

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



SECTION 1115 DEMONSTRATION PROJECT EXTENSION REQUEST

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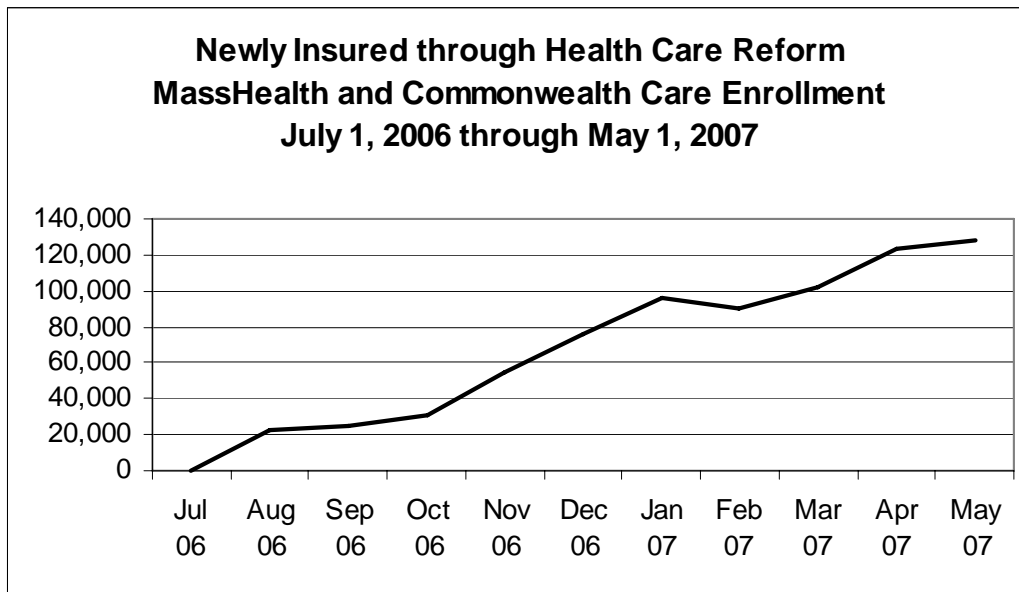
**Attachment C: Proposed Changes to Section 2 of the Demonstration’s
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**Attachment D: Proposed Changes to Section 11 of the Demonstration’s
Program Specifications (Attachment D of STCs)**

Section 1 The Critical Role of the 1115 Demonstration in Health Care Reform

In April 2006, Massachusetts passed landmark legislation to provide access to affordable health insurance to all Massachusetts residents. The legislation, Chapter 58 of the Acts of 2006 (Chapter 58), titled *An Act Providing Access to Affordable, Quality, Accountable Health Care*, was the result of a bipartisan effort among state leaders from government, business, the health care industry, community-based groups and consumer advocacy organizations. Massachusetts' health care reform plan is a series of bold interdependent activities and programs, each necessary for the other to be successful and to achieve the overall goal of drastically reducing the rate of uninsurance in Massachusetts. Since the implementation of the reform plan on July 1, 2006, nearly 125,000 previously uninsured individuals now have health insurance coverage (see Figure 1). One year into this historic endeavor, all of the stakeholders in the Commonwealth remain fully engaged in this effort and wholly committed to this initiative toward universal coverage in Massachusetts.

Figure 1:



Health care reform in Massachusetts, however, would not have happened without the long-standing and critical partnership between Massachusetts and the federal government on the MassHealth 1115 Demonstration Project (the Demonstration). The opportunity to renew the Demonstration on July 1, 2005 served as a catalyst for health care reform in Massachusetts and a fundamental building block of the health care reform plan.

The framework for health care reform was established in the Demonstration extension that the Centers for Medicare and Medicaid Services (CMS) approved on January 26, 2005 when the Safety Net Care Pool (SNCP) was created. The SNCP centralizes a pool of money dedicated to providing health care services to uninsured and underserved state residents and memorializes CMS's commitment to keeping critical federal revenue in Massachusetts' health care system. Financing for the SNCP comes from various sources of state and local government funds that CMS has approved and designated as eligible for federal Medicaid matching dollars.

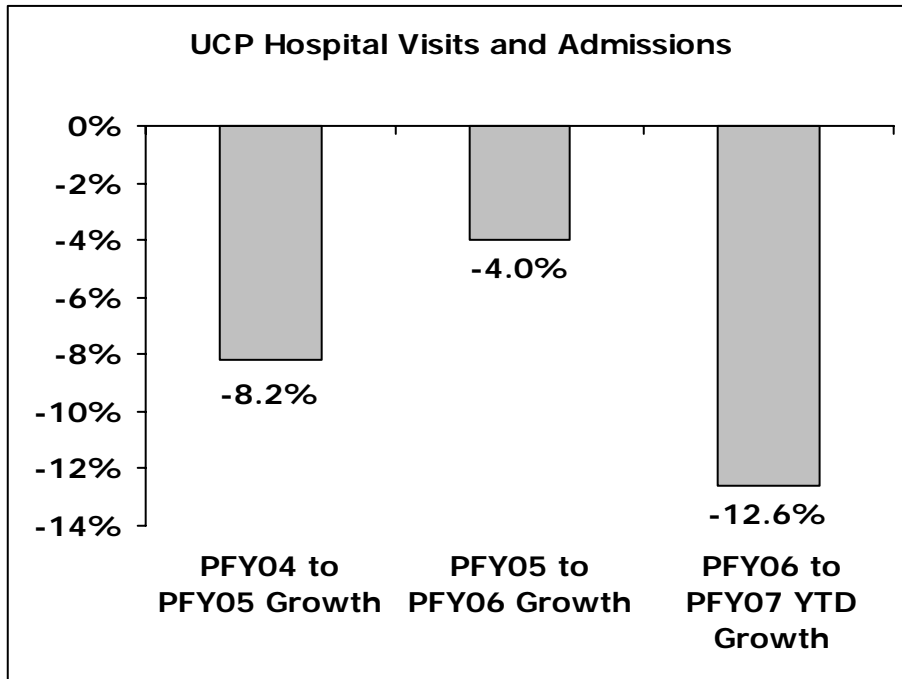
Through the SNCP, the Commonwealth can use state and federal Medicaid dollars creatively to expand coverage to more people by redirecting public funds from providers of uncompensated care to individuals in an insurance-based health care system. The SNCP maximizes the use of private dollars in providing insurance and includes mechanisms to prevent limited public dollars from replacing privately-funded coverage. A hallmark of the health care reform plan that is a part of the SNCP is the Commonwealth Care premium assistance program, which is administered by an independent public authority called the Commonwealth Health Insurance Connector Authority (the Connector). Commonwealth Care makes health insurance products affordable by subsidizing or partially subsidizing the premiums for low-income individuals not eligible for MassHealth. Finally, the SNCP recognizes the need for a safety net system of providers to care for individuals not served by the insurance system by preserving state and federal funding historically dedicated to this purpose. The SNCP serves as a critical bridge between the traditional publicly-funded MassHealth program and a purely private health insurance market and helps ensure that viable health coverage options exist for all Massachusetts residents.

The broader health care reform plan in Massachusetts builds upon the MassHealth Demonstration by creating unsubsidized, but affordable health insurance products for individuals who historically have found non-group or small-group health insurance difficult to afford or financially out of reach. The Connector serves as an organized marketplace for all of these affordable private plans, enabling individuals and small businesses to compare plan premiums and benefits and select a plan that best meets their or their employees' needs. Other key elements of the health care reform plan include initiatives to increase transparency around health care quality and costs, insurance market reforms, an individual health insurance requirement, and employer participation responsibilities. The federal-state partnership for subsidized coverage created by the Demonstration and the other private market principles underlying health care reform in Massachusetts have become a model for states around the country.

Through intense focus and unwavering commitment to these principles and the overall goals of health care reform, Massachusetts has made significant progress in the past year in reducing the rate of uninsurance. As health insurance coverage has expanded dramatically, the number of uninsured individuals determined eligible to receive services paid for by the state's uncompensated care pool has decreased by 35% from October

2006, when the state implemented Commonwealth Care, through March 2007. Uncompensated Care Pool utilization has decreased by almost 13 percent during this same period, demonstrating that the success-based model originally envisioned is working (see Figure 2).

