

**COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**One Ashburton Place, 11th floor
Boston, MA 02108**

**The HEALTH EQUITY INCENTIVES FOR CERTAIN MASSHEALTH
HOSPITAL, MANAGED CARE AND RELATED PROGRAMS
REQUEST FOR INFORMATION**

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REQUEST FOR INFORMATION

**REGARDING HEALTH EQUITY INCENTIVES FOR CERTAIN MASSHEALTH
HOSPITAL, MANAGED CARE AND RELATED PROGRAMS**

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Section 1: Introduction

The Executive Office of Health and Human Services (EOHHS) is the single state agency responsible for the administration of the Medicaid program and the State Children's Health Insurance Program within Massachusetts and other health and human services programs designed to pay for medical services for eligible individuals pursuant to M.G.L. c. 118E, Title

XIX of the Social Security Act (42 U.S.C. sec. 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. sec. 1397aa et seq.), and other applicable laws and waivers.

EOHHS is issuing this Request for Information (RFI) to solicit information regarding health equity and social risk factor data collection and the identification, prioritization, and reduction of disparities in health and health care, and related accountability. MassHealth may use responses it receives to this RFI to inform its continued efforts to reduce health inequities among its members.

EOHHS seeks comments from all interested parties, including but not limited to organizations or individuals with experience identifying and addressing health and health care disparities, health plans (including those contracted with MassHealth), other payers of health care, Community Partners, MassHealth members, and providers. Please feel free to respond to only those questions on which you would like to provide input. Please submit your response, according to the instructions provided in **Section 5, no later than December 17, 2021**. EOHHS encourages you to respond and thanks you in advance for your participation.

Section 2: Overview

MassHealth provides health coverage to more than two million Massachusetts residents, including families, individuals with disabilities, children, low-income adults and older adults. MassHealth covers services that commercial insurance typically covers, plus other benefits such as long-term services and supports (LTSS) and additional behavioral health services. MassHealth's mission is to improve the health outcomes of our diverse members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life.

MassHealth is committed to health equity. Health equity has been defined to mean that every person has the opportunity to be as healthy as possible and that socioeconomic position or other socially determined circumstances do not hinder anyone from achieving this potential.¹ MassHealth has, over the last several years, implemented focused efforts to address health disparities, including the Flexible Services Program and the Disability Access Incentive Program, and by incorporating community-level social determinants of health into risk adjustment for the accountable and managed care rate setting process, among other efforts.

Over the next five years and as part of the renewal of its Section 1115 demonstration, MassHealth proposes building on these past efforts through significant new investments in health equity. For example, MassHealth intends to add doula services as a covered service under its State Plan and is proposing providing 12 months of postpartum eligibility for all members. The Commonwealth is also proposing additional supports for incarcerated individuals to improve the continuity of care and support transitions following release from incarceration. Further, MassHealth intends to enhance accountability for health equity for its contracted health system entities including but not limited to Managed Care

¹ NASEM (National Academies of Sciences, Engineering, and Medicine). Accounting for social risk factors in Medicare payment: Identifying social risk factors. Washington, DC: The National Academies Press; 2016.

Organizations (MCOs), Accountable Care Organizations (ACOs), Community Partners (CPs), hospitals, and MassHealth’s managed behavioral health vendor.² While multisectoral efforts will be necessary to address health inequities, health systems serving MassHealth members must contribute by ensuring equitable access and universally high-quality care to all people regardless of their individual characteristics.

Section 3: Questions for Response

MassHealth seeks information related to the following areas in which MassHealth may take action to reduce inequities in health and health care impacting its members:

- 1) Enhancing understanding of and attention to inequities through collection of standardized, member-level data on social risk factors, defined as individual-level social attributes or exposures that increase the likelihood of poor health³, including race, ethnicity, language, disability status, gender, sexual orientation, and gender identity; and
- 2) Identifying inequities and prioritization for action; and
- 3) Developing and refining policies to enhance accountability for health equity for MassHealth contracted health system entities including but not limited to MCOs, ACOs, CPs, hospitals, and MassHealth’s managed behavioral health vendor.

Please respond to any of the following questions:

1. Enhancing Understanding of and Attention to Social Risk Factors

- a. What social risk factor data should MassHealth collect and/or require its contracted health system entities (e.g., MCOs, ACOs, CPs, hospitals, managed behavioral health vendor) to collect?
- b. What benefits and/or risks to collecting social risk factor data on MassHealth members should MassHealth consider? If any risks, how should MassHealth mitigate those risks?
- c. How should MassHealth most efficiently and accurately increase the completeness of its social risk factor data for members?

² MCOs are health plans run by insurance companies that provide care through their own provider network that includes primary care providers (PCPs), specialists, behavioral health providers, and hospitals.

ACOs have groups of PCPs and other providers who work together to improve member care coordination and better meet overall health care needs and who are accountable for the quality, member experience, and total costs of care.

Community Partners are community-based organizations that collaborate with ACOs and MCOs to provide care coordination and care management supports to individuals with significant behavioral health and/or complex long-term services and supports needs.

³ Green G, Zook M. “When Talking About Social Determinants, Precision Matters, ” Health Affairs Blog, October 29, 2019.

- i. Using a five-year timeline from calendar year 2023 (CY2023) to CY2027, when should MassHealth and/or its health system partner entities be expected to achieve more complete and accurate self-reported member-level data on social risk factors? What threshold level of completeness should be targeted for year one of the five-year period? Year three? Year five? Please describe your reasoning.
 - 1. Should a member response of “choose not to answer” for a social risk factor count towards any future data completeness thresholds for contracted health system entities? Why or why not?
- ii. Before complete self-reported data are available, should MassHealth consider alternative approaches to estimating social risk factors at the individual and/or population levels (e.g., through imputation, use of administrative data such as claims, etc.)? Why or why not?
- d. MassHealth is considering updates to the data standards that it uses *internally* for member-level data related to social risk factors. Data standards being considered are detailed in “**Appendix A: MassHealth RELD, Gender & SOGI Data Standards**”.
 - i. What feedback do you or your organization have on the proposed data standards that are detailed in Appendix A?
 - ii. What alternative standards, if any, should MassHealth consider using (including any standards currently in use in your organization)?
 - iii. Should MassHealth require its health system partner entities to use the same standards? Why or why not?

