MEMORANDUM

TO: Cambridge Health Alliance

FROM: Amy Wu-Wu, Jaskirat Kaur, Yujie Jiang, Grey Xu, Stephan Garner

DATE: November 19, 2023

RE: Recommendations for Improving Access to Healthcare for newcomers in Massachusetts

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Executive Summary

This document discuss the challenges faced by newcomers accessing healthcare in Massachusetts, identifying barriers such as eligibility complexities, administrative burdens, language obstacles, and a climate of fear. Recommendations include implementing a newcomer education program using tools like WhatsApp Business, developing a patient-hosted medical record system, and extending MassHealth eligibility to all newcomers.

Background and Motivation

A range of studies and news reports have highlighted the challenges faced by newcomers in accessing healthcare in Massachusetts in the past. Lindsay (2016) and Joseph (2017) both underscore the impact of sociocultural differences, communication barriers, and documentation status on healthcare access. Ives et a (2014) further explores the use of social networks and transnational healthcare connections by newcomer workers to address their health concerns. Joseph (2015) compares the Affordable Care Act and Massachusetts health reforms, emphasizing the influence of citizenship status on coverage options. These studies collectively underscore the need for interventions to address these barriers and improve healthcare access for newcomers in Massachusetts. Popular health policy studies (Joseph, 2017) correlate having health insurance to increase the use of medical services, with the influx of newcomers assuring they know they can access medical services and what options they have should become a priority.

Massachusetts leads the United States of America in insurance coverage as recently as 2021, as of November 17, 2023, the Office of Housing and Livable Communities (2023) reports a total of 7,505 households in Emergency Assistance shelters (EA Shelters) a snapshot of the distribution between cities can be found in appendix 1. Maintaining this state goal, its position and assuring the health of newcomers remain in the states interest, as demonstrated by Governor Healey instituting a state of emergency (Office of the Governor,2023).

Findings and Analysis

- **Enhancing Healthcare for Newcomers in Massachusetts: Navigating Immigration Challenges and Overcoming System Constraints for Improved Access and Quality Care.**

  From previous studies we can gather above, in addition to state and federal information we have synthesize the barriers into the following critical points 1) Eligibility and complexity of applications 2) related administrative burdens[1], 3) languages, literacy and cultural barriers 4) transportation[2] 5) Climates of fear and distrust. To summarize changes in federal laws regarding health and human services programs, along with complex eligibility rules and documentation requirements, posed challenges for immigrant-serving

[1] A simple solution would be creating a WhatsApp business account since most newcomers have better familiarity with this app

[2] In general, the implementation of telehealth has eased the burden of transportation.

organizations. Immigrant families faced difficulties obtaining and providing necessary documents, leading to delays and rejections in benefit applications. Concerns about document security and past experiences of document mishandling added to apprehensions. Long waits for benefit approval, reapplication requirements upon moving, and issues during recertification led to high turnover among enrolled families. Caseworkers and supervisors grappled with the administrative burden of managing a plethora of immigration documents.
Language barriers, reliance on phone-based interpretation/family members, limited education, and cultural differences further complicated interactions with public agencies. Fear of mistreatment, deportation, and pervasive misconceptions discouraged newcomers from seeking public assistance and health services. Growing immigration enforcement programs and anti-immigrant press amplifies the climate of fear and mistrust, deterring newcomers from engaging with public services.

- **Towards Inclusive Healthcare Policies: Addressing Insurance needs and giving data back to people.**

  The bottleneck we have identified is the way data has been collected and shared, in an overview hospitals are zealous with medical records which hinders a newcomer's ability to transfer to a new hospital or state. Electronic Medical Records(EMR) are virtual medical files that have to be filled out every time an individual visits a new healthcare institution, which translates into more cost for both parties involved.

