

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



SECTION 1115 WAIVER AMENDMENT

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Section 1 Introduction

Massachusetts health reform, as enacted in Chapter 58 of the Acts of 2006 and implemented by the Commonwealth with the support and partnership of CMS, has been an unparalleled success. Over 97% of Massachusetts residents now have health insurance, the highest rate in the country. More than 408,000 people in Massachusetts are newly insured since the implementation of Chapter 58. Private group and individual purchase make up more than 32% of the newly insured, with enrollment in group insurance increasing by 83,000 lives and individual purchase more than doubling. The percentage of employers offering health insurance in Massachusetts has remained steady at 72% while the percentage of offering employers has been dropping nationwide. The need for free care has significantly declined with volume and payments dropping drastically between hospital fiscal years 2007 and 2008.¹ For these reasons, the United States Congress has looked to the Massachusetts experience in crafting federal reforms and the legislation passed by each house of Congress bears a striking resemblance to the Massachusetts model.

Opponents of federal health reform, in expressing skepticism for the Massachusetts model, have claimed that Massachusetts health reform has resulted in uncontrolled costs. This is not true. As the Massachusetts Taxpayer Foundation, a business-supported think tank in Massachusetts, found in its 2009 report, “The cost of this achievement has been relatively modest and well within initial projections of how much the state would have to spend to implement reform.”² The report credits the high percentage of privately insured as one of the reasons for health reform’s success within reasonable costs. As the Center for Health Law and Economics found in their report, *Shared Responsibility*, individuals, employers and government have shared the costs of health reform proportionately.³ The authors found that because government costs for uncovered services declined sharply, government’s share of total payments was similar to its share before reform. As the authors of that report articulate and people working in Massachusetts health policy already knew, the largest factor contributing to increased spending for health care coverage in Massachusetts is health care cost inflation, which affects all payers.

Massachusetts, like states around the country, the federal government, the private sector, and individuals, is burdened by health care cost inflation and a payment system that does not reward efficiency. A recent study by the Massachusetts Division of Health Care Finance and Policy found that the way health care providers are paid in Massachusetts rewards those that provide a higher number of individual services, rather than those that

¹ Health Care in Massachusetts: Key Indicators, a report released by the Massachusetts Division of Health Care Finance and Policy, November 2009. (Available on line at www.mass.gov/dhcfp)

² Massachusetts Health Reform: The Myth of Uncontrolled Costs, Massachusetts Taxpayers Foundation, May 2009, pg 2. (Available on line at www.masstaxpayers.org)

³ Sharing the Cost of Health Care Reform by Robert Seifert and Paul Swoboda, April 6, 2009, prepared by the Center for Health, Law and Economics at UMASS Medical School for the Blue Cross Blue Shield Foundation of Massachusetts. (Available on line at www.bluecrossfoundation.org)

are best at coordinating care or delivering good quality services in less expensive settings.⁴ The report also found a health care system in Massachusetts dominated by a high number of specialty doctors - rather than primary care doctors that specialize in disease prevention and management of chronic diseases - and by academic medical centers, both of which tend to provide costlier care. Massachusetts also has a high concentration of physicians in academic medical centers compared to national averages.

All states, including Massachusetts are challenged in trying to sufficiently support institutions that provide a significant proportion of care for persons with state sponsored health care coverage. Institutions that depend on state programs more than commercial payments continue to face budgetary challenges post health reform in Massachusetts.

The Commonwealth is actively engaged in remedying these problems in Massachusetts. The Massachusetts General Court enacted cost control legislation in Chapter 305 of the Acts of 2008, creating a special commission on payment reform that has recommended that all payers in the Commonwealth move to a system of global payments, which is discussed in greater detail in the proposals below. The Patrick Administration, the legislature and a comprehensive and robust group of health care business partners and consumer advocates are jointly committed to the continued success of Massachusetts health reform and the cost containment and payment reform strategies necessary to make the entire system more efficient, while ensuring access and quality.