Figure 2:



Health care reform in Massachusetts, however, is still in its infancy. There is much more work to do in finding individuals who remain without health insurance and enrolling them in health plans, monitoring the affordability of the private health insurance products, implementing and enforcing the health insurance requirement on July 1, and ensuring that all of the financing remains in place to fully fund the health care reform plan. Ongoing commitment by all of the partners in this initiative, including the federal government, will be critical to fully implementing the model and maximizing access to affordable health insurance coverage for Massachusetts residents.

While only a portion of the health care reform plan is tied to the Demonstration, it is a vital component and building block for the comprehensive reform effort. The Demonstration authorizes federal funding for important MassHealth expansions and the Commonwealth Care program, and provides critical funding to support the health care safety net. The Commonwealth seeks approval from CMS to extend the Demonstration for another three-year period starting July 1, 2008 and looks forward to working collaboratively with CMS to continue this important federal-state partnership that is essential to the success of health care reform in Massachusetts.

Section 2 Special Significance of the Requested Extension

The MassHealth Demonstration has been a critical tool since 1997 for expanding coverage to low-income children, families and individuals in Massachusetts and a key factor in why Massachusetts has one of the lowest rates of uninsurance in the country. In 2004, the state saw and took advantage of an opportunity to continue to make meaningful inroads in covering the uninsured in Massachusetts. The Demonstration provided one vehicle for doing so and for implementing long-term and fundamental reform to Massachusetts' health care system.

Massachusetts has made tremendous progress in covering the uninsured after one year of health care reform implementation. However, the Commonwealth always envisioned health care reform as an initiative that would take several years to implement fully. As we continue down the path of covering all Massachusetts residents and making substantive improvements to the quality and cost of delivering care, the state will continue to rely on its 1115 Demonstration waiver authority for flexibility and innovation, while continuing to ensure the budget neutrality of federal Demonstration expenditures. While we remain fully committed to the health care reform plan as originally designed, as implementation evolves the state will continue to need this flexibility to adapt to unanticipated challenges and opportunities, and to be able to sustain the successes we have achieved to date.

The next three years of health care reform implementation will be high-profile nationally and illuminating for state policy makers. The success of health care reform will be judged over time as we know more about:

- the impact of a major public awareness campaign and its resulting effect on enrollment in public programs and affordable private insurance products;
- the appropriate balance between the MassHealth and Commonwealth Care programs and the uncompensated care pool;
- the sufficiency of the ongoing support for the safety net;
- the implications of the affordability standards;
- the effectiveness of the insurance requirement and its enforcement mechanism;
- the impact on health insurance premiums as more people enroll in coverage;
- the impact of health care reform on employer participation in the provision of health insurance;
- the effectiveness of quality and cost initiatives; and
- the full costs of comprehensive health care reform.

Extension of the Demonstration for another three years, therefore, is essential to fully implementing health care reform and measuring its success over time. State and federal officials must “stay the course” and maintain the commitments to and investment in health care reform in Massachusetts made over two years ago.

Section 3 Health Care Reform Achievements to Date

The Commonwealth's May 1, 2006 request to CMS to amend the Demonstration to incorporate relevant provisions of Chapter 58 set out an implementation timeline that included key milestones with scheduled target dates. The Commonwealth has met each of the following milestones on time:

- establishment of the Commonwealth Health Insurance Connector Authority;
- implementation of the Commonwealth Care and Commonwealth Choice health insurance programs;
- creation of the Health Care Quality and Cost Council and the MassHealth Payment Policy Advisory Board;
- expansions and other changes to the MassHealth program; and
- distribution of outreach grants to community-based organizations to reach individuals eligible for these programs.

The outstanding milestones identified last May, including the individual mandate, the creation of the Health Safety Net Office and reforms to the uncompensated care pool, are scheduled to be in place in the coming months.

A more detailed status update on each of the key components of health care reform implementation, including components not directly authorized or funded by the Demonstration, follows. All of these components, both inside and outside of the Demonstration, combine to form the structural context necessary for success. The following updates tell the story of a year of tremendous progress in the long-term policy and infrastructure development that was promised and is being delivered in Massachusetts.

3.1 Establishment of the Commonwealth Health Insurance Connector Authority

One of the most innovative and exciting features of Massachusetts' health care reform model is the creation of the Commonwealth Health Insurance Connector Authority (the Connector). The Connector has broad statutory responsibilities for implementing many of the key components of the reform strategy, including making affordable health insurance products available to the uninsured and small businesses.

The Connector is a new, independent public authority that is governed by a 10-member board, including state administrative officials and representatives of various interests appointed by the governor and attorney general. The Connector board hired an Executive Director to manage the day-to-day operations of the Connector programs and responsibilities. The Connector's roles, evident in the sections below, span a broad range of business and policy functions. Programmatically, the Connector administers both the Commonwealth Care and Commonwealth Choice programs. The Connector's website at www.mahealthconnector.org provides comprehensive information about health care

reform and about eligibility, benefits, cost-sharing and health plan enrollment for these programs.

3.2 Commonwealth Care Premium Assistance Program

Effective July 28, 2006, CMS approved the Commonwealth Care Premium Assistance program in the amended Special Terms and Conditions (STCs) of the MassHealth Demonstration. CMS granted the Commonwealth expenditure authority to provide subsidies for health plan premiums offered to individuals with income at or below 300% of the FPL, who are not otherwise eligible for MassHealth. These expenditures are made from the capped Safety Net Care Pool (SNCP) established in the July 2005 renewal of the Demonstration.

Chapter 58 specifies that the four managed care organizations already under contract to cover MassHealth members will be able to participate in Commonwealth Care on an exclusive basis for the first three years of the program. The MCOs were required to submit proposals to the Connector, outlining the details of their benefit packages, enrollment systems, utilization management, information systems, grievance and appeals procedures, and their premium rates, which were required to be certified as actuarially sound. Chapter 58 further required that the Commonwealth Care program begin offering health plans in October 2006.

The Connector board determined that each Commonwealth Care managed care organization would offer four plan types with the same basic benefits but different enrollee contributions and out-of-pocket costs. As specified by Chapter 58, individuals with earnings less than the federal poverty level are fully subsidized, make limited copayments for pharmacy and emergency care that are no greater than those required in the MassHealth program, and receive a comprehensive benefit package modeled on MassHealth Essential, that includes dental coverage. Enrollees with family income between 101% and 150% of the FPL are also fully subsidized, but receive a benefit package that does not include dental coverage, and includes copayments on more services than in MassHealth.

The lowest cost plans for enrollees with family incomes between 151% and 300% of the FPL range from \$35 to \$105 a month. Enrollees with family income between 151% and 200% of the FPL pay a monthly premium and small copayments apply to most types of care. Enrollees with family income between 201% and 300% of the FPL are able to choose from two plan types, one with lower monthly premiums and higher copayments, the other with higher monthly premiums and lower copayments. Individuals for whom employer-sponsored insurance is available are generally not eligible to participate in Commonwealth Care.

Bidding among the four MCOs took place in two rounds, with the premium rate differences between the first and second rounds resulting in substantial program savings. In less than four months, the Connector specified Commonwealth Care benefits and

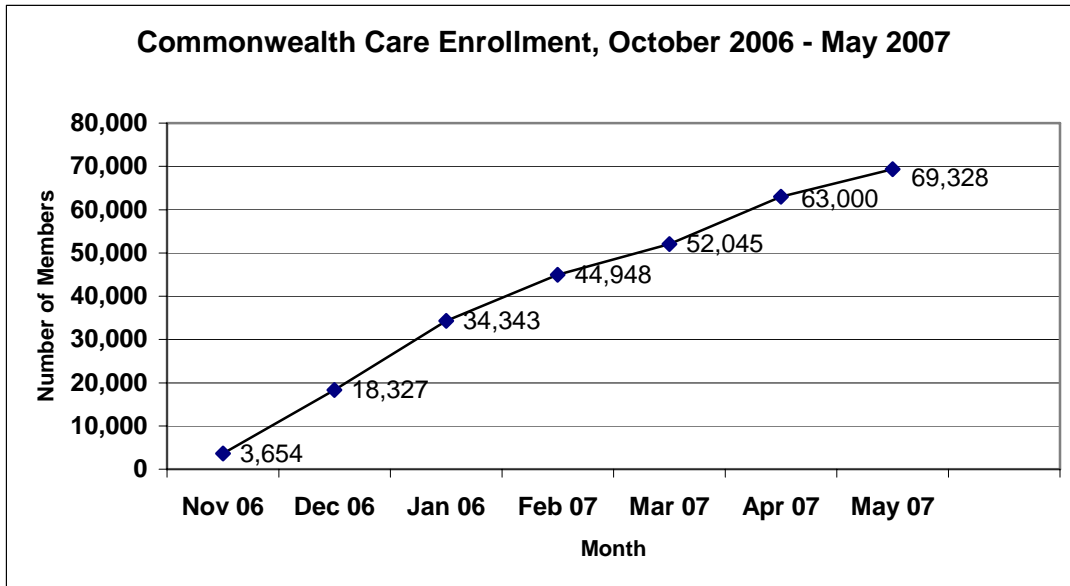
enrollee contributions, completed negotiations and contracting with each of the MCOs, and worked in conjunction with MassHealth and contractors to develop outreach, eligibility and enrollment procedures and materials, and to train key staff and stakeholders.