  These files usually contain records from doctor visits, demographics, test results, medical history, history of present illness and medications (HHS, 2022). The most popular provider for EMR is Epic holding a 34.1% of the market share. The HHS has identified 18 protected health identifiers[3] in most that are prime targets to cyber-attacks, data breaches in this area have been estimated to cost in 2021 $9.23 million (HHS,2022)

  Storage is usually in dedicated servers in specific known physical locations, it can be in clinic or remotely hosted (Appendix 2). Two legislatures actively affect the access to insurance[4] to newcomers in Massachusetts the Affordable Care Act and the Massachusetts Health reform. In Massachusetts, Medicaid, and the Children's Health Insurance Program (CHIP) are combined into one program called MassHealth. MassHealth members may be able to get doctors' visits, prescription drugs, hospital stays, and many other important services. Only certain newcomers are allowed to enroll into MassHealth (Office of Attorney General), a detail table can be found in appendix 3. Regardless of status, programs are available to any newcomers such as MassHealth limited or the health safety net.

- **Comparative Analysis of Newcomer Health Insurance Strategies: Medi-Cal**
  An exhaustive list of projects done in California can be found in appendix 4, in general we recognize California success with immigrants stems from allowing Medi-cal eligibility to all newcomers, even undocumented ones to the age of 26 and the creation of an office of health care affordability as stated in the California Blueprint program.

- **Unpacking Healthcare System Constraints: Analyzing Capacity and Cost.**
  Key scarcity points for medical practitioners can be found in appendix 5. To summarize Massachusetts finds scarcity in cities that move away from Boston and similar to issues nation wide nurses are in an all time low.

[3] A deepen analysis of the trade-offs of HIPAA policies can examined in appendix xx

[4] Insurance in Mass has this distribution Employer (KFF,2021) private insurance 56.5% Non-group 3.6% (Includes individuals and families that purchased or are covered as a dependent by non-group insurance.) 21.9% Medicaid, 14.7% Medicare and 3% Uninsured.

Recommendations and alternatives

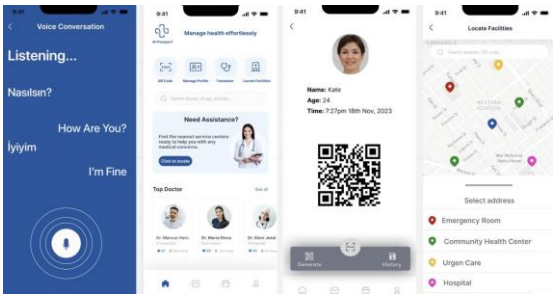
Enhancing Healthcare for Newcomers in Massachusetts: Navigating Immigration Challenges and Overcoming System Constraints for Improved Access and Quality Care.

We recommend a holistic newcomer education program that strives to bridge the gap between cultures while facilitating information via readily available tools like WhatsApp Business. We also recommend the program to instruct the newcomers with online telehealth channels to further remove the transportation barrier.

> *Possible Alternatives: Consider partnerships with community organization for in-person one on one sessions.*

Towards Inclusive Healthcare Policies: Addressing Insurance needs and giving data back to people.

We recommend the development of a patient hosted medical record system[5], one that covers all necessary points to integrate to popular EMRs, eliminates the language barrier with immediate AI translation, and provides a readily available health sheet for new practitioners or community health professionals.



> *Possible Alternatives: Intergrating all ERM databases or asking private providers to facilitate that.*

Comparative Analysis of Newcomer Health Insurance Strategies: Medi-Cal

We recommend extending standard MassHealth eligibility to all undocumented populations to curtail the administrative complexity to all newcomers.

> *Possible Alternatives: A private public partnership that creates a tailor made insurance solution to the influx of newcomers coming in.*

Unpacking Healthcare System Constraints: Analyzing Capacity and Cost.

We recommend the active recruitment of foreign medical practitioners (focusing on nurses) to work in areas that have been less attractive to national providers.

Possible Alternatives: Incentivicing national providers to work in underserved areas through financial incentives or other support programs, similar to Americore.