The requests to amend the Demonstration contained in this proposal reinforce our commitment to health reform and the goals articulated in the Demonstration. These proposals will help sustain the Commonwealth's extraordinary accomplishments through this unanticipated and unprecedented fiscal crisis and build a bridge to a more sustainable health payment system, to be implemented in the next Demonstration period.

Section 2 Requested Changes to the MassHealth Demonstration

2.1 Restore Authorization for Designated State Health Programs (DSHP) to 2007-2009 Levels

Starting in SFY 2007, CMS granted authority to the Commonwealth to claim federal reimbursement on spending for otherwise fully-state-funded health programs (referred to as 'Designated State Health Programs') through the expenditure authority of the Demonstration. In SFY 2007, SFY 2008, and SFY 2009, DSHP was limited to \$385 million in gross expenditures.

The Commonwealth agreed to a phase-down in DSHP authorization for SFY 2010 and 2011 late in the most recent renewal negotiations as a concession to secure the overdue

⁴ Health Care Cost Trends, a report released in February 2010 by the Massachusetts Division of Health Care Finance and Policy. (Available on line at www.mass.gov/dhcfp/costtrends)

Demonstration approval for SFY 2009 through 2011. However, the Commonwealth continues to appropriate funds to these important health programs.

The authorized DSHP programs continue to provide vital health services to the Commonwealth's residents as a complement to the services available through the Medicaid and Commonwealth Care programs. Despite the severe economic downturn and the reduction in the availability of federal funds under the current Demonstration agreement, the Commonwealth has prioritized these vital programs, preserving \$366 million of the \$385 million in expenditures, because of their importance to the overall health of the Commonwealth's residents. Accordingly, the Commonwealth asks CMS to revisit this provision and agree to return federal participation to the level authorized for SFY 2007-2009.

2.2 Increase Authorization for Unreimbursed Expenses at Hospitals Operated by the Departments of Public Health and Mental Health

The Commonwealth has claimed federal reimbursement for unreimbursed Medicaid and uninsured costs at non-acute hospitals operated by the Departments of Mental Health (DMH) and Public Health (DPH) for many years, both under the former Massachusetts disproportionate-share hospital (DSH) program, and the Safety Net Care Pool (SNCP). The 2009-2011 renewal of the Demonstration maintained that authority, at paragraph 45 (c) and in attachment E of the STC. Attachment E included approved annual SNCP expenditures of \$130 million for DMH and DPH facilities.

Attachment E also includes the following footnote: "Expenditures for items #5-6 (DPH / DMH) in chart A are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth." The approved amount of \$130 million was based on older data, and as such, the Commonwealth is requesting authorization to increase the amount in chart A to reflect 100% of unreimbursed Medicaid and uninsured costs as these facilities for 2010 and SFY 2011. This represents \$10 million for DPH facilities and \$14 million for DMH facilities, for a total of \$24 million in incremental gross expenditures for each year.

2.3 Authorize Relief Payments to Cambridge Health Alliance

Background

Cambridge Health Alliance (CHA) is the only public acute hospital system in the Commonwealth. CHA was founded to fulfill a public mission: the provision of high-quality medical and mental health services to the most vulnerable, underserved populations.

CHA evolved over many years as a Commonwealth-wide resource, filling voids in the Commonwealth-wide and regional safety net, by expanding to incorporate insolvent but

critical community hospitals in Somerville (Somerville Hospital) and Everett (Whidden Memorial Hospital), in collaboration with the Commonwealth.

CHA now includes three hospital campuses, and a total of 447 beds. CHA operates a community medicine-oriented teaching program, a primary care-focused physician practice, and 22 ambulatory sites, and covers approximately 80,000 inpatient days and 706,000 ambulatory visits each year. CHA is also the Commonwealth's largest acute mental health provider, with 199 licensed behavioral health beds, 42% of the total, of which 142 were acquired or developed to respond to critical mental health needs.

CHA's primary service areas have large, diverse working class populations, with about 30% of patients with incomes below 200% of the federal poverty level (FPL) and a native language other than English.