MassHealth systems and processes support eligibility and enrollment for Commonwealth Care. The joint application process for MassHealth, Commonwealth Care, and the Uncompensated Care Pool (UCP) provides a single point of access to several state health programs and ensures that applicants receive the most appropriate benefit. Persons who meet the categorical and financial requirements of Title XIX are identified, enrolled in MassHealth, and coded into the Demonstration's budget neutrality base. MassHealth expansion eligibles also are appropriately enrolled and coded for budget neutrality purposes. MassHealth's eligibility system has been modified to establish coding for Commonwealth Care eligibles that allows their expenditures to be properly assigned to the SNCP in Demonstration reporting. The Connector contracts with a vendor to fulfill certain administrative requirements of the Commonwealth Care program, including customer service and premium billing.

As of May 1, 2007, total enrollment in Commonwealth Care reached nearly 70,000 people (see Figure 3). On October 1, 2006, the first phase of Commonwealth Care was launched as planned, starting with the automated enrollment of adults with income below the federal poverty level whom had received care paid for by the UCP. After seven months, 53,768 low-income residents with income at or below 100% of the FPL had enrolled in Commonwealth Care.

In January 2007, the next phase of Commonwealth Care was implemented for adults with family income up to 300% of the FPL for whom subsidies decline as income rises. In this phase the concept of price-sensitive choice became important as consumers weighed their options among the available MCOs and contribution levels. After four months, 15,560 individuals with income between 100% and 300% of the FPL had enrolled in Commonwealth Care. These numbers are consistent with the expectation that enrollment of those at the higher income levels of the program would be somewhat slower because consumers must choose among various options and must pay the first month's premium prior to enrollment. Implementation of the individual mandate, discussed below, is expected to further stimulate enrollment.

Figure 3:



3.3 Commonwealth Choice

Commonwealth Choice, also administered by the Connector, is the unsubsidized coverage program for residents with income above 300% of the FPL and for small businesses. Unlike Commonwealth Care, the Commonwealth Choice program is not part of the MassHealth Demonstration. Its purpose is to provide affordable health insurance options, not subsidized coverage. Commonwealth Choice offers coverage from private insurance carriers, both directly and through the Connector. Insurance products bearing the Connector’s “seal of approval” became available for individuals on May 1, 2007, with coverage to begin July 1, 2007, and will be available to small businesses as of October 1, 2007.

In developing Commonwealth Choice, the Connector had many important objectives to balance: to offer a meaningful array of choices of affordable options; to offer a set of benefits that truly meet people’s needs; and to protect both patients and providers from medical debt that could result from patients carrying insurance but not being able to pay their out-of-pocket costs.

The Connector issued a Request for Responses (RFR) in December 2006 requiring bidders to submit five coverage options: one *premier* plan, two *value* plans, one *basic* plan, and one *young adult* plan. All plans provide similar benefits (with the exception of the young adult plan) with varying levels of cost sharing. The premier options were to have the highest monthly premium but very limited copayments and no deductibles. Design of the value plans, with mid-level premiums, was left to the plan’s discretion, although it was assumed that some combination of network selection, cost-sharing, and aggressive medical management would be required to reach the target actuarial value

prescribed by the Connector board (72.5 percent to 87.5 percent of the value of premier plans). The basic plans, targeted at 60 percent of the actuarial value of the premier plans, would offer the lowest premiums and the highest out-of-pocket costs.

Two rounds of bidding, with the direct intervention of Governor Patrick and refinements to plan specifications, were necessary to offer a wide range of choices of affordable insurance products for residents of Massachusetts.

In March 2007, the Connector board gave its seal of approval to and entered into contracts with plans offered by six of the state's health insurers—Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, and Tufts Health Plan.

Rates vary by plan type (renamed Gold, Silver, and Bronze), number of insured (one person, two people, family), age, and geography, but, in general, the premium rates for Commonwealth Choice plans will be significantly lower than those currently available in the non-group market. For a single individual at the average age of the uninsured in Massachusetts—37 years old—premiums as of July 1, 2007 for plans that include prescription drug coverage range from \$184 to \$279 per month in the most expensive region of the state. If purchased on a pre-tax basis through an employer's Section 125 plan (see Section 3.5), the average net cost of the \$184 plan is reduced to \$115 for a single individual earning \$50,000 per year. Individuals can use the Connector's website to compare the Commonwealth Choice plans and choose one that best meets their needs.

3.4 Requirement to Obtain Health Insurance

A fundamental principle of health care reform in Massachusetts is that most Massachusetts residents must have health insurance starting July 1, 2007, so long as it is affordable to them, or face income tax penalties. This feature of the comprehensive reform plan is necessary to significantly reduce the number of uninsured individuals, ensure a viable health insurance risk pool and create affordable health insurance products. An insurance requirement will help reduce cost-shifting from the uninsured to the insured and minimize adverse selection (whereby healthy individuals remain outside of the insurance system and sicker more costly users are insured)—both of which drive up health insurance premiums. Additionally, having most people in the insurance system will expose the true costs of health care in Massachusetts and set the stage for more productive discussions about health care cost containment.

Starting with tax year 2007, every state resident 18 and older must indicate on his or her tax return whether he or she had a certain level of health insurance coverage (called "minimum creditable coverage") as of the last day of the taxable year, either individually or as a named beneficiary. In general, if the individual leaves this question on their tax return blank or marks "no," the individual will be subject to state tax penalties administered by the Department of Revenue. For tax year 2007, the individual will lose his or her personal tax exemption (or half of the exemption if one person said "no" on a

joint return). For tax year 2008 and beyond, the penalty will equal half of the amount of premiums the individual would have paid toward an affordable premium for each month the individual is without insurance. Some individuals, however, can claim an exemption from the insurance requirement for religious reasons, and others will be exempt from the requirement and any proposed tax penalty because they have demonstrated that they do not have access to affordable health insurance.

Two fundamental tasks necessary to implement the insurance requirement were defining “minimum creditable coverage” and the “affordability standards.” Minimum creditable coverage (MCC) refers to the lowest threshold health insurance plan that an individual must purchase to satisfy the legal requirement to have health insurance in order to avoid paying a tax penalty. MCC is designed to provide individuals purchasing the coverage with access to some preventive health care as well as protection against severe financial losses resulting from a serious illness. The affordability standards are used to determine whether health insurance is affordable so that individuals who have not purchased health insurance may then determine whether they are obligated to pay a tax penalty due to the insurance requirement. These regulations also set standards for an appeal process allowing individuals to claim that a penalty should not be assessed because of financial hardship that prevented them from purchasing coverage. Staff from the Commonwealth Connector, the Massachusetts Division of Insurance and the Massachusetts Department of Revenue worked closely with the insurance industry and employers to work out these complex details.

Another challenging issue the state needed to resolve is how to verify the health insurance information reported by taxpayers on their tax returns. Beginning in 2008, insurance carriers and certain employers are required to send an annual written statement, called the MA 1099-HC (Health Care), to every resident for whom coverage was provided in the previous calendar year. The statement will indicate the individual’s insurance policy number, coverage period and a representation on whether the coverage meets the MCC standards. Individuals will transcribe this information onto their tax returns. Every issuer of a MA 1099-HC will send this information annually via an electronic tape to the Department of Revenue so the state can confirm the information on the filed tax returns. In April 2007, the Department initiated a pilot initiative to develop the standards and procedures that all issuers of MA 1099-HCs will use to submit statements and reports. Six insurance carriers are participating in the initiative and have begun to transmit test files to the Department. The Department will determine the final specifications and business rules over the next few months.