2. Identification of Inequities and Prioritization for Action

- a. What are the most critical health and/or health care inequities that are experienced or observed by you, your organization, or your community?
- b. What strategies should MassHealth use to identify health inequities impacting its members?
 - i. MassHealth intends to stratify performance data by social risk factors to identify inequities.
 - 1. What criteria should MassHealth use to select performance metrics for stratification by social risk factors?
 - 2. How should MassHealth determine which performance metric stratifications it will perform first?
 - ii. What other strategies should MassHealth pursue to identify health inequities impacting its members?

- c. What factors should MassHealth consider when prioritizing interventions to address inequities (e.g., size of population impacted, magnitude of disparity, presence of specific social risk factors, etc.)?

3. Enhancing Accountability for Health Equity

- a. How should MassHealth hold its contracted health system entities (e.g., MCOs, ACOs, CPs, hospitals, managed behavioral health vendor) accountable for promoting health equity? Including but not limited to:
 - i. Contract requirements
 - 1. What contract requirements should MassHealth consider continuing, changing, or introducing, for MassHealth contracted health system entities related to health equity?
 - ii. Public reporting
 - 1. Should MassHealth publicly report health equity performance data for its contracted health system entities? If so, why?
 - 2. What conditions would need to be in place for public reporting to be introduced?
 - iii. Payment incentives
 - 1. Pay-for-Reporting⁴

MassHealth intends to hold certain health system entities financially accountable for identification and monitoring of health inequities (e.g., through stratified reporting of quality metric performance by social risk factors) within the early years of the 5-year period between CY2023 to CY2027 (the 1115 demonstration extension period).

 - a. What conditions would need to be in place to introduce financial accountability for stratified reporting and how should MassHealth promote achievement of those conditions?
 - b. On what time frame should financial accountability for stratified reporting be introduced, assuming a five-year timeline from CY2023 to CY2027? How might this differ by metric and/or social risk factor?
 - 2. Pay-for-Performance⁵

MassHealth intends to hold certain contracted health system entities financially accountable for reduction of health inequities

⁴ Pay for Reporting (P4R), comprises payment models that attach financial incentives/ disincentives (e.g., bonus, payment reduction) to reporting. P4R may tie reimbursement to complete, timely, and accurate reporting of metric-driven outcomes, best practices (process measures), or member experience.

⁵ Pay for Performance (P4P), also known as value-based payment, comprises payment models that attach financial incentives/disincentives to performance. P4P ties reimbursement to metric-driven outcomes, best practices (process measures), and member experience, aligning payment with value and quality.

within the 5-year period between CY2023 to CY2027 (the 1115 demonstration extension period).

- a. What conditions need to be in place (e.g., thresholds of data completeness) to introduce financial accountability for reducing health inequities?
 - b. On what time frame should accountability for reduction of health inequities be introduced, assuming a five-year timeline from CY2023 to CY2027? How might this differ by metric and/or social risk factor?
 - i. What should MassHealth consider in terms of the time lag between actions taken to reduce inequities and observed outcomes?
 - c. How should “success” in reducing inequities be defined for the five-year period between CY2023 to CY2027?
- b. Other: How can MassHealth ensure contracted health system entities that serve a disproportionately socially at-risk population are not unfairly impacted by the introduction of enhanced accountability for health equity?

Note: MassHealth is fielding a separate RFI specific to member engagement including as it relates to health equity. As such, questions about member and community engagement are not included in this RFI. This member engagement RFI can be found at www.commbuys.com.

Section 4: RFI Respondent Information

Please respond to the following questions with respect to the Respondent:

1. What is your name, organization, address, email address, and URL (if applicable)?
2. What is your affiliation or interest? Specifically, are you an advocate/advocacy organization, community member, Community Partner, consumer/patient, government organization, health care consultant, health care provider, health plan, payer, professional association/trade group, vendor, or some other entity?
3. What is your role in the health care system?
4. If applicable, in what geographic areas in Massachusetts do you provide services? If applicable, in what geographic areas outside of Massachusetts do you provide services?

Section 5: RFI Response Instructions

A. Response Submission Instructions

All responses to this RFI are due **no later than December 17, 2021**. Responses may be submitted in one of the following ways:

- By email to:** Amy.Butcher@mass.gov, placing “Health Equity Incentives RFI” in the subject line; or

- In writing to:**
Amy Butcher
Procurement Coordinator
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108
RE: Health Equity Incentives RFI

B. Format

All parties interested in responding to this RFI (Respondents) should use the “Health Equity Incentives RFI Response Template”, attached hereto as **Attachment B**. The questions in the template are identical to the questions found in Sections 3 and 4 of this RFI. Respondents should prepare an electronically submitted response or a typewritten response to the questions listed in Sections 3 and 4 above, using the Health Equity Incentives RFI Response Template (**Attachment B**). EOHHS prefers to receive electronic submissions but will also accept typewritten responses. Any typewritten response should be double-sided/single-spaced. Parties responding in hard copy should submit one copy of their Response.

Interested parties are invited to respond to any or all of the RFI questions; please respond to as many as you feel are appropriate. Responses, including the template and any attachments thereto, should be clearly labeled and referenced by name in the RFI response documents.