Before Massachusetts' 2006 health reform, 48% of CHA's patient care was for Commonwealth-insured or low-income uninsured individuals. After the implementation of health reform, CHA continues to provide the same high proportion (49%) of patient care for Commonwealth-insured and low-income uninsured individuals. Within this percentage, the share of low-income uninsured has decreased and the percentage covered by Medicaid and Commonwealth Care has increased. Overall low-income volume has increased as well.

CHA places a high emphasis on quality, which is reflected in key metrics. CHA's performance on national hospital core quality measures is within the top 25% nationally and statewide, CHA's HEDIS results compare favorably at levels equal to or greater than local health systems, and Joint Commission on Accreditation of Health Care Organizations results place CHA in the top 25% of state and national institutions (CHA scores 60 points using the Strategic Surveillance System). CHA has also been nationally recognized for excellence in health disparities reduction and serves as a first choice health system regionally for culturally and linguistically appropriate care.

Lastly, CHA also operates a managed care organization, Network Health, which offers MassHealth and Commonwealth Care products. However, 86% of Network Health members are outside of the CHA hospital primary service area.

CHA's Financing

Due to the concentration of primary care, outpatient, and mental health services, CHA has historically been at a disadvantage financially. However, particularly because of the capacity for primary care and mental health services, CHA has been and continues to be a critical provider for low-income individuals. As such, for many years, the Commonwealth and the federal government have supported CHA with supplemental payments. These payments have been authorized through the Commonwealth's Medicaid State Plan, through the former disproportionate-share hospital (DSH) and MCO supplemental payment programs, and most recently, through the Safety Net Care Pool.

The latest iteration of these payments was created in Section 122 of Chapter 58 of the Acts of 2006, the Commonwealth's health reform law. The section 122 authority expired at the end of state fiscal year 2009. Rather than try to create a new version of the same payments that had been supporting CHA for years, the Commonwealth and CHA instead chose to focus on a funding blueprint that would maximize limited resources, and ensure that CHA set the standard for a streamlined, high-quality safety net health system.

Reconfiguration

During early 2008, CHA retained Ernst and Young to conduct an assessment of CHA, develop a strategic plan for system transformation, and recommend specific strategies to reduce costs and provide for CHA's long-term sustainability. From November 2008 to January 2009, the Executive Office of Health and Human Services (EOHHS) and CHA engaged in intensive collaborative discussions that were informed by this assessment. This process resulted in a better mutual understanding of CHA's essential services and the Commonwealth's priorities, and further strengthened the working partnership between the Commonwealth and CHA.

As a part of this process, a multitude of options for restructuring the CHA hospital system were evaluated with respect to the following shared principles:

- Preserve critical local, public health services in communities
- Maintain primary care, secondary care, emergency care, and mental health services
- Maintain highest service quality and patient access
- Deliver services as efficiently as possible; implement cost savings opportunities
- Achieve greater financial stability

In February 2009, CHA's trustees approved a services reconfiguration plan, which was aimed at maximizing efficiencies/cost savings, preserving CHA's core mission, and restructuring to become an integrated medical home and accountable care organization (ACO) model to set the foundation for a sustainable and financially viable safety net health system.

The detailed approach of the reconfiguration plan was to preserve core services in CHA's communities while taking bold, yet difficult, steps to consolidate its clinical services footprint and achieve economies of scale. CHA committed to adhere to an aggressive timeline, pursue all possible avenues to reduce and contain costs and improve revenue (valued at \$70 million in SFY 2010 and \$32 million more in SFY 2011) and to combine one-time initiatives (salary freezes, employee benefit reductions, limiting capital expenditures) with longer-term projects (service reconfiguration, revenue cycle).