While more work needs to be done to finalize the format of the 2007 tax return forms and to ensure that all procedures, standards and software are in place at insurance companies to implement the requirement, significant progress has been made on this component of the comprehensive health care reform plan.

Finally, public awareness of the insurance requirement is essential to health care reform's success. While health care reform in Massachusetts has been a topic in the media for almost two years, many residents still do not know of or fully understand the implications of the July 1 insurance requirement. Last month, the Commonwealth, in partnership with the Boston Red Sox, Bank of America, CVS and other major corporations and community-based organizations, launched an extensive public awareness campaign about the insurance requirement. Attachment A of this document includes the press release announcing the campaign, called *Cover Your Bases – Connect to Health*. Television, radio and print ads are now every day features in media and sites across the Commonwealth. Additionally, the Connector mailed approximately three million postcards to taxpayers informing them of the insurance requirement and referring them to appropriate resources for enrollment information, and 200,000 letters to businesses detailing specific requirements for employers. Even before this marketing campaign began, a recent poll indicated that over 85% of Commonwealth residents were aware of the state's new health care reform law and two-thirds of those individuals were supportive of the reform effort.¹

3.5 Employer Contributions

Chapter 58 included several provisions related to employers' role in health care reform. Specifically, Chapter 58 created an Employer Fair Share Contribution and an Employer Surcharge for State Funded Health Costs to encourage employers to continue to do their part to provide coverage to their employees.

The state's Division of Health Care Finance and Policy adopted Employer Fair Share Contribution regulations on September 8, 2006. These regulations govern the determination of whether an employer with 11 or more full-time equivalent employees makes a fair and reasonable premium contribution to the health costs of its employees. If not, the employer is required to pay an annual assessment of up to \$295 per employee. The first annual reporting period for determining employer liability for the Fair Share Contribution (FSC) will begin on October 1, 2007 for the first 12-month base year ending on September 30, 2007.

The Connector has adopted regulations requiring all employers with 11 or more full-time equivalent employees to offer Section 125 plans by July 1, 2007. Section 125 plans, also referred to as "cafeteria" plans, are authorized under Section 125 of the Internal Revenue Code and allow individuals to pay for health insurance premiums on a pre-tax basis. An employer can meet this requirement either by offering a qualifying plan under its own group health plan or through the Connector.

The Division of Health Care Finance and Policy adopted the Employer Surcharge for State Funded Health Costs regulations on June 20, 2007. The regulation will take effect

¹ "Massachusetts Health Reform Tracking Survey," Kaiser Family Foundation/Harvard School of Public Health/Blue Cross Blue Shield of Massachusetts Foundation, June 27, 2007.

on July 1, 2007. Under this regulation, the state would assess a surcharge of between 20%-100% of state funded hospital and community health center costs for employees, or their dependents, of employers with 11 or more full-time equivalent employees who do not establish a Section 125 plan *and* whose employees, or their dependents, meet utilization thresholds and incur more than \$50,000 in free care services in one year. This regulation serves as the enforcement tool for the Section 125 plan regulations.

The Division of Health Care Finance and Policy has also adopted regulations requiring employers of 11 or more full-time equivalent employees to complete an annual Employer Health Insurance Responsibility Disclosure Form. This form will indicate whether the employer has offered health insurance or Section 125 plan participation to its employees. These employers are also required to issue, collect and retain an annual Employee Health Insurance Disclosure Form from employees to whom the employer offers either health insurance or Section 125 plan participation, but decline coverage or participation. The employee must complete the form and indicate whether he or she has alternative coverage, and must acknowledge that he or she may be liable for his or her health care costs and subject to penalties if he or she fails to maintain health insurance coverage.

3.6 Insurance Market Reforms

Chapter 58 included several reforms to the private insurance system designed to increase access to more affordable health insurance products for individuals who historically have had a difficult time finding affordable insurance. These insurance market reforms apply across the insurance system, not only for products offered by the Connector.

Merger of Non-group and Small Group Insurance Markets

Chapter 58 tasked a Special Commission with studying the impact of merging the non-group and small group insurance markets on the availability of products and the premiums charged, as well as the potential impact of reinsurance on the newly merged market. An independent contractor completed the study and submitted it to the state's General Court on December 29, 2006. The contractor worked with all of the major insurance carriers and intermediaries in the Commonwealth to produce the data necessary for the study.

The report estimated that the merger of the markets on July 1, 2007 would result in an increase to current small group premiums of about 1-1.5% and a decrease to current non-group premiums of about 15%. However, the report noted that the impact to rates would vary substantially by carrier. The report also makes clear that the projections necessarily were based on many assumptions in certain areas for which decisions were not yet final, for which the impact was yet to be determined, or for which accurate data was not readily available.

Since December 2006, officials from the Division of Insurance and the Connector have met regularly with the insurance industry to finalize changes to the non-group and small

group health insurance regulations. The revised regulations were published on April 20, 2007, and the merger of the markets is scheduled for July 1. The Division of Insurance has developed a communications plan related to the merger of the markets and is distributing the information during the open enrollment period (May 1, 2007 – July 31, 2007).

Health care reform has had the intended and very desirable effect of significantly enlarging the product options available in the non-group market and improving their value. Specifically, the typical uninsured individual in Massachusetts—a 37-year old, living in Boston—had very few insurance products available to him or her prior to July 1st and they were expensive: for \$335 a month, this individual could buy a policy with a \$5,000 annual deductible and no drug benefits. With reform, this same individual can purchase a policy for \$175 that covers drugs, carries a \$2,000 annual deductible, and covers office and ER visits before the deductible. This is, in effect, half the price and twice the benefits as before. Working in tandem, the following four reasons account for this very significant improvement in value:

1. By merging the non-group and small-group regulated markets, cross subsidies from the small-group effectively lower the premiums for the non-group;
2. By mandating participation for most adults in insurance, health care reform improves the risk pool for both the non-group and small-group, thereby reducing premiums on average across this entire, newly merged market;
3. By soliciting bids from carriers in a competitive situation, the Connector has exerted downward pressure on premiums and led to the development of new, select-network health plan designs; and
4. By offering individuals an easy way to compare the prices and benefits of the many new health plan options now available, the Connector encourages individuals to buy right and take advantage of the values available in the market.

As a result, health care reform has made it easier and more affordable to buy private health insurance.

Young Adult Health Benefit Plan

Chapter 58 also allowed insurers to develop more affordable young adult health plans, which are sold through the Connector and have an effective date of coverage starting July 1, 2007. These plans are limited to individuals ages 19-26 who do not have access to employer-sponsored insurance. The Division of Insurance published emergency regulations on April 7, 2007 and held a public hearing on the regulations on May 30, 2007. The Division is working with the Connector to review comments provided at the public hearing, and the Connector already is enrolling previously uninsured young adults in these more affordable insurance products.

Health Carrier Requirements

Chapter 58 made two other important changes to the insurance laws that are scheduled for July 1. It increased the dependent coverage age up to age 26 or two years past the dependent's status as a dependent as defined by the federal Internal Revenue Code. The health care reform law also created a statutory non-discrimination requirement that carriers may only contract to sell health insurance plans to employers that offer the health plan to all full-time employees who live in Massachusetts and only if the employer does not require a greater premium contribution from lower wage employees than they do from higher wage employees. The Division of Insurance issued a bulletin on the non-discrimination provision on April 6, 2007 that clarified the statutory requirement and provided definitions for full-time, temporary and seasonal employees intended to be consistent with definitions used by the Division of Health Care Finance and Policy and the Connector in their respective regulations related to health care reform.

3.7 Uncompensated Care Pool Reform

Chapter 58 prescribed comprehensive reform to the uncompensated care pool reimbursement starting October 1, 2007 (pool fiscal year 2008). The Division of Health Care Finance and Policy, in conjunction with the Office of Medicaid and the Executive Office of Health and Human Services, has begun the process of formulating policy options for pool reform under new Health Safety Net regulations (the successor to the uncompensated care pool). To this end, the Division filed with the legislature on May 1, 2007 a report outlining a new methodology for "equitably allocating free care reimbursements" in hospital fiscal year 2008 using a Medicare-based payment system, adjusted for several factors prescribed in Chapter 58 to account for differences between the Medicare and Medicaid programs and as further deemed necessary.