Section 6: Additional RFI Information

A. COMMBUYS Market Center

COMMBUYS is the official source of information for this RFI and is publicly accessible at no charge at www.commbuys.com. Interested parties are solely responsible for obtaining all information distributed for this RFI via COMMBUYS. It is each interested party’s responsibility to check COMMBUYS for any amendments, addenda, modifications to this RFI and any related document. The Commonwealth accepts no responsibility and will provide no accommodation to interested parties who submit a Response based on out-of-date information received from any source other than COMMBUYS. Interested parties may elect to obtain a free COMMBUYS Seller subscription which provides value-added features, including automated email notification associated with postings and modifications to COMMBUYS records. To learn more about the

COMMBUYS system, please visit the [COMMBUYS Resource Center](#). Questions specific to COMMBUYS should be made to the COMMBUYS Help Desk at OSDHELPDESK@MASS.GOV.

B. Communications

Interested parties are prohibited from communicating directly with any employee of EOHHS or any of its constituent agencies with regard to the subject matter of this RFI except as specified above, and no other individual Commonwealth employee or representative is authorized to provide any information or respond to any question or inquiry concerning this RFI. Interested parties may contact the RFI contact person in **Section 5.A** above in the event the interested party is having trouble obtaining any documents or attachments electronically through COMMBUYS.

C. RFI Amendments

Interested parties are solely responsible for checking COMMBUYS for any addenda or modifications that are subsequently made to this RFI. The Commonwealth and its subdivisions accept no liability and will provide no accommodation to interested parties who fail to check for amended RFIs.

D. Costs

By submitting a Response, Respondents agree that any cost incurred in responding to this RFI, or in support of activities associated with this RFI, shall be the sole responsibility of the Respondent. EOHHS shall not be held responsible for any costs incurred by Respondents in preparing their respective Responses to this RFI.

E. Use of RFI Information

Please note that this RFI is issued solely for the purpose of obtaining information. The RFI does not obligate EOHHS to issue a RFR nor to include any of the RFI provisions or responses in any RFR. No part of the response to this RFI can be returned. Receipt of RFI responses will not be acknowledged.

Information received in response to this RFI shall serve solely to assist the Commonwealth in the development of policy. No information received in response to this RFI is binding on the Commonwealth or any of its agencies. Responding to this RFI is voluntary and will not affect consideration of any proposal submitted in response to any subsequent procurement or solicitation. Responses to this RFI become the property of the Commonwealth of Massachusetts and, except as otherwise provided in section 3 of this RFI, or in this section 4.B., are public records under the Massachusetts Freedom of Information Law, M.G.L.c.66, section 10 and c.4, section 7, clause 26, regarding public access to such documents. Information provided in response to this RFI and identified by the Respondent as trade secrets or commercial or financial information, or which EOHHS has determined is such, shall be kept confidential to the extent permitted by law and shall be considered by EOHHS as exempt from disclosure as a public

record (see Massachusetts General Laws, Chapter 4, section 7(26)(g). This exemption may not apply to information submitted in response to any subsequent procurement solicitations.

Responses to this RFI may be reviewed and evaluated by any person(s) at the discretion of EOHHS, including independent consultants retained by EOHHS now or in the future. EOHHS retains the right to request additional information from any Respondent. EOHHS may, at its sole discretion, elect to request formal presentations from certain Respondents and/or create an RFR based, at least in part, on the Responses received from this RFI. EOHHS may request further explanation or clarification from any and all Respondents during the review process.

F. Information Regarding Procurements

Information regarding EOHHS procurements, including but not limited to Requests for Responses for ACOs, CPs, and the MassHealth behavioral health vendor, will be posted on COMMBUYS. Interested parties should check COMMBUYS for procurement information. Procurement information will not be provided in response to this RFI.

Attachments

Attachment A: MassHealth RELD, Sex, and SOGI Data Standards

Attachment B: RFI Response Template

ATTACHMENT B – RFI RESPONSE TEMPLATE

Please use this template to respond to the questions contained in the RFI. The questions in the template are identical to the questions found in **Sections 3 and 4** of the RFI. *Interested parties are invited to respond to any or all of the questions; please respond to as many as you feel are appropriate.*

SECTION 3.1 Enhancing Understanding of and Attention to Social Risk Factors

- a. What social risk factor data should MassHealth collect and/or require its contracted health system entities (e.g., MCOs, ACOs, CPs, hospitals, managed behavioral health vendor) to collect?

MassHealth should require its contracted health system entities to collect race, ethnicity, language, disability status, geographic information, housing status/instability, gender identity, sexual identity, referred eligibility status, literacy level, SNAP participation and food instability, and state agency involvement.

- b. What benefits and/or risks to collecting social risk factor data on MassHealth members should MassHealth consider? If any risks, how should MassHealth mitigate those risks?

A recent December 2021 report by the Blue Cross Blue Shield of Massachusetts Foundation, [*Racism and Racial Inequities in Health: A Data-Informed Primer on Health Disparities in Massachusetts*](#), reported racial and ethnic disparities in household income, child poverty, food insecurity, housing stability, educational status, and English proficiency in Massachusetts. Such social determinants of health, or social risk factors, impact health access and outcomes more than medical care and point to structural and systemic deficits across housing, education, legal, and healthcare systems. Improved collection of social risk factor data would enable MassHealth to better understand health disparities and trends in access, utilization, and outcomes as well as risks, inequities and protective factors stratified by social risk factors. This data may allow for targeted interventions, policy solutions, and a clearer understanding of areas of programmatic success and failure.

Risks may include privacy and data sharing concerns, and sensitivity with answering some of the questions. There may be many reasons why an individual is hesitant to share information or shares incomplete information. In behavioral healthcare, this includes hesitancy caused by historic discrimination and racial bias in healthcare, differential access and provision of behavioral health services, and the criminalization of substance use, particularly within the Black community. In addition, children/adolescents may not be comfortable answering all questions with a guardian present, or may not know how to answer all questions.