The reconfiguration began in February 2009, and will be completed by June 2011. The detailed changes are as follows:

- Inpatient medical / surgical
 - Transitioned from three to two inpatient hospital facilities
 - Relocated 3 inpatient units from Somerville campus to Cambridge / Everett campuses, and transformed Somerville into an ambulatory and emergency center (Cambridge provides inpatient capacity for Somerville emergency department)
- Behavioral health
 - Based on consultations with the Commonwealth, refocused from being a statewide mental health provider to prioritizing mental health services for patients of CHA's primary care system and primary service area
 - Reduced CHA's inpatient mental health services (by 35 adult beds and 26 addictions beds) while retaining the pediatric, adolescent, adult and geriatric continuum of care
 - Currently reducing outpatient mental health care services by 20% to reflect available capacity at other more geographically appropriate providers
- Ambulatory care
 - Currently consolidating six primary care practices, four specialty practices, and a dental clinic with other existing practices to achieve economies of scale while minimizing patient access impact
- Workforce impacts
 - CHA has reduced workforce by 447 FTEs below the July 1, 2007 level
 - All executives and physician leaders have given back 9% in compensation, building on two prior years of forgone merit/bonus programs
 - All managers have reduced benefit time (by five days annually)
 - CHA employees have voluntarily reduced salary/earned time by over \$1 million
 - Non-union and union employees' share of health insurance premiums has increased, and salaries are frozen for current fiscal year
- Revenue improvements
 - CHA is actively renegotiating commercial managed care contracts (roughly 18% of revenues) to improve payment rates
 - CHA has implemented many revenue cycle improvements, which have already increased revenue
 - Improved cash collection
 - Reduction in claims denials
 - Enhancing preregistration and authorization functions

In addition to the above, CHA is working towards becoming a medical home and an ACO, which supports the Commonwealth's payment reform initiative, and is expanding care management and quality improvement programs. As a part of this effort, CHA is currently implementing a joint care transformation pilot with Network Health that is focused on managing care for 3,000 complex patients who are both health plan members and who have CHA primary care providers. CHA is also defining requirements for

strategic partnerships with tertiary providers as part of an intentional extension of its continuum of care and organization into an ACO.

In order to ensure that the reconfiguration is not simply a one-time adjustment, CHA has committed to continuously pursuing revenue cycle improvements and evaluating service mix and geographic footprint, as well as to assessing potential changes to align primary care physician compensation with quality and outcomes.

Additional payments to support reconfiguration and the reconfigured health system

Throughout the discussions regarding the reconfiguration plan, the Commonwealth and CHA understood that despite the substantial changes that have and will be implemented, support in excess of existing rates would continue to be required to ensure the financial viability of CHA. While the reconfiguration reduces CHA's costs substantially, it does not address the underlying challenges that CHA faces within the current health care payment system.

Such support is necessary to prevent CHA from having to reduce the level of high-quality and much-needed primary care and mental health services, or prevent it from venturing into high-margin medical technology that is already sufficiently available in the geographic area. These alternatives would create problems for the individuals who rely on CHA for services that are unavailable elsewhere, would escalate overall health care costs, and would represent a move away from the health system that we strive to have.

In order to support CHA through the reconfiguration, the Commonwealth is proposing an additional \$110 million in payments to CHA for SFY 2010, and an additional \$100 million for SFY 2011. The SFY 2010 payments have been authorized through the Commonwealth's 2010 General Appropriations Act (Chapter 27 of the Acts of 2009), and the SFY 2011 payments are included in the Governor's budget request. Like the approved payments to CHA, the non-federal share of these amounts will be provided by the Cambridge Public Health Commission through permissible intergovernmental transfers. The Commonwealth has updated Charts B and C of Attachment E to reflect these proposed payments, as well as updated cost and rate payment information for CHA.

It is important to note that these proposed payments slightly exceed CHA's low-income expenses less payments for each year, with SFY 2011 being closer than SFY 2010. This reflects an investment in the infrastructure necessary to support the reconfiguration, as well as the beginning of a transition to restructured government payments.

Through an ambitious reconfiguration effort, CHA has demonstrated a commitment to innovation in quality and efficiency. This commitment ensures that additional funding will truly be an investment bearing returns for the vulnerable populations that will continue to rely on CHA and the payers that support this population, as well as for Commonwealth and federal taxpayers. The Commonwealth looks forward to continuing to collaborate with CHA to keep CHA on the front lines of innovation in the delivery of

high-quality, efficient health care to the vulnerable populations of the Commonwealth, and in doing so, leverage maximum value for the taxpayers' investments.