Additionally, the Division held a public consultative session on June 19, 2007 seeking input from interested parties and stakeholders about the services and eligibility for the uncompensated care pool going forward, and will continue to work with hospitals, community health centers and others on these issues. The Division expects to propose the Health Safety Net regulations in July 2007 for an October 1, 2007 effective date.

3.8 Health Care Quality and Cost Council

Chapter 58 established a Health Care Quality and Cost Council (Council) to set quality improvement and cost containment goals for the Commonwealth. One of the Council's primary tasks is to collect cost, quality and racial and ethnic disparities data from health care providers, pharmacies, payers, and insurers and maintain the information on a website for consumers and purchasers. This effort will ensure greater transparency and accountability on the part of providers and insurers to inform better decision-making. By 2012, the Council has set a goal to ensure that Massachusetts consistently ranks among the states achieving the highest levels of performance in health care that is safe, effective, patient-centered, timely, efficient, equitable, integrated and affordable.

The Council is chaired by the Secretary of Health and Human Services and its members include other senior state officials, including the Insurance Commissioner and the head of the state employee benefit plan, and executives from the state's insurers, providers, and various health care quality improvement organizations. The Council has an Advisory Committee and recently hired an Executive Director.

On June 21, 2007, the Council announced its first set of statewide goals for improving the quality and controlling the costs of health care in Massachusetts (see Attachment B of this document). These goals for state fiscal year 2008 include:

- reducing the cost of health care; reducing the annual rise in health care costs to no more than the unadjusted growth in the Gross Domestic Product (GDP) by 2012;
- ensuring patient safety and effectiveness of care;
- improving screening for and management of chronic illnesses in the community;
- developing and providing useful measurements of health care quality in areas of health care for which current data are inadequate;
- eliminating racial and ethnic disparities in health and in access to and utilization of health care; health indicators will be consistent and consistently improving across all racial and ethnic groups; and
- promoting quality improvement through transparency.

To manage its substantive workload, the Council created four subcommittees on Communications, Cost, Quality, and Governance. Some highlights from the subcommittees include:

- Communication Subcommittee: The subcommittee developed a Request for Proposals (RFP) from communications consultants to begin formalizing a comprehensive communications plan to make price and quality information about health care available and useful to a multitude of constituencies, including consumers, media outlets, providers, policy makers, brokers and the general public. The communications plan will include steps to inform people about the availability of information on cost and quality; guidelines for presenting information in the most understandable and useful way, based on input from consumers; strategies for disseminating the information via multiple media, including a website; and a means to solicit ongoing feedback from consumers to inform adjustments to the approach.
- Cost Subcommittee: The subcommittee released a Request for Information (RFI) from individuals or groups to help the Council identify reasonable statewide cost containment goals that are within the control of that individual or group's health care sector. Using this information, the subcommittee will work with the Quality subcommittee to develop quality improvement goals in these areas. The RFI generated 26 responses with a broad range of recommendations towards lowering or containing the growth in health care costs. The responses fell into four main

- areas: improving hospital care quality; promoting e-prescribing; analyzing and improving use of diagnostic imaging; and improving end-of-life care.
- **Quality Subcommittee:** The subcommittee developed a draft proposal of overarching quality goals for the Commonwealth for the Council to discuss. The proposal leverages the many quality improvement initiatives and measurements currently going on within the Commonwealth and develops a strategy to centralize the information. The initial proposal for quality goals includes:
 - improving patient safety and effectiveness of care in hospitals;
 - improving screening and the management of chronic illnesses in the community;
 - eliminating racial and ethnic disparities in health and in access to and utilization of health care; and
 - developing and providing useful measurements of health care quality in areas of health care for which current data are inadequate.

3.9 MassHealth Coverage and Program Initiatives

Expansion to the State Children's Health Insurance Program (SCHIP)

On July 1, 2006, MassHealth expanded eligibility in its Family Assistance program to children in families with income up to 300% of the federal poverty level (FPL). CMS approval of the Commonwealth's Title XXI State Plan amendment allowed the Commonwealth to raise the income level from 200% of the FPL, a level that was leaving too many children without comprehensive health coverage in Massachusetts.

To date, the Family Assistance expansion has brought coverage to an additional 14,000 children. In families where employer-sponsored family coverage is available, but was previously unaffordable, the program provides premium assistance for insurance that is cost-effective and meets a basic benefit level. When a parent works for an employer who contributes at least 50% of the health insurance premiums, MassHealth forms a partnership with the parent and their employer to make private health coverage affordable for the entire family. For children in families where there is no access to qualifying employer-sponsored health insurance, MassHealth provides managed care coverage to children through a contracted managed care organization or the MassHealth Primary Care Clinician plan. The MassHealth children's expansion combines with Commonwealth Care adult coverage to ensure that comprehensive coverage is affordable to every resident in a family with income at or below 300% of the FPL.

When the children's expansion was approved, it was clear to the Commonwealth and CMS that to the extent Massachusetts' SCHIP allotment was insufficient to cover additional children's expenditures, it would be necessary to shift expenditures to the Demonstration that would otherwise be charged to SCHIP. The Commonwealth included \$85 million in its Demonstration budget neutrality projections to account for this possibility. Fortunately, the SCHIP redistributions authorized by the National Institutes of

Health Reform Act of 2006, and additional federal funding provided by the U. S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, combined to substantially protect Demonstration budget neutrality from SCHIP shortfalls in the current Waiver term (SFY 2006 - SFY 2008). The Commonwealth is optimistic that the terms of SCHIP reauthorization starting in federal fiscal year 2008 will support continued children's coverage efforts in Massachusetts, mitigating the potential impact of children's expansion on budget neutrality for the Demonstration.

Increase of Enrollment Caps for MassHealth Essential and HIV/Family Assistance

Long-term unemployed adults have been recognized as a population requiring special attention and unique solutions since the inception of the MassHealth Demonstration Project. The underlying factors leading to chronic unemployment often are related to physical and/or behavioral health issues. Strategies to reduce uncompensated care hospital expenditures cannot be complete without addressing the long-term unemployed—a low-income population without categorical eligibility for Medicaid and an obvious lack of access to employer-sponsored health insurance.

Chapter 58 provided increased state funding for MassHealth Essential, a program providing comprehensive health coverage to long-term unemployed individuals with income at or below 100% of the FPL through the Primary Care Clinician plan. CMS approved a Waiver amendment to allow the enrollment cap for Essential to be raised from 44,000 to 60,000.

On July 1, 2006, MassHealth implemented the higher enrollment cap, allowing the Commonwealth to enroll more than 12,000 long-term unemployed individuals from a waiting list into managed care and diverting them from the uncompensated care pool. There currently are approximately 52,000 persons enrolled in MassHealth Essential.

Non-disabled persons with HIV disease with income at or below 200% of the FPL are eligible for comprehensive health coverage through the Family Assistance program. Raising the enrollment cap for this program from 770 to 1,300 has ensured that this vulnerable population has access to the full range of medical and prescription services that will maximize their chances to manage their disease. There was no waiting list for this program, however, the higher enrollment cap has allowed the HIV/Family Assistance program to reach its current enrollment of 1,041.

Expansion to the Insurance Partnership

The Insurance Partnership is a demonstration program to assist small employers (less than 50 employees) and their employees in providing and purchasing employer-based health insurance. The program has two components: a subsidy (incentive payment) for qualified small employers, and premium assistance for their low-income employees.

Employers must contribute at least 50% of the health insurance premium for coverage that meets a basic benefit level in order to participate.

In the context of a broad strategy for creating partnerships among government, employers, insurers, and low-income employees in the insurance marketplace, the Commonwealth has made the following changes to the Insurance Partnership to create better alignment with other features of health care reform:

- On October 1, 2006, MassHealth successfully implemented an increase in the income limit for eligibility in the Insurance Partnership from 200% to 300% of the FPL. As of April 2007, the Insurance Partnership has added 3,440 covered lives through this expansion of the program.
- Along with expansion, MassHealth implemented a crowd-out protection in the program, excluding employees whose employer or family member's employer has provided insurance coverage in the preceding six months for which the employee was eligible.
- Effective July 1, 2007, the Insurance Partnership will no longer provide both employer and employee subsidies to self-employed persons. Self-employed individuals will receive employee subsidies only.