[5] See appendix 7 for a detail view of the workflow and link to prototype

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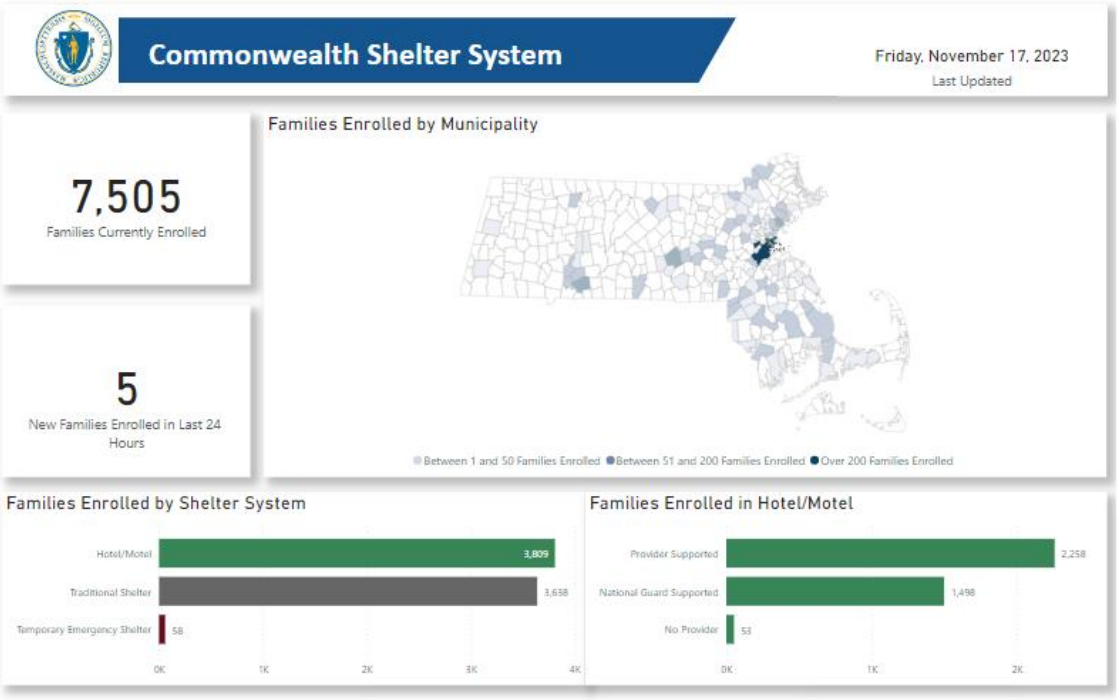
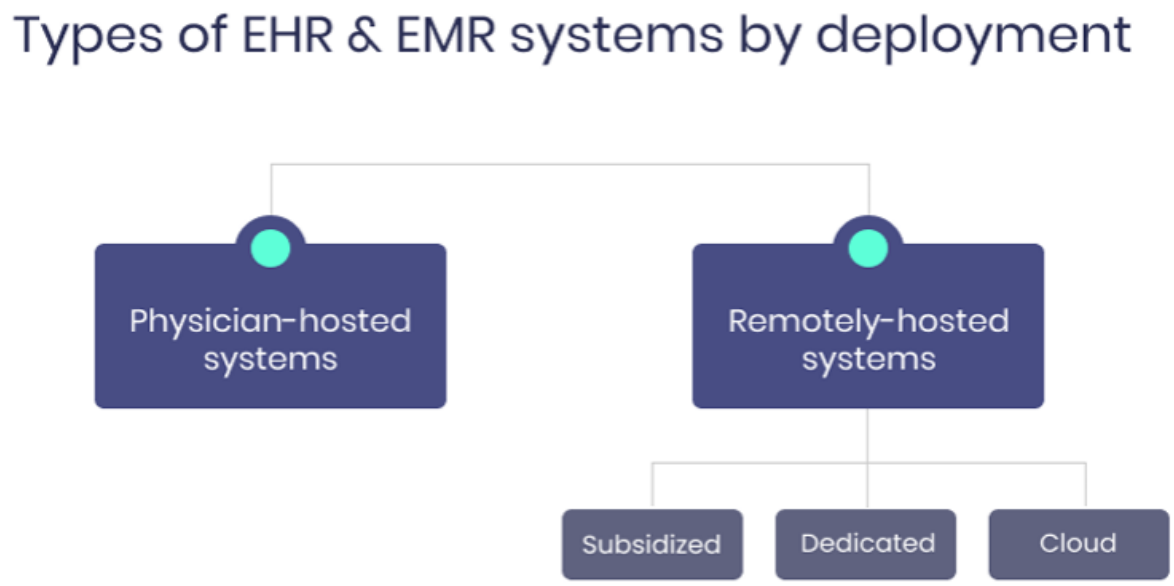
Appendices