2.4 Authorize Relief Payments to Private Hospitals

Acute hospitals are a critical component of the continuum of care, particularly for low-income individuals who live in areas with a large percentage of low-income populations who are underserved. As are all states, the Commonwealth is faced with the challenge of maintaining access to essential hospital services for low-income individuals in a health care system where payments do not ensure efficiency of care or the best outcomes for patients. Massachusetts' hospitals that provide traditionally lower margin services and have a high concentration of state and federally supported populations are particularly challenged in the current economic.

The current payment system creates at least three distinct but interrelated problems, as follows:

First, under fee-for-service, providers have no incentives to provide the most appropriate, cost-effective care to patients; rather, the fee-for-service system rewards volume.

Second, all payers generally provide higher levels of reimbursement for inpatient services, with the highest rates for complex care, while outpatient services, behavioral health, and primary and preventive care are less well-reimbursed, despite agreement that they are critical to decreasing overall health care costs and improving outcomes.

Third, hospitals which have higher percentages of individuals supported by state programs, provide unique services for those individuals, and have lower degrees of involvement with commercial insurance, have additional financial challenges.

As a part of Chapter 305 of the Acts of 2008, the Massachusetts General Court established the Special Commission on the Health Care Payment System. Chapter 305 charged the Commission with three responsibilities: (1) to examine payment methodologies and purchasing strategies, (2) to recommend a common transparent methodology, and (3) to recommend a plan for the implementation of a common payment methodology across all public and private payers in the Commonwealth.

The Commission included members of the administration involved in health care delivery, legislators, an expert on health care payments, and representatives from physician, hospital, and insurer groups. The Commission met throughout the spring of 2009. On July 16, 2009, the Commission released a unanimously-approved final report⁵, which recommended a shift by all payers to a system of global payments, through a framework of accountable care organizations (ACOs) and an emphasis on the medical home model. When implemented, this payment system will help rebalance public and private payments, reduce the financial advantage that accompanies inpatient services and

⁵ Available at www.mass.gov/dhcfp

tertiary care at the expense of primary and preventive care, and expand effective primary and preventive services, because providers will have financial incentives for cost-effective care.

The Commonwealth is currently developing legislation to enact these recommendations, and looks forward to integrating them into the Commonwealth's upcoming Demonstration renewal. In the interim, the Commonwealth must create a transitional approach for hospitals that mitigates the combination of existing problems of the payment system and the economic downturn.

In accordance with this goal, the Commonwealth is requesting authorization to provide a total of \$135 million in additional payments to all private hospitals for SFY 2010 and SFY 2011 through the Safety Net Care Pool. These payments will be authorized on the state level through forthcoming legislation.

The proposed calculation prioritizes those hospitals for which Medicaid and other state-supported programs for low-income individuals represent a large share of total services delivered, and for which commercial insurance represents a small share. The calculation then adjusts the payments to reflect the total level of expenses for state-supported programs for low-income individuals at each hospital. This ensures that the level of relief reflects the extent to which individual hospitals are negatively affected by the current payment system and the economic downturn.

It is important to note that this proposal is consistent with the Commonwealth's commitment to shift from a system reliant on opaque institutional payments to one of payments for insurance. The Commonwealth, together with the federal government, has been immensely successful in decreasing the level of uninsurance. However, this has further exposed the need for changes to the payment system, and galvanized the group of stakeholders that came together to support health reform in 2006 to tackle the complex issue of payment reform.

With the work of the Commission, the Commonwealth is fully engaged in the critical next phase of health reform, and these transitional payments will ensure that the safety net will remain stable until payment reform can be implemented.

2.5 Eliminate the Provider Subcap

The Commonwealth proposes that the provider subcap, created in paragraph 46 (c) of the current Demonstration agreement, be eliminated, in order to accommodate the spending requested in this amendment, and to normalize the treatment of spending within the SNCP. This subcap was created in the last waiver negotiation as an additional restraint on spending within the SNCP, which is itself a cap within the budget neutrality limit within which all state demonstrations must operate.