The Insurance Partnership has enrolled more than 5,900 employers, providing incentives to promote employer-sponsored health insurance at significant employer contribution levels. CMS's continuing support of the Insurance Partnership and its approval to raise the employee eligibility level has resulted in the program reaching more than 16,000 covered lives of low-income workers and their families.

Outreach to Eligible, but Unenrolled, Individuals and Families

Analysis of uninsured populations in the Commonwealth in 2004 identified over 100,000 persons who were eligible for, but not enrolled in, MassHealth. The Commonwealth has addressed this problem through intensified, targeted, community-based outreach to identify both MassHealth and Commonwealth Care eligible individuals.

In November 2006, MassHealth awarded \$3 million in outreach grants to community and consumer-focused public and private non-profit organizations for activities directed at reaching and enrolling eligible Commonwealth residents.

MassHealth awarded Twenty-four "Model A" grants for traditional community-based outreach, enrollment and re-determination services. Model A grantees are heavily involved in day-to-day outreach and enrollment activities on the local level. Many creative outreach strategies have emerged to engage difficult-to-reach populations.

MassHealth awarded Seven "Model B" grants to conduct comprehensive broad-scale media or grassroots campaigns targeting potentially eligible individuals. Model B grantees are involved in collaborative efforts to produce widely-distributed materials for

outreach. These include public service announcements for radio and television, video broadcasts for use in patient waiting rooms, and a website that is used to make outreach materials, including materials developed by Model A organizations, available to other outreach and community organizations state-wide. The website, at www.gethealthcoverage.net, equips community-based organizations and outreach workers with resources, tools and ideas for educating the general public, especially hard-to-reach populations, about health care reform requirements and insurance options.

Together, the MassHealth expansions and outreach efforts have resulted in increasing MassHealth participation by almost 53,000 members since July 2006.

MassHealth Payment Policy Advisory Board

The MassHealth Payment Policy Advisory Board is charged with collecting and analyzing data from MassHealth and the state's Division of Health Care Finance and Policy to evaluate and recommend provider rates and rate methodologies that provide "fair compensation for MassHealth services and promote high-quality, safe, effective, timely, efficient...care."

The Secretary of Health and Human Services designated the Medicaid Director to chair the Board, which includes representatives from major Medicaid providers, including hospitals, physicians, Community Health Centers, nursing facilities, home care agencies, and behavioral health providers. The Board has reviewed the Medicaid rate-setting process generally and discussed different methods utilized by the Medicaid program for pricing health care goods and services, including an analysis of the methods MassHealth employs for different provider types. Going forward, the Board will review pricing policies and report to the General Court its findings about methodological approaches that promote fairness, quality and efficiency in Medicaid rates. Board members also receive information from the Division of Health Care Finance and Policy on proposed MassHealth rate changes in advance of their adoption. The Board will meet in July of 2007 to review MassHealth's acute hospital pay-for-performance (P4P) proposal, discussed below.

MassHealth Pay-for-performance

Chapter 58 required annual acute hospital rate increases and, beginning in state fiscal year 2008, required that MassHealth combine the rate increases with a pay-for-performance (P4P) program. MassHealth is consulting with the Health Care Quality and Cost Council and the MassHealth Payment Policy Advisory Board, as well as with providers and other payers, to develop appropriate quality measures, performance benchmarks and payment incentives. The selected performance measures will focus on high-volume or high-risk areas, including maternity and newborn care, pediatric asthma, community acquired pneumonia, and surgical infection. The acute hospital P4P program also will include a component to measure and reduce health disparities.

These measures, which the state will incorporate into hospital contracts starting in hospital fiscal year 2008 (October 1, 2007), align with areas of strategic importance to the MassHealth program and with national standards. MassHealth intends to build upon this acute hospital initiative over time and to expand value-driven health care purchasing to other provider settings.

MassHealth Wellness Program

Health care reform in the MassHealth program is about more than just eligibility expansions. Major efforts are underway to ensure that coverage delivers tools to maximize health, not simply address illness. This strategy will promote better health outcomes, better quality of life, and decrease health care costs over time. To this end, Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates incentives for members who meet wellness goals.

The Commonwealth has established a project structure for the Wellness Program that includes a joint MassHealth/DPH Project Team, which reports to a Steering Committee chaired by the Medical Director of the MassHealth program. The Steering Committee includes representatives from the Office of Medicaid, DPH, the Executive Office of Elder Affairs, and the Department of Mental Health. Both the project team and Steering Committee receive guidance from a Wellness Program External Advisory Group.

The project team has completed research and data analysis to set a baseline for accurate tracking of MassHealth members' wellness behaviors. This work is essential for effective measurement and evaluation of the success of the Wellness project.

The work of the Wellness Program project management team has centered on development of a flexible and sustainable incentive program and a strategy to ensure that MassHealth members and providers support and buy-in to wellness objectives. The first phase began in June of 2007 and focused on promoting and educating MassHealth members about the concept of wellness and healthy lifestyle activities. This education is being coordinated with the broad base of MassHealth providers. In phase two of the project, incentives will be introduced, following research about the best way to track wellness activities and incentivize wellness behaviors for MassHealth members. Implementing the Wellness program incentive system requires surveying the marketplace, which will be accomplished with a formal Request for Information (RFI) to vendors throughout the state. MassHealth has initiated discussions with CMS about exploring appropriate and effective wellness incentive approaches, and looks forward to continuing this dialogue as the Wellness program continues to evolve.

Section 4 MassHealth Demonstration Project and Requested Changes

4.1 Brief History of the MassHealth 1115 Demonstration

The Commonwealth implemented the MassHealth 1115 Demonstration in July 1997. The initial waiver period ran from State Fiscal Year (SFY) 1998 to SFY 2002 and mandated enrollment in managed care for most of Medicaid's non-institutionalized members under the age of 65. In addition, the Demonstration:

- streamlined Medicaid eligibility by eliminating face-to-face interviews, using gross income rather than net income, and significantly limiting the use of spend-downs;
- eliminated asset test requirements;
- expanded income eligibility for pregnant women, infants, children, and disabled individuals;
- expanded eligibility to certain non-categorically eligible populations, including certain unemployed adults and non-disabled persons with HIV disease; and
- created the Insurance Partnership program, which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance.

CMS approved a three-year extension of the Demonstration in 2002 for SFY 2003 – SFY 2005, and a second three-year extension in 2005 for SFY 2006 – SFY 2008. As part of mandating managed care, the MassHealth Demonstration authorized unique financial support for two critical safety net providers in the state designed to ensure access to care for Medicaid enrollees during the transition from a fee-for-service to managed care delivery system. As the Medicaid managed care system evolved in Massachusetts and federal rules around managed care payments changed, the state and CMS saw an opportunity to preserve this historic funding and apply it toward expanded health insurance coverage for individuals, while continuing a level of support for providers of uncompensated care to individuals not served through the insurance system or vulnerable underserved populations. This opportunity became the building block for the Commonwealth's health care reform effort, represented by the Commonwealth Care premium assistance program, and was incorporated into Massachusetts' Demonstration authority when CMS extended the Demonstration beginning in SFY 2006.

After Massachusetts' health care reform legislation passed in April 2006, the Commonwealth submitted a request to CMS on May 1, 2006 to amend the MassHealth Demonstration to incorporate critical components of the new comprehensive health care reform plan. The amendment included authority for:

- the establishment of the Commonwealth Care program to provide sliding scale premium subsidies for the purchase of private health plan coverage for uninsured persons at or below 300% of the FPL;

- the development of payment methodologies for approved expenditures from the SNCP;
- eligibility expansions for children and the Insurance Partnership; and
- an increase to enrollment caps for MassHealth Essential and the HIV/Family Assistance Program.

CMS approved these amendments to the Demonstration on July 26, 2006, with revised special terms and conditions effective July 28, 2006. As a result of these demonstration programs and policies, MassHealth covers nearly 1.1 million low-income people.