Appendix 1



Source: Executive Office of Housing and Livable Communities (2023)

Appendix 2 Type of EHR and EMR



Appendix 3 Eligibility

Non-Citizen Group	Sub-Groups	Brief Description
		part of a series of treaties known as the Compacts of Free Association (COFA). ➢ **Protected Noncitizens:** Noncitizens who were receiving MassHealth on June 30, 1997.
Lawfully Present Immigrants	**Qualified Noncitizens Barred**	➢ Individuals who have had one of the following immigration statuses for fewer than five years: • legal permanent residents (LPR); • parolees granted parole status for at least one year; or • a battered spouse, battered child, or child of battered parent, or parent of battered child.
Lawfully Present Immigrants	**Nonqualified Individuals Lawfully Present**	➢ Immigrants who • are paroled in the United States for less than one year in accordance with 8 USC 1182(d)(5). This does not include those paroled for prosecution, deferred inspection, or pending removal proceedings; • belong to one of the following groups: ○ granted temporary resident status in accordance with 8 USC 1160 or 1255(a); ○ granted Temporary Protected Status (TPS), in accordance with 8 USC 1254a, and individuals with pending applications for TPS who have been granted employment authorization; ○ granted employment authorization under 8 CFR 274a.12(c); ○ Family Unity beneficiaries in accordance with 301 of Public Law 101-649; ○ under Deferred Enforced Departure (DED) in accordance with a decision made by the President; ○ granted Deferred Action status, except for applicants or individuals granted status under Department of Homeland Security (DHS) Deferred Action for Childhood Arrivals Process (DACA); ○ granted an administrative stay of removal under 8 CFR 241; or

Non-Citizen Group	Sub-Groups	Brief Description
Lawfully Present Immigrants	**Qualified Noncitizens**	➢ Individuals who have had one of the following immigration statuses for at least five years or Individuals who have been continuously present in the United States since before August 22, 1996, until receiving one of the following statuses below: • legal permanent residents (LPR); • parolees granted parole status for at least one year; or • a battered spouse, battered child, child of battered parent, or parent of battered child. ➢ Individuals who have or had a status which is not subject to the five-year bar: • persons granted asylum under section 208 of the Immigration and Nationality Act (INA); • refugees admitted under section 207 of the INA; • persons whose deportation has been withheld under 243(h) or 241(b)(3) of the INA; • veterans (former members of the armed forces, including certain immigrants who fought under U.S. command) and those on active duty in U.S. armed forces, or the spouse, un-remarried surviving spouse, or unmarried dependent children of veterans or those on active duty; • conditional entrants under 203(a)(7) of the INA (previously listed as a five-year bar status); • Cuban/Haitian entrants under 501€ of the REA Act of 1980; • Native Americans with at least 50% American Indian blood who were born in Canada, or other tribal members born in territories outside of the U.S. (for Medicaid purposes); • Amerasians under 402 of Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA); • victims of severe forms of trafficking, and the spouse, child, sibling, or parent of the victim; • Iraqi or Afghan Special Immigrant; or • Migrants from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau who legally reside in the U.S. as

Non-Citizen Group	Sub-Groups	Brief Description
		○ beneficiary of approved visa petition who has a pending application for adjustment of status. • are in a valid nonimmigrant status as otherwise defined in 8 U.S.C. 1101(a)(15) or otherwise under immigration laws (as defined in 8 U.S.C. 1101(a)(17)); • have a pending application for asylum under 8 USC 1158 or for withholding of removal under 8 USC 1231, or under the Convention Against Torture who ○ have been granted employment authorization; or ○ are under the age of 14 and have had an application pending for at least 180 days. • have been granted withholding of removal under the Convention Against Torture; or • a child who has a pending application for Special Immigrant Juvenile status as described in 8 USC 1101(a)(27)(J), or a person who has received SIJ and has not yet received a green card
Nonqualified Persons Residing Under Color Law (PRUCOL)	Nonqualified PRUCOL	• Noncitizens living in the United States in accordance with an indefinite stay of deportation; • Noncitizens living in the United States in accordance with an indefinite voluntary departure; • Noncitizens and their families who are covered by an approved immediate relative petition, who are entitled to voluntary departure, and whose departure the DHS does not contemplate enforcing; • Noncitizens granted voluntary departure by the DHS or an Immigration Judge, and whose deportation the DHS does not contemplate enforcing; • Noncitizens living under orders of supervision who do not have employment authorization under 8 CFR 274a.12(c); • Noncitizens who have entered and continuously lived in the United States since before January 1, 1972; • Noncitizens granted suspension of deportation, and whose departure the DHS does not contemplate enforcing;