As discussed above, the Massachusetts health reform experience has highlighted the need to find a consistent, transparent, reliable mechanism for supporting hospitals, particularly those that provide a disproportionate amount of care for state supported populations, and has galvanized stakeholders around payment reform. Planning for payment reform in Massachusetts is underway, but a transitional approach to provide relief to health care institutions is necessary. Such an approach cannot be accommodated within the existing provider subcap.

This is not a retreat from the commitment to insure all residents. Despite, and even because of the economic downturn, the Commonwealth remains committed to maximizing enrollment and preventing even temporary lapses in insurance coverage. (See discussion of the Robert Wood Johnson Maximizing Enrollment grant and other outreach and enrollment activities in the Commonwealth's 2008 and 2009 quarterly Demonstration reports.) The Commonwealth maintains the lowest percentage of uninsured residents in the country at less than 3%, and strives to reduce it even further. The additional authority proposed in this amendment will support those efforts by helping the Commonwealth bridge the gap to large-scale cost containment while maintaining access for low-income populations.

The Commonwealth believes that elimination of the provider subcap is not only critical to allowing the Commonwealth to make important expenditures, but is also appropriate within the structure of the Demonstration. The existing provider subcap is based on the Commonwealth's annual DSH allotment. However, the Commonwealth no longer has a DSH program, as it has redirected 100% of the federal DSH allotment into the Demonstration. As such, the Demonstration allows the Commonwealth to utilize funding that would flow to a DSH program in the absence of the Demonstration to support Demonstration spending, regardless of whether that spending supports DSH-like programs.

Further, as described in the SNCP section, the Commonwealth has argued and continues to argue that any subcap within the budget neutrality limit represents an unnecessary restriction on spending from what would otherwise be savings. The Commonwealth understands the need of CMS to maintain appropriate oversight of the Commonwealth's spending under the Demonstration, which the Commonwealth believes exists through the budget neutrality agreement and the line-item authorization for hospital supplemental payments created in the Special Terms and Conditions.

Overall, eliminating the provider subcap and authorizing the requested relief payments to hospitals will ensure that residents can use the insurance that the Commonwealth, in partnership with the federal government, has worked so hard to make available, without compromising financial monitoring or the goals of the Demonstration.

2.6 Increase the Aggregate Safety Net Care Pool Cap (SNCP)

The current SNCP cap for SFY 2009-2011 is \$4.727 billion. The proposed changes included in this amendment require an additional \$473 million in room within the SNCP for the SFY 2009-2011 period, for a total SNCP of \$5.200 billion over the three years.

The Commonwealth's request for the most recent renewal of the Demonstration proposed that CMS normalize the treatment of SNCP spending under the Demonstration by eliminating the SNCP cap, as the Commonwealth believed that it represented an artificial limit on certain categories of waiver spending below the true limit of budget neutrality. That is, the Commonwealth proposed to treat SNCP spending in the same way that all other spending allowable by expenditure authority in the Demonstration is treated with respect to budget neutrality.

This proposal was not adopted as a part of the renewal. The Commonwealth continues to believe that this is an appropriate construct, and plans to propose this change again as a part of the forthcoming renewal effort. Because the Commonwealth understands that this is a major structural change to the existing Demonstration agreement, this amendment would not eliminate the SNCP cap; rather, this amendment would expand the SNCP cap to support the level of expenditures requested.

As noted in the budget neutrality section, the proposed expenditures fit well within the budget neutrality limit for the Demonstration. Further, the Commonwealth believes that they are within the defined purpose of the SNCP, and critical to the sustainability of the Demonstration and the Commonwealth's health reform effort as a whole.

The Commonwealth understands CMS's need to actively monitor the Demonstration and carefully authorize federal Medicaid funds. To this end, even under an expanded SNCP, CMS would continue to retain specific authorization for hospital supplemental payments, and the Commonwealth would continue to work collaboratively with CMS to provide all necessary information regarding SNCP and overall Demonstration spending. The Commonwealth looks forward to discussing the proposed changes to the SNCP to ensure that CMS has sufficient information with which to evaluate, and if approved, monitor them.