4.2 Objectives of the Demonstration

There have been four main strategic objectives of the MassHealth Demonstration Project since its inception:

1. Expand access to health coverage for low-income residents
2. Enhance efficiency and accuracy in the eligibility determination process
3. Maximize employer-sponsored health insurance
4. Continuous quality improvement through managed care

The MassHealth program has not only consistently met these objectives over the life of the Demonstration, but also has, in partnership with CMS, continued to raise the bar for innovation, access, and quality care, culminating in one of the most ambitious uses in any state of Medicaid 1115 demonstration authority to impact the health care landscape and dramatically lower uninsurance.

Expanding Access

The Demonstration has as its base populations receiving MassHealth Standard coverage, Title XIX mandatory and optional children, parents, pregnant women, and disabled individuals. The Commonwealth has recently added Independent Foster Care Adolescents as a State Plan base population.

Through Demonstration expenditure authority, the Commonwealth has added access to comprehensive medical care for persons with HIV and breast and cervical cancer diagnoses. MassHealth Basic and Essential cover long-term unemployed persons with household income at or below the poverty level. The Commonwealth program allows disabled individuals of any income to buy into MassHealth. The Insurance Partnership program assists low-income workers by providing subsidies to employers and employees to encourage employer-based coverage. The Medical Security Program provides coverage to unemployed workers receiving unemployment benefits. And, the Demonstration combines with SCHIP to provide premium assistance for employer-sponsored family coverage or direct coverage for children in families with income too high to qualify for Medicaid.

With the addition of Commonwealth Care in year two of the current Demonstration period, Massachusetts is now able to offer affordable health coverage to almost all residents with family income at or below 300% of the FPL who do not have access to employer-sponsored health insurance.

The Commonwealth continues to leverage the internet, media, community-based outreach strategies, and point-of-service provider contacts to provide information and application assistance for all health programs.

Enhancing the Eligibility Process

MassHealth continues to take full advantage of the eligibility simplification made possible by the waivers granted by CMS in the Demonstration. The use of gross income, elimination of spend-downs for families, and other provisions, significantly reduce barriers in the process. The state uses a single application and eligibility determination system for MassHealth (including SCHIP), Commonwealth Care, the Uncompensated Care Pool, the Children's Medical Security program (for children who do not qualify for MassHealth) and Healthy Start (for pregnant woman who do not qualify for Medicaid).

A simplified application form was introduced in 1997 and has been revised several times, most recently in April of 2007. Improvements in the system for receiving and processing applications reflect the fact that Massachusetts has: (1) worked hard to continuously improve mail-in and electronic application process as part of its expansion efforts; (2) increased the speed and efficiency with which applications can be processed; (3) standardized the outcome of eligibility determination decisions; (4) worked to develop verification and matching processes with the Social Security Administration and the Department of Revenue; and (5) developed Virtual Gateway technologies (on-line applications that can pass through the automated determination process).

MassHealth ensures the integrity of these processes with a robust alternative quality control program. Every six months the Commonwealth completes a statistically significant sample based on enrollment and approved by CMS. Studies are performed to validate eligibility and various program and process components. Findings are submitted to CMS and are used internally for monitoring and process improvement.

Maximizing Employer-based Coverage

In addition to the Insurance Partnership, MassHealth provides the opportunity for members in every comprehensive coverage type to receive premium assistance whenever they have an employer who contributes at least 50% of the health insurance premium, the policy meets a basic benefit level, and the insurance is cost-effective. More than 41,000 covered lives benefit from premium assistance programs in MassHealth.

Several key objectives have continued to guide development and implementation of the MassHealth premium assistance programs, including:

- Preservation and promotion of private employer-sponsored health insurance dollars to avoid commercial sector crowd-out;
- Provision of premium assistance payments to help low-income families, individuals working for small employers, and self-employed individuals obtain and maintain employer-sponsored insurance which would otherwise prove cost-prohibitive;
- Provision of Insurance Partnership employer incentive subsidies to assist in preventing long term decline in the private insurance market by encouraging small employers to offer health insurance coverage and by acting as a “cushion” for small employers who offer coverage to their employees;
- Provision of premium assistance to enable the purchase of family coverage which allows not only the child(ren) but also their parent(s) to obtain coverage;
- Continued utilization and interface with systems, mechanisms, and structures in the private insurance market through contracts with Insurance Partnership vendors, including Billing and Enrollment Intermediaries (BEIs) and Employee Benefit Resources (EBR), to work specifically with small business employers.

Quality Improvement through Managed Care

The Demonstration requires managed care participation for most enrollees through a variety of health plan options. The Primary Care Clinician (PCC) Plan (a primary care case management model) links members to a specific primary care clinician, who in turn serves as the gatekeeper for the medical care delivery systems. Members who are enrolled in the PCC Plan receive behavioral health services on a capitated basis from MassHealth’s behavioral health contractor, the Massachusetts Behavioral Health Partnership (MBHP).

Alternatively, MassHealth members can enroll in one of four contracted capitated managed care organizations (MCOs): Neighborhood Health Plan, Network Health, Fallon Community Health Plan, and Boston Medical Center HealthNet Plan.

MassHealth employs a variety of methods to monitor the quality of health care delivered by its health plans and members’ satisfaction with these plans. For all managed care plans, including the PCC Plan and MBHP, MassHealth requires specific HEDIS measures to assess clinical quality and utilization, conducts an annual Independent External Quality Review through its EQRO (APS HealthCare), and conducts a member satisfaction survey.

The MassHealth program consistently compares well against other Medicaid programs around the nation as well as against private plans in Massachusetts.

4.3 Requested Changes to the Special Terms and Conditions

The Commonwealth is aware that CMS is in the process of creating greater standardization in the documentation for demonstration projects. We understand that is important in order to facilitate general understanding of the projects outside of the states in which they operate and to allow for comparisons on the basis of populations groups, eligibility rules, managed care enrollment requirements, covered services, cost sharing, delivery systems, and other primary features. Our understanding is that CMS would like to see the waiver documentation rely less on attachments, moving all substance into the main body of the special terms and conditions (STCs). Massachusetts looks forward to working closely with CMS, starting immediately, to re-format the documentation in a way that meets CMS objectives while ensuring that the nature of the demonstration project is well represented and all necessary specifications are preserved.

The Commonwealth has included as attachments to this document certain redlined sections of the STCs. These reflect certain changes that we are requesting to include in the renewal STCs that we will negotiate for July 1, 2008, as of June 29, 2007. As noted in the following section, the Commonwealth will submit proposals for the Safety Net Care Pool sections and those related to budget neutrality in a subsequent correspondence. Also note that activities related to the further evolution of health care reform, managed care contract procurement objectives, and state legislative activity, may lead to further STC revision requests by Massachusetts over the coming year as renewal STCs are negotiated.

A summary of the attached redlined changes follows.

Proposed changes to MassHealth Program Specifications (Attachment D of the STCs) to:

- Eliminate obsolete references in the document;
- Reflect changes to the MassHealth premium requirements that have been made to align the MassHealth program with affordability standards established pursuant to the health care reform initiative (see Attachment C of this document); and
- Reflect Insurance Partnership changes to conform to premium schedule and Insurance Partnership requirements of health care reform (see Attachment D of this document).

4.4 1115 Demonstration Financing

Massachusetts finances its 1115 Demonstration using several sources of non-federal funds that CMS has approved as eligible for federal Medicaid matching dollars. These sources of non-federal funds include state appropriations from the state's General Fund, certified public expenditures, a permissible provider tax on certain hospital revenue, and an insurer surcharge. Massachusetts receives 50% federal reimbursement for its Demonstration expenditures. The federal budget neutrality ceiling, which the state calculates according to a complex formula and through negotiations with CMS, caps federal Demonstration spending at an amount that estimates what the federal government

would have spent on Massachusetts' Medicaid program in the absence of the Demonstration.

Two years ago, the state and CMS worked together to review the Demonstration's budget neutrality calculation in detail, rectify any inconsistencies, and refine or clarify any ambiguities in how the calculation is structured. When CMS approved the state's Demonstration amendment in July 2006 to incorporate provisions of the health care reform bill, the state projected and CMS approved an \$82 million budget neutrality cushion over the first eleven years of the Demonstration (SFY 1998 – SFY 2008). This means that over the life of the Demonstration through SFY 2008, we project spending on the Demonstration to be roughly \$82 million less than what spending on the Massachusetts' Medicaid program would be if we did not operate the Demonstration. This is significant given the coverage expansions and innovations that the Demonstration authorizes.