Non-Citizen Group	Sub-Groups	Brief Description
		• Noncitizens with pending applications for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention against Torture who have not been granted employment authorization, or are under the age of 14 and have not had an application pending for at least 180 days; • Noncitizens granted Deferred Action for Childhood Arrivals status or who have a pending application for this status; • Noncitizens who have filed an application, petition, or request to obtain a lawfully present status that has been accepted as properly filed, but who have not yet obtained employment authorization and whose departure DHS does not contemplate enforcing; or • Any noncitizen living in the United States with the knowledge and consent of the DHS, and whose departure the DHS does not contemplate enforcing. (This includes persons granted extended voluntary departure due to conditions in the noncitizen's home country based on a determination by the U.S. Secretary of State.)
Other Noncitizens	Other Noncitizen	Persons with a status that is not described as Lawfully present, Protected Noncitizens, or Nonqualified PRUCOLs

Appendix 4 HIPAA

General HIPAA Information

HIPAA, which stands for the Health Insurance Portability and Accountability Act, is a significant piece of legislation in the United States that relates to the protection and confidential handling of protected health information (PHI). Enacted in 1996, HIPAA has several key components and implications, especially for healthcare providers, insurance companies, and certain other entities handling health information.

HIPAA Main Aspects

1. Privacy Rule

• Purpose: To protect the privacy of individually identifiable health information.

• Protected Health Information (PHI): Covers information that can be linked to a specific individual, including demographics, and relates to their past, present, or future physical or mental health condition.

• Covered Entities: Health plans, healthcare clearinghouses, and healthcare providers who transmit any health information electronically in connection with certain transactions.

2. Security Rule

• Focus: Specifies a series of administrative, physical, and technical safeguards for covered entities to use to ensure the confidentiality, integrity, and security of electronic PHI (ePHI).

• Risk Analysis and Management: Requires covered entities to perform risk assessments and implement appropriate security measures.

3. Transactions and Code Sets Rule

• Standardization: Mandates the use of standard codes and electronic transactions to improve the efficiency and effectiveness of the healthcare system.

• Transactions: Includes claims, eligibility inquiries, referral authorization requests, and other types of health information.'

4. Unique Identifiers Rule

• National Provider Identifier (NPI): Requires that healthcare providers have a unique 10-digit identification number for billing and other transactions.

5. Enforcement Rule

• Compliance and Penalties: Details the procedures for compliance and investigations and

establishes civil money penalties for violations.

• Enforcement Agencies: The Office for Civil Rights (OCR) within the U.S. Department of Health and Human Services (HHS) enforces the Privacy and Security Rules, while the Centers for Medicare & Medicaid Services (CMS) enforce the Transactions and Code Sets and Unique Identifiers Rules.

6. Breach Notification Rule

Notification Requirements: Mandates that covered entities and their business associates notify individuals, HHS, and, in some cases, the media when a breach of unsecured PHI occurs.

7. Impact and Compliance

• Healthcare Providers: Must follow HIPAA regulations in handling patient records and interactions.

• Business Associates: Entities that perform services for covered entities involving the use or disclosure of PHI must also comply.

• Training and Policies: Organizations must provide training and implement policies and procedures to ensure HIPAA compliance.

8. Recent Updates and Considerations

• Expansion and Amendments: HIPAA has been amended over the years, including updates to address technological changes and enhance patient rights.

• Telehealth and Digital Health: With the growth of telehealth, there's increased focus on securing ePHI transmitted electronically.

9. Challenges and Criticisms

• Complexity: The complexity of HIPAA can make compliance challenging, especially for smaller providers.