2.7 Authorize Modest Increase in MassHealth Pharmacy Co-Payments

Governor Patrick and the Massachusetts General Court have been steadfast in their commitment to Massachusetts health reform, maintaining eligibility and virtually all services for all health reform programs, despite extraordinary reductions in state revenue during this waiver term. The Commonwealth has also strongly resisted shifting any costs to members. However, to avoid reductions in services or eligibility, the Governor has proposed a modest increase in co-payments for generic prescription drugs from \$2 to \$3 per prescription in his SFY 2011 budget. The proposed increase in co-payments excludes generic anti-hyperglycemics, anti-hypertensives, and anti-hyperlipidemic prescriptions

used for chronic, long-term medical conditions to help ensure consistent use of these important health maintenance drugs. The co-payments for these drugs will remain at \$1.

The current Demonstration agreement states in Attachment B that co-payments for generic prescriptions in the MassHealth Standard program shall not exceed \$2. When the Demonstration agreement was written, the Commonwealth did not anticipate needing to increase pharmacy co-payments. However, in accordance with the Governor's budget submission, the Commonwealth is requesting an amendment to Attachment B that allows generic co-payments to increase to \$3. The Commonwealth anticipates no other changes to the cost-sharing limits articulated in the Demonstration agreement.

Section 3 Notification of Changes Consistent with Current Demonstration Authority

3.1 Infrastructure and Capacity Building Expenditures at Hospitals and Community Health Centers

Paragraphs 45 (d) and 46 (b) of the Demonstration agreement authorize the Commonwealth to claim expenditures that, "support the continuation of health care services that benefit the uninsured, underinsured and SNCP populations, such as capacity building and infrastructure." (Paragraph 45 (d)) Paragraph 46 (b) states that no amendment is required for such expenditures, only that the Commonwealth notify CMS of the activities planned with this authority. The Commonwealth hereby notifies CMS of our plan to make Infrastructure and Capacity Building (ICB) awards to hospitals and community health centers with this description and with the accompanying updates to Attachment E.

The SFY 2010 budget and the Governor's proposed budget for SFY 2011 both included \$20 million to improve the delivery of health care at hospitals and community health centers. In both cases, \$4.2 million is being set aside for fee-for-service rate increases for community health centers. The remaining \$15.8 million is being distributed through a request for proposals. Awards will be granted based on certain deliverables that have been developed to address health system improvement. These activities include: re-directing non-emergent use of emergency rooms to community health centers; showing progress in implementation of health information technologies; demonstrating readiness for a transition to global payments; and providing after-care appointments and monitoring for patients released from behavioral health facilities. The RFP for SFY 2010 is currently under internal review and will be released shortly.

3.2 Providing Pharmacy as a Fee-for-Service Benefit to MassHealth MCO Members

Currently, MassHealth members who elect coverage through a contracting Managed Care Organization (MCO) receive covered out patient drugs through the MCO. As a revenue

initiative for SFY 2011, the Governor's budget proposes to provide MassHealth MCO members with their covered outpatient drugs through the larger MassHealth fee-for-service pharmacy program. This will allow the Commonwealth to take advantage of the rebates available to Medicaid programs. This is projected to save \$42 million in the MassHealth program in SFY 2011. This proposal has been widely vetted with the legislature, consumer groups, the MCO's and other interested stakeholders. As is currently the case, MassHealth will continue to contract with MCO's under comprehensive risk contracts. Therefore, no waiver amendment is necessary, but the Commonwealth takes this opportunity to notify CMS of this policy change.