The Demonstration's Safety Net Care Pool (SNCP) is a sub-component of the overall Demonstration program, and includes the Commonwealth Care program, the uncompensated care pool, expenditures for formerly state-funded health programs (called Designated State Health Programs), and other important payments to providers that provide care to uninsured or underserved individuals. When the SNCP was created in 2005, CMS capped SNCP expenditures for SFY 2006 through SFY 2008 at \$1.344 billion annually. The SNCP cap is a sub-cap of the Demonstration's overall budget neutrality limit, but for SNCP expenditures only. As a sub-component of the overall Demonstration program, the SNCP also is funded using several permissible sources of non-federal dollars and the federal government provides reimbursement for 50% of the costs.

In sum, the state has operated its Demonstration program since its implementation in SFY 1998 below the projected budget neutrality cap, and has operated the SNCP since its implementation in SFY 2006 at or below the SNCP cap. Going forward, Massachusetts fully intends to operate its Demonstration so that it continues to be budget neutral to the federal government, but must ensure sustainable long-term funding for full implementation of health care reform, including the parts of health care reform authorized by the Demonstration.

To be better able to project the funding needed for the next three years of health care reform implementation and its implications for budget neutrality, the Commonwealth requests to submit the details on the continued structure and financing of the SNCP and the budget neutrality calculation through SFY 2011 in the Fall of 2007. By October 2007, the Commonwealth will have better enrollment information for Commonwealth Care and Commonwealth Choice, more experience with the effects of the public awareness campaign about the insurance requirement that begins on July 1, and will have developed and started to implement reforms to the uncompensated care pool that were mandated by Chapter 58.

The follow-up submission specifically will include:

- any necessary proposed revisions to the Demonstration's special terms and conditions #24-29 (SNCP and Commonwealth Care), Attachment C (Monitoring Budget Neutrality) and Attachment E (SNCP Payment Methodologies);
- a budget neutrality worksheet for the three-year extension request;
- information on ongoing or new quality and cost containment initiatives the Commonwealth will implement both in MassHealth and system-wide, including initiatives related to pay-for-performance and health information technology; and
- any other necessary proposed revisions to the terms and conditions identified throughout the Summer, based on further evolution of health care reform, managed care contract procurement objectives, and state legislative activity.

4.5 1115 Demonstration Evaluation – Monitoring the Rate of Uninsurance

The Demonstration terms and conditions include requirements relating to the monitoring, tracking and reporting of the rate of uninsurance in the Commonwealth and the effectiveness of the Safety Net Care Pool in reducing the rate.

Specifically, CMS required the Commonwealth to submit a draft evaluation design that included:

- A description of the indicators that will be used to measure the rate of uninsurance annually and over the three-year extension period;
- A description of the baseline measures that will be used;
- Other indicators as appropriate to demonstrate effectiveness of the Safety Net Care Pool, including Commonwealth Care enrollment and Uncompensated Care Pool utilization;
- How the effects of the demonstration will be isolated from those other initiatives occurring in the Commonwealth.

On June 2, 2005, the Commonwealth submitted its draft evaluation design for the Demonstration to CMS. The design was developed by MassHealth staff in collaboration with the University of Massachusetts Center for Health Policy and Research, and is organized to present strategic objectives, key metrics, and data collection and evaluation methodologies that will provide clear indicators of how successful the MassHealth Demonstration project is in meeting the objectives of the demonstration project overall, with particular focus on the Safety Net Care Pool's goal of reducing the rate of uninsurance through the provision of subsidies to make private health insurance affordable to lower income uninsured residents.

The major tool the Commonwealth will use to establish baselines and monitor the uninsurance rate in Massachusetts is the Division of Health Care Finance and Policy's (DHCFP) survey on Health Insurance Status of Massachusetts Residents.

This state specific survey is designed expressly to provide reliable estimates of the number of uninsured residents in Massachusetts. The survey provides statistically reliable estimates of uninsured rates on a statewide basis, as well as for five regions in the state. The survey design also allows for comparison of the data among each of the years surveyed to date: 1998, 2000, 2002, 2004, and 2006 (2007 is currently in the field). Prior to 2006, the DHCFP survey has been conducted every two years. Given the critical nature of the health care reform initiative to the citizens of the Commonwealth and the importance to CMS of measuring the impact of the effectiveness of the Safety Net Care Pool concept in the 1115 Demonstration Project, the Commonwealth has increased the frequency of DHCFP surveys to every year for the duration of the Demonstration. This will provide solid baseline data for the new Commonwealth Care program implemented in SFY 2007, as well as annual measures based on consistent methodologies that will offer comparable data. These surveys will be critical to measuring the ultimate success of the Massachusetts health care reform plan in reducing the rate of uninsurance in the Commonwealth.

The 2004 Health Insurance Status of Massachusetts Residents survey identified 460,000 uninsured residents (7.4%). Estimates based on the survey indicate that approximately 200,000 of those uninsured residents might be eligible for Commonwealth Care. While other surveys that provide slightly different measures of the uninsured exist, the state used this DHCFP survey as the starting point for developing its health care reform proposal. The 2006 survey identified 371,800 uninsured residents (6%). The Commonwealth will apply the Safety Net Care Pool metrics to this baseline in the draft Demonstration evaluation report that it will submit to CMS no later than February 28, 2008 for the current Demonstration term. The Commonwealth will finalize the results of the 2007 survey in the Fall or Winter of 2007, and will incorporate these very early results of health care reform into the draft Demonstration evaluation report.

Section 5 Timeline and Key Milestones

As the update in Section 3 demonstrates, the Commonwealth has made significant progress in implementing health care reform in a very short timeframe. However, there is still much more to do to identify and enroll residents in health insurance, continue to develop initiatives to improve quality and control costs, and implement some of the technical features of health care reform. Key milestones in the coming year include:

July 2007

- Implementation of the health insurance requirement
- Implementation of requirement that employers with 11 or more full-time equivalent employees must have Section 125 plans, or face Employer Surcharge
- Merger of non-group and small-group insurance markets
- Release of proposed regulations reforming the uncompensated care pool

- Release of fiscal year 2008 state budget

August 2007

- Public hearing on proposed uncompensated care pool regulations

October 2007

- Implementation of reforms to the uncompensated care pool
- Implementation of acute hospital pay-for-performance

November 2007

- Massachusetts adults required to have insurance must enroll in a health insurance plan, effective December 2007, or lose their personal income tax deduction on their 2007 state taxes
- Deadline for employers to file Health Insurance Responsibility Disclosure form

July – Fall 2007

- Continued work by the Commonwealth and stakeholders on development of proposed ongoing structure and financing of the SNCP, and its component pieces, through the next Demonstration period
- Follow-up submission to CMS on the SNCP, budget neutrality, and ongoing or new quality and cost containment initiatives

Fall-Winter 2007

- Release of 2007 Health Insurance Status of Massachusetts Residents survey

January 2008

- Penalties for adults who are uninsured increase to equal half the premium of the lowest-cost Connector certified insurance plan

February 2008

- Submission to CMS of draft 1115 Demonstration evaluation

Spring 2008

- Filing of income tax returns for tax year 2007, including for the first time information on minimum creditable coverage

July 2008

- Extension of the MassHealth 1115 Demonstration

Section 6 Conclusion

Massachusetts has embarked on a historic health care reform experiment. We have made tremendous progress in covering the uninsured in the short timeframe since health care reform implementation began. The collaboration among stakeholders from the state and federal governments, business, health insurance plans, the provider community, consumer advocates, community-based organizations and academia has created one of the broadest based approaches to health insurance coverage found anywhere in the nation. Continued support from CMS for health care reform in Massachusetts through the 1115 Demonstration Project will be critical to achieving the ultimate success of dramatically reducing the rate of uninsurance in the Commonwealth.

List of Attachments:

Attachment A: Press Release on Public Awareness Campaign

Attachment B: Health Care Quality and Cost Council 2008 Statewide Goals

Attachment C: Proposed Changes to Section 2 of the Demonstration's Program Specifications (Attachment D of STCs)

Attachment D: Proposed Changes to Section 11 of the Demonstration's Program Specifications (Attachment D of STCs)