• Technological Evolution: Keeping up with changes in technology and ensuring security measures remain effective.

HIPAA's importance cannot be understated in the context of healthcare privacy and security in the United States. It has shaped the way healthcare providers, insurers, and other entities handle health information, emphasizing the protection of patient privacy and the security of health data.

Difficulties in Managing Patient Information During ACO Transitions

• Restricted Information Flow:

o HIPAA regulations often limit the seamless transfer of patient information between different healthcare providers or ACOs. This is because patient consent is required for each separate entity, leading to delays and inefficiencies.

• Administrative Burdens:

o The process of obtaining consent and ensuring HIPAA compliance each time a patient switches ACOs can be time-consuming and administratively burdensome. It can slow down the healthcare delivery process, affecting patient care.

• Lack of Continuity in Care:

o Disruptions in the flow of patient information can lead to a lack of continuity in care. Providers may not have immediate access to critical health records, hindering their ability to make informed decisions about ongoing treatment plans.

• Risk of Errors:

o In the absence of comprehensive and timely health information, there's an increased risk of medical errors. Providers might not be aware of allergies, previous diagnoses, or current medications, leading to potentially harmful treatment decisions.

Challenges in Emergency Situations

• Delayed Response Times:

o In emergencies, time is of the essence. HIPAA regulations can create critical delays in accessing vital patient information, impacting the ability to provide immediate and appropriate care.

• Limited Information Sharing:

o Emergency responders and healthcare providers might face limitations in sharing patient information among themselves or with other necessary entities (like family members), potentially impacting the coordination and effectiveness of emergency care.

• Legal Uncertainties:

o Healthcare providers often face uncertainties about what information can be legally shared under HIPAA during emergencies, leading to either over-caution or inadvertent non-compliance.

• Inadequate Emergency Protocols:

o While HIPAA does have provisions for emergencies, these may not be adequately understood or implemented across different healthcare settings, leading to inconsistent practices in emergency information management.

Appendix 4:Californa Projects

California Case Study on getting Health Care Access

Expanding Medi-Cal to all income-eligible, undocumented Californians.
California in 2019 became the first state to extend Medi-Cal coverage to all eligible undocumented young adults up to the age of 26. Last year's State Budget which made California the first in the nation to expand full-scope Medi-Cal eligibility to low-income adults age 50+, regardless of immigration status. These expansions of the Medi-Cal program mean that, as of January 2024, essentially all low-income Californians are eligible for no-cost comprehensive health care coverage.

Enhance State Executive power to support the health care affordability.

The Governor's plan calls for the creation of an Office of Health Care Affordability, which will address underlying cost drivers and improve the affordability of health coverage, benefiting all Californians. OHCA will collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by OHCA's Health Care Affordability Board. To ensure a balanced approach to slow spending growth, OHCA will promote high value system performance by measuring quality, equity, adoption of alternative payment models, investment in primary care and behavioral health, and workforce stability. Through cost and market impact reviews, OHCA will analyze transactions that are likely to significantly impact market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on results of the review, OHCA will then coordinate with other state agencies to address consolidation as appropriate..

- Link: https://hcai.ca.gov/ohca/

Health Workforce Pilot Projects Program
The HWPP Program allows organizations to test, demonstrate, and evaluate new or expanded roles for healthcare professionals, or new healthcare delivery alternatives before changes in licensing laws are made by the Legislature. Various organizations use HWPP to study the potential expansion of a profession's scope of practice to:

- Facilitate better access to healthcare
- Expand and encourage workforce development
- Demonstrate, test and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives
- Help inform the Legislature when considering changes to existing legislation in the Business and Professions code

What types of projects does the state pilot?
The healthcare industry is invited to think about innovations in the role of the health care worker (personnel) with the changing mode of health care delivery. The pilot projects may involve expanding the scope of practice for licensed health professionals for:

- The role of medical auxiliaries
- The role of nursing
- The role of dental auxiliaries
- The role of maternal child care personnel
- The role of pharmacy personnel

- The role of mental health personnel
- And other healthcare personnel (ex. chiropractic, podiatric, geriatric, therapy personnel, veterinary, and the healthcare technician.)