Section 4 Budget Neutrality Impact

Budget neutrality prior to amendment

The Commonwealth's projected budget neutrality cushion as of the quarterly report for the quarter ending December 31, 2009 is \$2.46 billion, or approximately 11% of projected without waiver expenditures for SFY 2009-2011. This projection, which is discussed in detail in the quarterly report for the quarter ending December 31, 2009, incorporates actual expenditures and member months through SFY 2009 as reported through the quarter ending September 30, 2009, combined with the MassHealth budget forecast as of October, 2009 (for SFY 2010-2011) and Commonwealth Care and Health Safety Net (HSN) information from the SFY 2010 budget and SFY 2011 Governor's proposed budget.

This budget neutrality projection reflects significant realized and anticipated savings that include creating consistency among providers in hospital rates, limiting current-year inflation in provider and MCO rates, and enhancing compliance activities and utilization management. It also includes projected spending for the Children's Behavioral Health Initiative (CBHI), which, per paragraph 73 (d) of the Demonstration, may be included in the expenditure limit for the Demonstration after the submission of an evaluation plan, and CMS approval thereof.

Effect of amendment

The budget neutrality statement for the quarter ending December 31, 2009 includes projected SNCP spending of \$4.38 billion over SFY 2009-2011. As reflected in the accompanying redlined Attachment E, this amendment would increase projected SNCP spending to \$5.200 billion over the three-year period, which would result in a three-year budget neutrality cushion of \$1.64 billion, or 7% of projected without waiver expenditures for SFY 2009-2011⁶. As such, after integrating the proposed amendment, the Commonwealth and the federal government would continue to realize savings on the Demonstration.

⁶ This amendment has no impact on projected without waiver spending under the Demonstration.

Section 5 Public Process

The State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994) referenced in paragraph 15 of the Demonstration STC's articulate a number of different ways that a state may satisfy the public process requirement. All of them are designed to ensure that people who may be affected by changes to the demonstration have an opportunity to learn about the changes and have an opportunity to provide input. The Commonwealth strongly supports this principle. The Patrick administration has built a reputation for sharing information with all its constituencies and considering consumer input.

While the waiver amendments requested in this proposal are of vital importance to the fiscal health of the state and its safety net providers, they do not represent significant changes to the waiver programs. In fact, the only programmatic change requiring amendment is the \$1 increase in pharmacy co-payments. No other change has a direct impact on members. For that reason, the Commonwealth did not engage in a designated public input process for this amendment submission in the way that it has done for waiver applications in the past, and in the way it has already begun to do for the 2011 renewal. The Commonwealth therefore opts for option 2 of the State Notice Procedures requirement as articulated in 59 Fed. Reg. 49249, and is hereby submitting a description of the process that was used to obtain public input.

1. State Legislative Approval

Requests 2.3, 2.4, and 2.7 of this proposal - payments to CHA, payments to private hospitals and the co-payment increase, respectively - are all subject to approval by the state legislature. The commitment to seek additional payments for CHA was widely publicized when the hospital alliance announced their reconfiguration plan in February 2009. Further, the reconfiguration plan was subject to a number of public hearings. The requested SFY 2010 payments to CHA have been approved by the Governor and the General Court in the SFY 2010 budget. The requested SFY 2011 payment to CHA was included in the Governor's SFY 2011 budget proposal. The proposed payments to private hospitals are the result of more recent discussions with private hospitals and are subject to legislative approval for both SFY 2010 and SFY 2011. The co-payment increase was accounted for in the Governor's budget proposal for SFY 2011, featured in a MassHealth fact sheet on the Governor's budget proposal available on line, and has been discussed at various stakeholder briefings and advocacy meetings.

2. Publication of Notice in Newspapers

The other requests in this proposal, 2.1, 2.2, 2.5, and 2.6, seek to amend spending limits and subcaps created in the waiver agreement. They are not associated with any programmatic changes and do not have any direct impact on members. The Commonwealth elected to use newspaper publication as the means of satisfying the public process requirements for those elements of the waiver proposal. The notice provided herewith in Attachment C, was published in the Springfield Republican, the

Worcester Telegram and Gazette and the Boston Globe. These publications are the newspapers of widest circulation in the three Massachusetts cities with populations greater than 100,000: Springfield, Worcester and greater Boston, including Cambridge.