MassHealth may mitigate risk by having a standard disclosure and consent process that is accessible, easy to understand, offered in a wide variety of languages, and voluntary. The consent process should detail how information will be used and how data will be de-identified and used in the aggregate. The consent process should also incorporate care that is not only culturally and linguistically competent, but also takes into

consideration an individual's literacy level and any existing cognitive impairments that may impact comprehension and consent.

Some questions may require that a supportive relationship be established between a person served and a provider, which may mean allowing for the flexibility to return to questions later to get the appropriate response. Questions or completion expectations may differ based on whether an individual is a child, adolescent, or adult. To implement effectively, MassHealth must invest in a diverse workforce that speaks members' preferred languages and understands their culture and should also offer provider education about how to explain the reasons for data collection that addresses existing biases among providers.

Another risk is the cost to providers to collect this data and adjust their electronic health records (EHRs) to capture this data. MassHealth can mitigate this risk by providing funding to support these efforts. This must include technical assistance and training, funding for staff time, as well as funding for data collection and reporting infrastructure. MassHealth must also develop their own infrastructure in order to accept electronic files and have EHR interoperability in order to limit and/or eliminate redundancy of data entry. Successfully implementing robust data collection measures and EHR interoperability will be hampered if costs are passed on to providers.

Other risks involve the ability of MassHealth systems to ingest, aggregate, analyze, and report this data and to do so in conjunction with utilization and outcomes data. MassHealth can mitigate these risks by investing in the necessary internal systems and expertise.

- c. How should MassHealth most efficiently and accurately increase the completeness of its social risk factor data for members?

MassHealth should establish a clear and standardized data set and clear and standardized definitions to ensure that health care entities are collecting comparable data, including assessment of existing standardized tools for measuring social determinants of health and embedding factors into clinical practice. MassHealth might consider technical assistance for health care entities on data collection and how to engage with clients in dialogue around social risk factors to improve completeness and accuracy of the data reported. MassHealth should obtain robust input from members and advocates to design the data set and develop strategies to engage members to feel comfortable sharing this information.

- i. Using a five-year timeline from calendar year 2023 (CY2023) to CY2027, when should MassHealth and/or its health system partner entities be expected to achieve more complete and accurate self-reported member-level data on social risk factors? What threshold level of completeness should be targeted for year one of the five-year period? Year three? Year five? Please describe your reasoning.

It will be important that healthcare entities work with community-based provider entities who are closest to the member, particularly members who experience inequities in access and outcomes related to health. Those community providers

will need to be resourced to enhance and streamline their data collection and reporting capabilities. This is a core principle in the Learning & Action Network (LAN) [Alternative Payment Model Framework](#) that states, “to the greatest extent possible, value-based incentives should reach providers across the care team that directly delivers care.” As such, it will be important that resources and incentives are shared across the system, with emphasis on those directly involved with the member.

It is also crucial to accept that equity does not mean equal sharing of resources; it means identifying gaps in resources and targeting those areas where there are deficits. An equitable system will recognize that some providers are further along in the development of their EHR data collection and reporting systems, while others may need more time and resources to achieve this goal. In particular, smaller organizations that often work with traditionally under-served populations will likely require more funding, technical assistance and more time.

Following the LAN framework for value-based purchasing, MassHealth might consider introducing a value-based payment construct that offers infrastructure investment with bonus incentives based on completeness. This construct would resource providers to build up their data reporting capabilities while implementing threshold levels of completeness over the proposed five year period as they strive to earn incentive payments.

Under the current Section 1115 Demonstration, through statewide investment projects and infrastructure funding, ACOs/MCOs, and Community Partners were resourced to develop and enhance their systems to advance initiatives and interventions with a population health lens. Other parts of the service delivery system, including components of the ACOs/MCOs’ and CPs’ continuums of care, did not have access to this infrastructure funding. In addition to financial resourcing, technical assistance was critical to supporting these efforts in the ACO/MCO and CP programs and it will be critical to ensuring data collection consistency and improving data completeness going forward. Learnings from the current demonstration revealed that establishing the system wide infrastructure for such initiatives required more resources and time than initially anticipated. For example, the infrastructure funding disbursement was increased for the first years of the CP program based on providers’ needs. This approach will require iteration as well.

As the initiative advances, MassHealth might consider advancing to APMs that offer shared savings for identified health equity metrics.

1. Should a member response of “choose not to answer” for a social risk factor count towards any future data completeness thresholds for contracted health system entities? Why or why not?

Yes, the response should count. There are legitimate reasons why an individual may feel uncomfortable or unwilling to share social risk factor information, and that should not count against data completeness thresholds. Consistent lack of data for certain factors may instead represent an

opportunity to improve risk mitigation efforts, strategize more effective approaches to collecting the missing data and prompt further engagement with both providers and members to better understand gaps in responding.

- ii. Before complete self-reported data are available, should MassHealth consider alternative approaches to estimating social risk factors at the individual and/or population levels? (e.g., through imputation, use of administrative data such as claims, etc.)? Why or why not?

Yes, while use of claims data and other approaches may not provide a complete picture of social risk factors, it provides baseline measures that may be utilized and analyzed in the near term.

Learnings from MassHealth's use of social risk factor data in risk adjustment approaches should be extended beyond risk adjustment and continue to iterate. For example, the use of Z codes related to housing status has been an important factor, and identifying strategies to encourage providers to implement these administrative markers will be important. In addition, the leveraging of available, relevant information, e.g., DMH eligibility, as well as reasonable proxies, e.g., address changes indicating housing instability, should continue to iterate and be refined. It will be important to obtain input and buy-in from members and advocates around any methodology for estimating social risk factors.

- d. MassHealth is considering updates to the data standards that it uses *internally* for member-level data related to social risk factors. Data standards being considered are detailed in “**Appendix A: MassHealth RELD, Gender & SOGI Data Standards**”.