Paramedicine

The applicant proposes to generate, collect and analyze data that will examine the practice of Community Paramedicine (CP) and serve as a basis to recommend changes to existing statutes and regulations in the following general project areas:

a) Transport patients with specified conditions to alternate locations that can be managed in health care settings other than an acute care emergency department, such as an urgent care or general medical clinic.

b) Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments by helping them access primary care and other social or psychological services.

c) Provide short-term home follow-up care for persons recently discharged from the hospital and at increased risk of a return visit to the emergency department or readmission to the hospital with referral from the hospital, clinic, or medical provider.

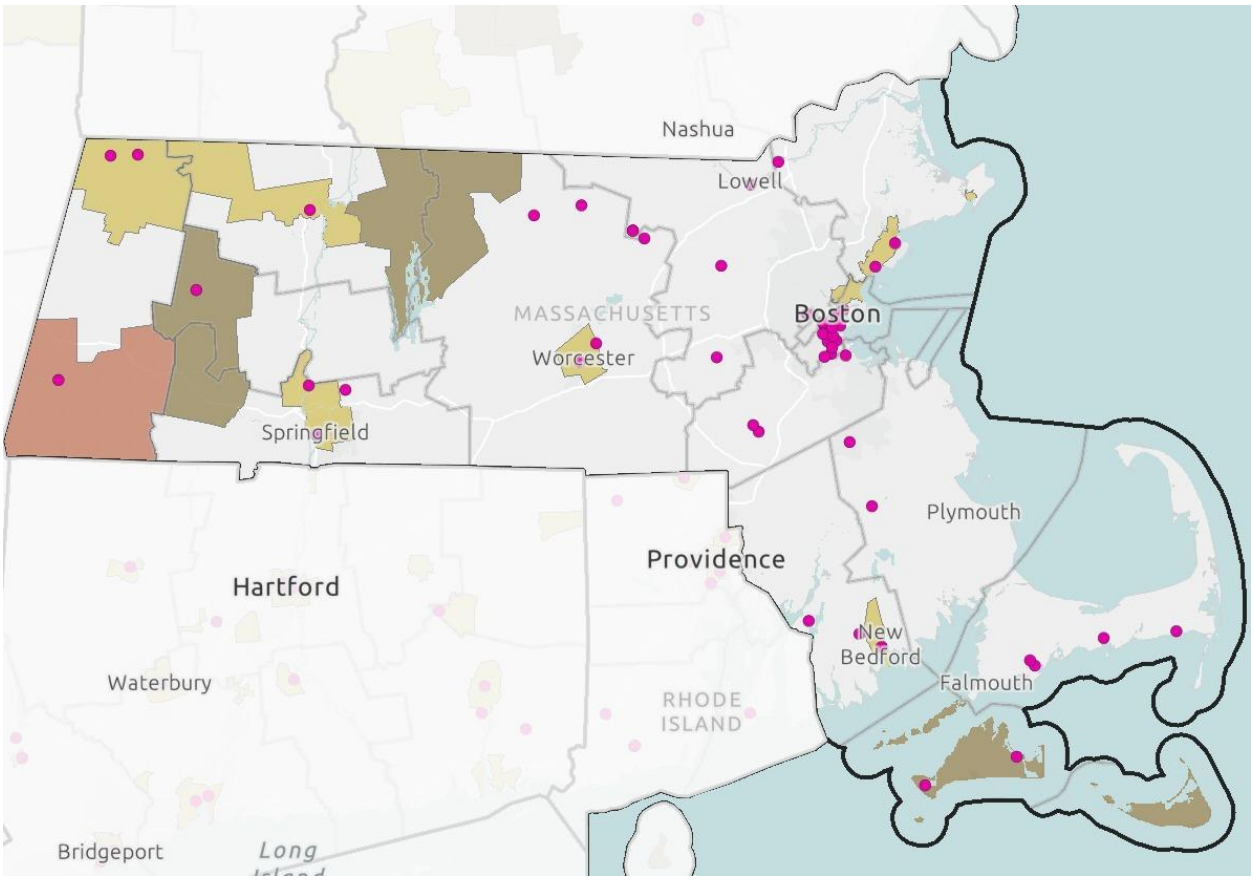
d) Provide short-term home support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions with referral and under protocol from the medical home clinic or provider.

e) Partner with public health, community health workers and primary care providers in underserved areas to provide preventive care.

