO membership, and the need for a hospital discharge or ED visit and other limitations in the proposed criteria in order to create a more robust and flexible service to meet the needs of unhoused people with complex medical needs.

7. **Increase the Expenditure Authority for the Social Service Organization Integration Fund**. We support this provision.

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

We strongly support this initiative and, along with the Center for Health Law and Policy Innovation and other organizations have submitted separate comments addressing it. In these separate comments we make five recommendations intended to improve and strengthen the agency's proposal on pre-release services and the successful implementation of this important reform.

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Thank you for the opportunity to submit these comments. If you have further questions, please contact Vicky Pulos at vpulos@mlri.org or 617-357-0700 ext. 318, or Kate Symmonds at ksymmonds@mlri.org or 617-357-0700 ext. 349.

Yours truly,

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