- i. What feedback do you or your organization have on the proposed data standards that are detailed in Appendix A?

ABH strongly recommends standardization of data collection wherever proposed standards differ from current state funding request methods for data collection. We also recommend allowing the flexibility for options and terminology to change over time. This must be accompanied with resources for providers to make concurrent updates and changes to their EHRs.

Ethnicity: It would be helpful to clarify or separate “Spanish origin” as individuals from Spain are typically considered European and not included in Hispanic or Latinx/e populations. We would also recommend including “Latinx/e” in addition to “Latino/a” for individuals who identify as non-binary. Otherwise, option 1 is feasible for our members to implement, and as presented is most similar to federal funding requests for ethnicity. It does, however, differ from standard state requests for ethnicity.

Race: Option 1 seems most similar to what our members currently collect and it is appreciated that respondents may specify their own race under “Other”. Some ABH members utilize Option 2, CDC Race and Ethnicity Code Set (“Other standards and value sets considered”), which gives clients a detailed option list to select from (approx. 45 – 50). It is noted that Option 2 does not include a very

exhaustive list of Asian race categories that may roll-up to the “Asian” category.

Language: According to Appendix A: MassHealth RELD, Gender & SOGI Data Standards, 23 spoken and written language options are listed in the current state of MassHealth’s electronic application dropdown. This number is reduced to 14 options in Appendix A’s possible structure for how MassHealth might collect language data, significantly decreasing the number of language options displayed to applicants. ABH recommends that MassHealth utilize the 2020 Massachusetts census data to determine languages to list in the element, or leverage their own language data that is evidenced in its [Language Access Plan](#). MassHealth may also consider adding “none” or “no literacy” as a “Written language” option for individuals who would need materials read out loud to them. While language information is important to collect, there are concerns about the utility, sensitivity and reliability of collecting information about English proficiency specifically.

Disability: Disability as we understand its use in Appendix A seemingly captures data on populations that are often discriminated against, similar to how the Americans with Disabilities Act (ADA) defines disabilities. However, data about behavioral health diagnoses would presumably be captured elsewhere, so it is unclear to us what additional information this would provide. ABH recommends further tailoring this question or providing options to identify the disability type/category for which a person identifies. It is also noted that deaf/hard of hearing is not specifically referenced, although “legally blind” is.

Sex: ABH recommends including an option for “Declined to Answer” as an option.

Sexual Orientation: It is important to ensure that individuals are able to choose the specific term with which they identify, and for MassHealth to enable changes to the data collection element over time. ABH recommends removing “straight” from sexual orientation as it implies a norm, and instead to leave heterosexual as the category.

Transgender: ABH supports the options under “Are you transgender?” as a drop-down descriptor as indicated in the example, and appreciates the separation of this question from other questions in the SOGI element.

- ii. What alternative standards, if any, should MassHealth consider using (including any standards currently in use in your organization)?
- iii. Should MassHealth require its health system partner entities to use the same standards? Why or why not?

ABH strongly supports the standardization of data elements, as it improves the ability to analyze and make recommendations based on the data. Further, it simplifies the administrative lift for provider entities and facilitates and encourages on-the-ground compliance.

Section 3.2 Identification of Inequities and Prioritization for Action

- a. What are the most critical health and/or health care inequities that are experienced or observed by you, your organization, or your community?

There are several trends in outcomes, observable by state data and member experiences, that point to behavioral health access and utilization concerns, including: increases in fatal opioid-related overdoses, particularly among Black men, Hispanic women, and individuals experiencing housing instability or homelessness; increased risk of overdose for individuals with a history of incarceration and immediately after release from incarceration; increases in stimulant use and opioid-related overdoses with stimulants present; unaddressed mental health and substance use service needs for the LGBTQIA+ population and increases in emergency department boarding, particularly among pediatric patients.

There exists inequitable access to behavioral health services based on social determinants of health and demographics. Individuals who have unstable access to housing or broadband network rely on telehealth services, particularly audio-only services. Members whose primary language is other than English face inequities in accessing the full range of behavioral health services in their preferred language and experience longer waits for available services. Additionally, there are differences in access to medications for opioid use disorder and geographic disparities in access to harm reduction services.

- b. What strategies should MassHealth use to identify health inequities impacting its members?

Existing state and national data suggest areas of health inequities that may be further explored, and gaps for which additional data is necessary. For example, while CHIA, the Public Health Data Warehouse and Massachusetts Behavioral Health Access (MABHA) provide some information about substance use and mental health treatment access, “there are no cohesive data sources in Massachusetts systematically assessing access to care across all components of the Massachusetts behavioral health delivery system and how access may vary by race and ethnicity.” ([Racism and Racial Inequities in Health, Blue Cross Blue Shield Foundation, December 2021](#)). In early stages, any metrics for measuring social risk factors should not be tied to specific actions for mitigation of disparities, but should prioritize completeness of data collection. Health inequities and outcomes that impact morbidity and mortality should also be prioritized. This could include infant and maternal mortality and fatal overdoses.

- i. MassHealth intends to stratify performance data by social risk factors to identify inequities.

1. What criteria should MassHealth use to select performance metrics for stratification by social risk factors?

As noted above, ABH recommends focusing on metrics where morbidity and mortality disparities are known. ABH also recommends selecting and stratifying information like suicide attempts with different risk factors, including immigration status, overdoses, and postpartum depression. This might also provide opportunities to analyze data in order to gain a better understanding of the difference in potentially intentional versus unintentional overdoses.

2. How should MassHealth determine which performance metric stratifications it will perform first?

MassHealth could identify several potential stratifications and obtain input from members, advocates, and providers.

ii. What other strategies should MassHealth pursue to identify inequities impacting its members?

MassHealth should ensure that individuals with lived experience of mental health and substance use disorders, as well as staff serving individuals with inequitable access to services, contribute to the process of identifying inequities, developing strategies to impact these inequities, and measuring “success.” There should be a focus on differential access to services, including emergent, acute, diversionary, and ambulatory care.

We also recommend MassHealth leverage existing research within the community including reports completed by foundations, universities, and individual providers. Where Massachusetts is fortunate to have a rich system of universities and foundations focused on public health, we would recommend leveraging public/private partnerships to both collect and analyze data regarding health disparities.

We would also recommend that data is analyzed by geographic region in order to better understand the unique community factors that impact access and other inequities, such as public transportation.

c. What factors should MassHealth consider when prioritizing interventions to address inequities (e.g., size of population impacted, magnitude of disparity, presence of specific social risk factors, etc.)?

MassHealth should consider prioritizing interventions that address behavioral health outcomes and access to services as well as those that impact morbidity and mortality. As MassHealth is aware, prevalent data shows that the medical costs for individuals with co-morbid medical and behavioral health diagnoses is three- to six-times higher than treating individuals who do not have a co-morbid behavioral health condition. In Massachusetts, readmission rates in acute care facilities are 50-94% higher among patients with behavioral health co-morbidities and hospital stays are on average 14% longer (CHIA, 2018). Until investment in behavioral health services is prioritized,

individuals with medical conditions and co-morbid behavioral health diagnoses will continue to shift downstream to emergency departments and inpatient settings to seek care.

However, outpatient mental health and addiction services that could prevent utilization of emergency and acute services suffer from chronically low commercial and public reimbursement rates and dire workforce challenges. While ABH deeply appreciates recent investments by MassHealth in the public system, these programs continue to grapple with decreased service volume due to the effects of COVID-19 and staff vacancies, increasing financial losses, and rate stagnation. Data from some of ABH's highest volume provider organizations show that in FY20 the average loss exceeded \$1 million. These factors increase clinician and prescriber wait times and threaten to close programs. Consequently, individuals with severe and persistent mental illness and other behavioral health conditions do not have access to vital, cost-effective and medically necessary services.

Low reimbursement rates translate directly to access imbalances between primary and behavioral healthcare. As the Commonwealth continues to elevate issues of parity within the context of the delivery of behavioral health and physical health services, ABH urges recognition and action around continued wage disparities paid to staff in those settings. There is no reason that wages in behavioral health settings should not be on par with wages paid in physical health settings. Yet recent Gallagher survey data found that for an independently licensed clinical social worker (LICSW), ABH members pay \$58,781; community health centers pay \$67,246; and acute hospitals pay \$78,270.

Many of ABH's provider groups deliver specialty behavioral health services, including services that provide longitudinal treatment and diversionary services for individuals with mild to serious disorders and programs that offer many services in languages other than English. Many of these services are not well suited to primary care offices. Efforts must be made to coordinate and link these behavioral health services with primary care, so that an individual can access specialty, patient-centered care when clinically appropriate. This includes the promotion of payment methodologies that support PCPs' specialty behavioral health partners. In many collaborative care models, the specialty behavioral health system partnering with primary care is not additionally resourced. In addition to supporting medical/behavioral health integration in the primary care setting, payment methodologies and regulatory strategies should support integration in behavioral health settings, as many individuals with moderate to serious behavioral health disorders prefer to access their care through specialty behavioral health providers that are skilled in meeting their unique needs.

In 2015, legislation to address the opioid overdose crisis, referred to as Chapter 55, enabled the linkage and analysis of various datasets from agencies across state government. A new statute has since established the Public Health Data (PHD) Warehouse, authorizing DPH to continue to examine data and trends in opioid overdoses. Data from Ch.55 and the PHD has revealed public health trends and disparities in outcomes that have informed policy and legislative change to better address the overdose crisis. Such methods, including datasets utilized and factors

chosen to stratify outcomes, should be replicated for a broader set of outcomes beyond opioid-related overdoses.

Section 3.3 Enhancing Accountability for Health Equity

- a. How should MassHealth hold its contracted health system entities (e.g., MCOs, ACOs, CPs, hospitals, managed behavioral health vendor) accountable for promoting health equity? Including but not limited to:

i. Contract requirements

1. What contract requirements should be continued or introduced for MassHealth contracted health system entities related to health equity?

A contract requirement should be introduced that ensures that MassHealth contracted health system entities provide services or referrals to all eligible members, regardless of preferred language, gender identity, racial or ethnic identity, disability status, and the intentional development of a provider network to meet the needs of those members. Health systems should be measured on compliance. For example, systems should be measured on the number of members whose preferred language is other than English who received services from a provider that speaks this language. Services delivered via interpretation/translation should not count toward this measure.

MassHealth might look to the [Massport Model](#) (Example – Massachusetts Port Authority RFQ for the Parcel D-4 Mixed-Income Residential Project: Page 2, Section 1, Paragraph 2) which gives equal consideration and weight to a bidder’s staff diversity as it does to other more traditional elements of the evaluation process. This may incentivize partnerships between ACOs and specialty behavioral health and other health care providers with expertise serving special populations.

Relative to the [Supplier Diversity Office \(SDO\) certification](#), some Bureau of Substance Addiction Services (BSAS) procurements award points to organizations that partner with or subcontract to SDO-certified organizations, but does not award any points to organizations for being SDO-certified despite the host of requirements they must abide by in order to maintain their certification. Further, “partnering with” does not require payment to a SDO certification, and SDO certification does not guarantee that a business will be successful every time it bids. MassHealth may want to reconsider who benefits from the SDO certification partnership/subcontract construct to ensure that organizations are rewarded, and therefore incentivized, to incorporate culturally competent and diverse organizational practices. Enhanced compensation and/or preference should be given to diverse organizations.