Refugee Insurance policy

Humanitarian Parole Status Ukrainian entrants who arrive with humanitarian parole pursuant to section 212(d)(5) of the Immigration and Nationality Act, are qualified immigrants if paroled for one year or more. Immigrants paroled for less than one year are PRUCOL and can be granted full scope Medi-Cal if otherwise eligible. These individuals may have a valid and unexpired Ukrainian passport with a USCIS Parole stamp including the purpose for parole, date of admission, and date of expiration for parole. They may also have other documents, including a USCIS Form I-94. The I-94 will show that the individual is a Ukrainian citizen or national who is paroled in the U.S. under Section 212(d)(5) of the INA. The date of entry and date of expiration of parole are also identified on this form.

Appendix 5: Geo location of scarcity



Health Professional Shortage Area - Primary, Designated Population Group by Shortage Area, HRSA HPSA Database May 2021

- High Needs Geographic HPSA
- Geographic HPSA
- Population HPSA

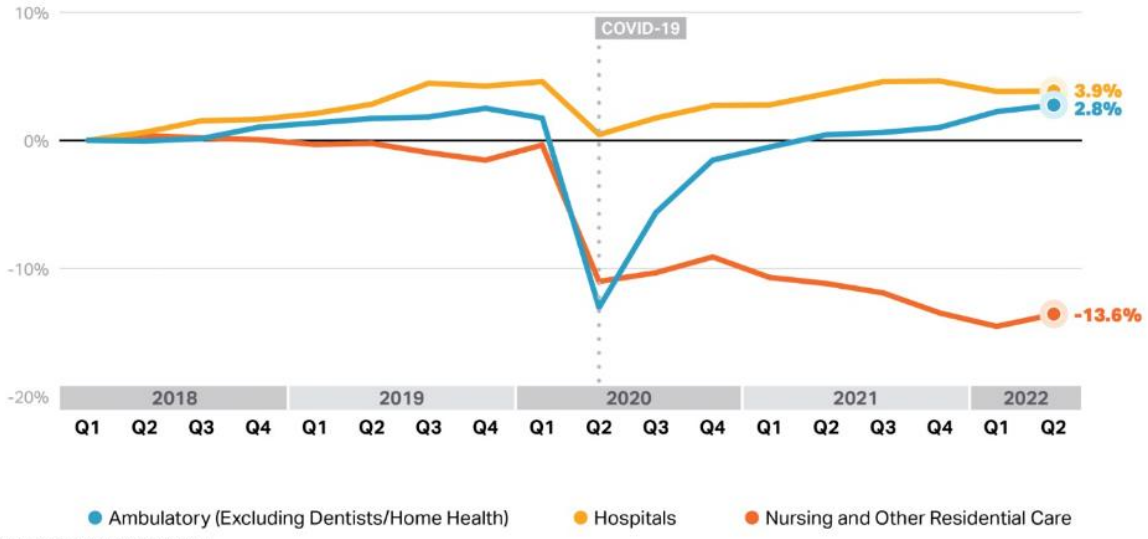
Facilities Designated as HPSAs by Discipline, Primary Care Facilities, HRSA HPSA Database May 2021

- ●

https://communityhealthdata.mass.gov/map-room/, 11/18/2023

These backups are partly driven by worker shortages in nursing and residential care facilities, where total employment in Massachusetts remains 14% below 2018 levels.

Quarterly change in total employment relative to Q1, 2018 by broad health care sector, Massachusetts, Q1 2018 – Q2 2022



Notes: Employment refers to average monthly employment.
Sources: Quarterly Census of Employment and Wages, Bureau of Labor Statistics, Q2 2022

Appendix 7 M-passport Prototype

Prototype Link: https://www.figma.com/proto/M0kogp6crv9EMP0PJoo0zl/Med-Webpage?type=design&node-id=2-3&t=weyuDIFtUCu0xf3b-1&scaling=scale-down&page-id=0%3A1&starting-point-node-id=2%3A3&mode=design

Prototype workflow: