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ALERT ▪ Health Care

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Massachusetts' Section 1115 Waiver Approval: Full Court Press on Health-Related Social Needs and Value-Based Care

I. Background and Overview

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On September 28, 2022, Center for Medicare & Medicaid Services ("CMS") and the Massachusetts Executive Office of Health and Human Services ("EOHHS") announced the approval of the Commonwealth's latest 1115 Medicaid waiver amendment ("Waiver"). The Waiver is a significant milestone in Massachusetts' Medicaid program and will impact every aspect of care delivery in the Commonwealth. The Waiver also serves as a harbinger for the types of investments CMS and the state Medicaid program will be making for years to come. The multibillion-dollar Waiver is effective October 1, 2022 through December 31, 2027, but many critical details—including the total incremental federal funding available—remain subject to further clarification, development and negotiation between EOHHS and CMS.

Key takeaways from the waiver include:

- **ACOs and Value-Based Care Are Here to Stay.** CMS has verified the early success of the unique Accountable Care Organization ("ACO") structure in Massachusetts, which has been a hallmark of the Commonwealth's Medicaid-managed care program since approval of the prior Waiver in 2017. ACOs will be the pathway through which Massachusetts integrates other new components of the Waiver, including Health-Related Social Needs ("HRSN"), expanded value-based care models, and new behavioral health interventions, into the delivery system.
- **Funding for Health-Related Social Needs.** No longer called the "social determinants of health," CMS is making significant new investments in HRSN services, building on prior waiver approvals in other states like California, North Carolina, and Oregon, which demonstrates a willingness to reimburse for nontraditional Medicaid services and providers, particularly as it relates to food, housing insecurity, and enhanced care management.
- **New Hospital Funding.** The Waiver continues to serve as a critical authority for the funding of safety net hospitals in Massachusetts, with substantial incremental funding being directed to private acute care hospitals in the Commonwealth that serve Medicaid and uninsured populations and achieve incentive targets for quality and health outcomes on measures that are focused on reducing disparities and promoting health equity. Additional funding will be made available to hospitals under the balance of the Delivery System Reform Incentive Payment ("DSRIP") program to further previous investments to transition hospitals to value-based care made under the prior waiver.
- **Direct Investments of Workforce.** Given the impact of the COVID-19 pandemic on staffing within the health care industry, the Waiver includes a number of novel investments in workforce development initiatives, including loan repayment, residency training, and similar initiatives that diversify and expand the provider community, especially in primary care and behavioral health.
- **Needed Details Are Coming.** Scant details on implementation are included in the Waiver, with most attachments being "reserved" for future development, which will tell ACOs, managed care organizations, providers, and others how these new investments and programs will be operationalized, including funds flows, data reporting, and quality measures. As protocol development continues in the coming months, investors and service providers should contemplate how new and existing technologies can create the necessary infrastructure

for HRSN-related services including data interoperability, social care provider networks, fee schedule development for HRSN services, and health care staffing.

II. Components of the 1115 Waiver Amendment

Massachusetts submitted the Waiver application to CMS in June 2021; funds will be reinvested and distributed, in part, as follows:

a. **Hospital Quality and Equity Initiative ("HQEI"):** Each year for the next five years, Massachusetts private acute care hospitals and Cambridge Health Alliance will receive $400 million and $90 million, respectively, to reduce health inequities by strengthening and improving quality and health outcomes. Participating hospitals can earn performance-based incentive payments for meeting data collection requirements and certain standards tailored to improvement in health care quality and equity. CMS must approve the Commonwealth's HQEI Implementation Plan describing activities to occur during 2022 and 2023. More details on performance expectations and incentive payments will be further specified in the HQEI Implementation Plan when it is released.

   HQEI Funds will be used for the following purposes:

   i. **Data Collection Incentive (25%):** Participating hospitals are incentivized to improve completeness of demographic data pertaining to their beneficiary populations, screening for health-related social needs, and improving health outcomes. Hospitals will be assessed on the completeness of data. This component is significant as accurate demographic data has been challenging for states to collect—as self-reported data is often incomplete or inaccurate—but critical as demographic information, especially on race and ethnicity, is necessary to stratify quality measures, which is contemplated by other parts of the program.