ABH recommends that MassHealth adopt a claims modifier that increases payment for language competence. In New York state, when a clinician delivers a service in a language other than English to a Medicaid member, that service is paid at a 10% higher rate. The New York Medicaid program implemented this through [a language competence modifier](#). This action will incentivize providers to improve language and cultural competence and help attract and retain bilingual staff in the field. The Commonwealth does not currently have a modifier assigned to language competence. It is essential that persons served have the ability to receive behavioral healthcare services in their preferred language, and that providers are recognized for culturally and linguistically appropriate care.

Safety-net providers, including community-based CPs, behavioral health centers, and health centers are often closest to the MassHealth members. This initiative will be more successful in collecting complete and accurate social risk factor data by leveraging providers with long histories and expertise in serving the most vulnerable and under-represented populations. The opportunity to earn incentives for the completeness of data collection and reporting and receiving investments in data collection infrastructure should be expanded to community-based, safety-net providers that know these vulnerable and underserved communities.

It will also be critical that ACOs, CPs, and other providers, including the new Community Behavioral Health Centers (CBHCs), have the resources to further develop data collection and analysis. This includes continued access to timely claims data to further develop strategies and targeted interventions to promote population health. Through DSRIP funding, BHCPs have built the infrastructure upon which to further advance their data analytics capabilities. ABH strongly recommends MassHealth continues to provide claims data at an expedited rate to the health plans, BHCPs, and the newly created CBHCs and continues to invest in data capabilities across its provider network.

Additionally, a consequential gap in data for BHCPs has been the lack of SUD data. Only recently through Mathematica have BHCPs had a way to understand the prevalence of SUD within their BHCP populations. Even still, BHCPs do not receive individual-level SUD claims data needed to drill down to the member level and develop targeted interventions. The inclusion of SUD diagnoses, utilization, and outcomes data is critical throughout any health equity initiative that MassHealth undertakes. Otherwise, it will be impossible to fully assess outcomes and identify health inequities for the large population with SUD conditions, which overlaps with many other populations and other types of health inequities.

As noted in the recent Massachusetts Medicaid Policy Institute (MMPI) report, [The MassHealth Accountable Care Organization Program](#):

[Uncovering Opportunities to Drive Future Success, May 6, 2021](#), on the MassHealth ACO program and opportunities for future success, while federal regulations pose obstacles to accessing this data, finding ways to work within or around these data limitations “is an essential step to ultimately making a measurable impact on health outcomes and total cost of care.” ABH strongly recommends MassHealth identify a path forward to sharing this vital data with those entities responsible for complex care management as well as those delivering care under value-based or pay-for-performance arrangements.

ii. Public reporting

1. Should MassHealth publicly report health equity performance data for its contracted health system entities? If so, why?

Yes, MassHealth should publicly report health equity performance data for its contracted health system entities because this transparency will enable providers to benchmark their health equity practices against other entities and system wide, while holding themselves accountable. Providers will be able to see how well they are serving diverse MassHealth members, particularly disproportionately socially at-risk and underserved populations, and thereby establish a baseline upon which to improve quality of care. Additionally, MassHealth members should have the opportunity to select providers that have good outcomes with specific populations.

2. What conditions would need to be in place for public reporting to be introduced?

For public reporting to be introduced, there must be clear expectations about what health equity data is being collected and reported, and accurate and standardized definitions to ensure that providers are all reporting on the same metrics.

Effective equity measures require accurate and complete collection of key sociodemographic data (e.g., race, language, income, and geography). In addition to standardized definitions, there should be consistent data collection guidance and resources to develop and standardize data collection tools, inclusive of financial and technical assistance.

Finally, reporting should be transparent about limitations to the data, such as geographic or demographic limitations or adjustments that were made.

As previously stated, it is also important to avoid unintentionally penalizing safety-net providers and smaller organizations that often have a greater share of patients with more acute and complex conditions, and may face additional challenges in data collection.

iii. Payment incentives

1. Pay-for-Reporting⁶

MassHealth intends to hold certain health system entities financially accountable for identification and monitoring of health inequities (e.g., through stratified reporting of quality metric performance by social risk factors) within the early years of the 5-year period between CY2023 to CY2027 (the 1115 demonstration extension period).

- a. What conditions would need to be in place to introduce financial accountability for stratified reporting and how should MassHealth promote achievement of those conditions?

It will be important to avoid unintentionally penalizing health care providers that are safety-net providers, often with more limited resources and high risk populations. Incentives for reporting and performance should be expanded across provider networks at an equitable scale to account for variation in provider and system resources or baselines.

- b. On what time frame should financial accountability for stratified reporting be introduced, assuming a five-year timeline from CY2023 to CY2027? How might this differ by metric and/or social risk factor?

As has been observed in the current Section 1115 Demonstration, there is a significant lag time between reporting and accountability scoring that can impede health system entities' ability to apply learnings to practice improvement. For example, the CP program is entering its fifth and final year under the current demonstration but is only just finalizing performance benchmarks for performance year 3 due to a number of factors, including but not limited to the COVID-19 pandemic's impact on performance. By the time these benchmarks are established, it will be too late to make changes to service delivery to impact performance in years 3 and 4. Based on this experience, ABH recommends pay-for-reporting be in place for the first couple of years with a gradual phasing in of accountability for reduction of health inequities. As this has never been measured in a systemic way, it will take a year or two to establish a baseline

⁶ Pay for Reporting (P4R), comprises payment models that attach financial incentives/ disincentives (e.g., bonus, payment reduction) to reporting. P4R may tie reimbursement to complete, timely, and accurate reporting of metric-driven outcomes, best practices (process measures), or member experience.

understanding of performance upon which to improve. From then, potentially phasing in pay-for-performance incentives over the remaining 3 years would be the most feasible approach. Accountability through downside risk, e.g., withholds or penalties, should not be imposed until MassHealth is ready to measure providers' performance in a timely fashion.

2. Pay-for-Performance⁷

MassHealth intends to hold certain contracted health system entities financially accountable for reduction of health inequities within the 5-year period between CY2023 to CY2027 (the 1115 demonstration extension period).

- a. What conditions need to be in place (e.g., thresholds of data completeness) to introduce financial accountability for reducing health inequities?

Before holding entities responsible for reducing health inequities, there must be system wide consistency in data collection and reporting and identification of the health inequities that the state wants to reduce. These efforts will take at least a couple of years. Then, expectations can be set for the inequities that are to be reduced, measures defined, and targets established. These steps must be articulated before the year begins in which the measurement will occur.

Focus and incentives to reduce health inequities cannot conflict with goals and incentives to reduce Total Cost of Care (TCoC). Reducing health inequities must be prioritized over TCoC, and doing so will likely have a positive impact on TCoC over time. There are certainly populations within the MassHealth membership that do not have the same access to services as well as a high likelihood of being offered different treatment options than others. There will need to be strategies and conditions that account for greater access to necessary and appropriate care as well as to ensure that concerns about adverse selection do not reduce access to care and networks.

Additionally, we feel it is important to note that some health inequities are often created by social determinants that are beyond the scope of behavioral health providers and will require cross-secretariat collaboration and higher-level policy changes

⁷ Pay for Performance (P4P), also known as value-based payment, comprises payment models that attach financial incentives/disincentives to performance. P4P ties reimbursement to metric-driven outcomes, best practices (process measures), and member experience, aligning payment with value and quality.

and targeted funding to resolve, i.e. education, housing, transportation, and corrections.

- b. On what time frame should accountability for reduction of health inequities be introduced, assuming a five-year timeline from CY2023 to CY2027? How might this differ by metric and/or social risk factor?

As observed in the current Section 1115 Demonstration, shifting to accountability requires time for participating entities to establish data collection strategies, refine data collection to ensure accuracy, and to then build targeted initiatives based on that data. It will be critical that performance benchmarks are established prior to introducing accountability of health inequities. This process will take some time before accountability for reducing health inequities can be introduced. In addition, improvement in outcomes will likely be observed over a number of years.

As mentioned above, there are some social risk factors that are beyond the control of health systems. It is critical to analyze what metrics are within the control of health providers to determine which outcomes can be accurately measured in Years 3-5 and which metrics will require more cross-agency or department collaboration.

- i. What should MassHealth consider in terms of the time lag between actions taken to reduce inequities and observed outcomes?
- c. How should “success” in reducing inequities be defined for the five-year period between CY2023 to CY2027?

Succeeding in reducing inequities should be prioritized based on those that directly impact mortality and morbidity. For example, a report from the Centers for Disease Control and Prevention (CDC), [Centers for Disease Control and Prevention, Morbidity and Mortality Report, Vol. 62 / No. 3 November 22, 2013](#), found racial and ethnic disparities in mortality due to heart disease and stroke, socioeconomic disparities in the prevalence of diabetes, disparities in suicide rates based on gender, and many others. In addition to health inequities impacting mortality and morbidity, healthcare inequities including differences in quality of care, access to care, appropriateness of treatment, and preferences need to be measured. Ultimately, the measurement of success will depend on clear definitions of the health inequity to be

reduced and reliable data identifying the baseline and measuring change.

ABH reiterates that this essential work should also take into consideration barriers to effecting change at the provider or health system level, including looking at the insurance-delivery system, statewide policies and other systems like housing, transportation, education and legal.

- b. Other: How can MassHealth ensure contracted health system entities that serve a disproportionately socially at-risk population are not unfairly impacted by the introduction of enhanced accountability for health equity?

There will need to be a methodology for risk adjustment, perhaps based on baseline data for the actual populations served by each entity. Not only should we ensure that these entities are not unfairly impacted but MassHealth should intentionally invest in strengthening these organizations to address persistent inequities in the care system, and recognize that penalization only exacerbates disparities by continuing and/or expanding the gap in resources.

Organizations that have served disproportionately at-risk populations have also been habitually under-funded and unable to access incentives available to larger organizations. This underfunding has created infrastructure challenges to continue to improve service delivery for under-served communities. Increased investment for these organizations is essential.

SECTION 4. RFI Respondent Information

1. What is your name, organization, address, email address, and URL (if applicable)?

Lydia Conley, President/CEO
Association for Behavioral Healthcare
251 W. Central Street, #21
Natick, MA 01760

2. What is your affiliation or interest? Specifically, are you an advocate/advocacy organization, community member, Community Partner, consumer/patient, government organization, health care consultant, health care provider, health plan, payer, professional association/trade group, vendor, or some other entity?

The Association for Behavioral Healthcare (ABH) is a statewide association representing 80 plus community-based mental health and substance use disorder treatment provider organizations. ABH members are the primary providers of publicly-funded community-based behavioral healthcare in the Commonwealth. Our members deliver the entire scope of MassHealth covered diversionary (24-hour and non24-hour); outpatient services; intensive home or community-based services for youth, i.e., Children’s Behavioral Health Initiative Services; and emergency service program (ESP) services. In addition to covered services, ABH members deliver care management services under the Behavioral Health Community Partner program.

3. What is your role in the health care system?

For four decades, ABH has been the leading advocacy organization in Massachusetts’ mental health and addiction services arena. Fighting for high-quality, community-based care for families and individuals with mental illness, addiction and substance-use disorders, ABH provides leadership and statewide coordination on important public policy, financing, preferred clinical models and quality assurance issues.

Our member organizations are the behavioral health safety net for residents of the Commonwealth. In addition to MassHealth services, our members deliver a variety of behavioral health services under contract to the Department of Mental Health, the Department of Children & Families, and the Department of Public Health’s Bureau of Substance Addiction Services.

4. If applicable, in what geographic areas in Massachusetts do you provide services? If applicable, in what geographic areas outside of Massachusetts do you provide services?

ABH members deliver services across the Commonwealth, including the Cape & Islands.