   ii. **Equitable Access and Quality Performance-Based Incentives (50%):** Participating hospitals are eligible to earn performance-based incentive payments based upon improvement on measures identified jointly by Massachusetts and CMS. Hospitals will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access including access for individuals with disabilities and/or limited English proficiency; access to preventive, perinatal, and pediatric care services; access to care for chronic diseases and behavioral health; and care coordination.

   iii. **Workforce Competence Incentives (25%):** Participating hospitals are incentivized to improve workforce competence to enhance their ability to provide accessible and culturally appropriate services based upon health status and health needs, and thereby more effectively address gaps in access to and quality of care. This component includes improving service capacity, workforce development, and health system collaboration to improve quality and reduce disparities.

b. **HRSN Services:** MassHealth will broaden the availability of HRSN services that promote coverage, access to and quality of care, improve health outcomes, reduce health disparities, and create long-term, more cost-effective alternatives or supplements to traditional medical services. Expenditures are limited to those for items and services not otherwise covered under traditional Medicaid, but consistent with Medicaid demonstration objectives. Services include housing support (e.g., security deposits/rent, relocation expenses, furniture, air conditioning/filtration, and home modifications), case management, outreach, and education including linkages to other state and federal benefit programs, nutrition support (e.g., counseling and meals for up to six months) and transportation to housing and nutrition support services. Those eligible for these services include MassHealth ACO-enrolled members ages 0 to 64 who meet certain clinical criteria and certain MassHealth beneficiaries experiencing homelessness, individuals with justice involvement (e.g., released from a correctional institution within one year), and members with behavioral health needs who are facing eviction due to a behavioral health condition. Individuals must have a documented medical need for the services, and the services must be determined to be medically appropriate. More details around HRSN services will be set forth in a HRSN

Implementation Plan. CMS authorized up to $8 million in expenditure authority to operationalize the services, but the total funding for these services will be far more than the costs of implementation.

c. **DSRIP Funding:** CMS authorized up to $1.8 billion in one-time DSRIP funding to support the transition to accountable care. Approximately $1 billion in funding will be distributed to ACOs, which will include:

   i. *Primary Care.* Investments in primary care including capital investments (e.g., inter-operable EHR systems), trainings and additional administrative staff calculated on a PMPM basis.

   ii. *Discretionary.* Discretionary spending (health information technology, contracting/network development, project management, and care coordination/management investment, assessments for members with identified LTSS needs, workforce capacity development and new or expanded telemedicine capability) calculated on a PMPM basis.

   iii. *Flexible Services.* Flexible services used to address HRSN by providing supports that, subject to certain conditions, are not currently reimbursed by MassHealth or other publicly funded programs calculated on a PMPM basis.

   iv. *Safety Net Hospital Restructuring.* Restructuring of demonstration funding for safety net hospital systems to be more sustainable and aligned with value-based care delivery and payment incentives.[1] Massachusetts will provide transitional DSRIP funding to safety net hospitals to create a sustainable transition from current funding levels to new, reduced levels. The remainder of the DSRIP authorization is for behavioral health and long-term services and supports community partnership.

d. **Value-Based Primary Care Structure:** Providers offering certain primary care services to Primary Care ACO-enrolled beneficiaries will receive a prospective payment and will not otherwise be eligible for a fee-for-service payment. Under this model, primary care practices (PCPs) are expected, for example, to work towards enhanced team-based care, behavioral health integration, and a more integrated primary care system. The shared savings payments to participating Primary Care ACOs may allow or require the Primary Care ACOs to distribute some portion of shared savings to or collect shared losses from select service providers that span outside the rules for traditional value-based care and managed care.[2] Providers participating in either the PCC Plan or a Primary Care ACO are also eligible to receive an additional case management fee on top of the shared savings payments. Additional details will be published in the Primary Care Payment Protocol to be approved by CMS.

e. **Provider Workforce Recruitment and Retention:** In efforts to reduce shortages of qualified health care providers and expand access to care, CMS authorized a primary care and behavioral health provider student loan repayment program and a family nurse practitioner residency program. Providers enrolled in these programs must provide services in community-based settings that serve substantial Medicaid and uninsured populations. The student loan repayment programs range from $50,000 - $300,000 per practitioner, depending on degree. The residency grant program supports up to 10 family nurse practitioner residency slots for four years in certain community health centers. Funding for these workforce programs is capped at approximately $43 million over the next five years.

f. **Funding for Serious Mental Illness ("SMI") and Serious Emotional Disturbance ("SED") + SUD:** CMS authorized funding for SMI and SED services including for short-term residents of facilities that are considered "Institutions for Mental Diseases" ("IMD"), and are otherwise carved out from the Medicaid program. Community crisis stabilization will be available to most MassHealth members, and community-based acute treatment will be available to all children and adolescents enrolled in a managed care plan. Massachusetts must achieve a statewide average length of stay of no more than 30 days in an IMD treatment setting – these services are subject to approval of an SMI/SED Implementation Plan. CMS also authorized funding for expenditures for SUD and SMI treatments services and ongoing recovery support.

g. **Eligibility Changes:** Among other changes, CMS authorized (i) continuous eligibility for at least 12 months for members experiencing homelessness and members recently released from a correctional institution, and (ii) streamlining the CommonHealth adult eligibility process and eliminating the one-time deductible for certain individuals.

III. Commonwealth Requests Not Contained in the Waiver

a. **Improve and Strengthen Access to Care and Health Outcomes for Individuals Enrolled in Medicaid.** Massachusetts requested coverage expansion for certain individuals in juvenile justice facilities during their commitment and for justice-involved adults 30 days prior to being released from carceral settings. While CMS expressed general support for these services, it did not approve the proposal. Massachusetts noted that its proposal to provide pre-release transition supports for justice-involved members is pending federal guidance for all states and is expected in late 2022 or early 2023.

b. **Continued Authority to Operate Hospital at Home Programs.** Massachusetts requested extension of CMS's Hospital at Home program, which permits payment for clinic services delivered via telehealth (when neither the provider nor member is at the clinic) and in other non-clinic locations. CMS declined this request but noted it will continue to review it.

Funding

Unlike waivers approved in other states, this Waiver does not expressly identify the incremental funding made available by CMS. Rather, EOHHS notes that the Waiver approval constitutes a $67.2 billion agreement between the Commonwealth and CMS; however, this number includes gross expenditures under the prior Waiver programs, including the entirety of ACO spending in the Commonwealth. Accordingly, the total incremental or "new" spending for this Waiver is more modest but will likely result in an increase of at least $4 billion of total new gross computable federal spending on MassHealth over the five-year term of the Waiver, and without counting any new investments in HRSN.

Conclusion

Overall, the Waiver suggests a collective desire for significant investment in HRSN services and aligns with recommendations identified in the State Attorney General's report on Racial Justice and Equity in Health and the EOHHS Roadmap to Behavioral Health Reform. However, many details around implementation are deferred to future negotiations between the state and CMS[3] and will likely take place in the coming year by way of the state's budget negotiation process. Given the substantial new investments being made in all aspects of the delivery system, but especially in HRSN, behavioral health, primary care and value-based care, payors, providers, investors, service providers, and convenors in the health care industry should monitor and be engaged in the protocol development process over the coming year. Approval of this Waiver by CMS is a significant development for health systems, health plans, and investors in markets outside of Massachusetts, as it conveys a willingness by CMS to once again use its broad 1115 waiver authority to make new federal investments that support safety net and financially distressed hospitals, especially for health systems that operate in underserved, high-Medicaid areas, and expand Medicaid coverage to both new populations and new service offerings, such as HSRN and behavioral health. This Waiver also likely serves as strong indication that pending 1115 waiver amendments, including New York's waiver submitted in September 2022, will receive similar approvals from CMS in the near future and collectively represent an exciting new opportunity for health care innovation and the development of new care models.

For more information, please contact one of the authors or your usual Ropes & Gray advisor.

Links/Resources

- MassHealth Demonstration Approval Letter dated Sept. 28, 2022.
- Fact Sheet: MassHealth's Newly Approved 1115 Demonstration Extension Supports. Accountable Care and Advances Health Equity dated September 2022.
- Press Release: Baker-Polito Administration, Centers for Medicare and Medicaid Services Announce Five Year, $67.2 Billion Agreement for MassHealth Reforms dated Sept. 28, 2022.

1. The seven safety net hospitals currently receiving funding through the DSTI program will instead receive a reduced amount of ongoing operational support through Safety Net Provider payments authorized under the state's restructured Safety Net Care Pool.
2. *See* 42 C.F.R. § 438.
3. 18 of the 23 Waiver attachments, which provide specificity for implementation, are "Reserved," meaning, they are still being developed and are subject to additional approval by CMS.