

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



SECTION 1115 DEMONSTRATION PROJECT EXTENSION REQUEST

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

Massachusetts pioneered a transformation in health care coverage that became the inspiration for the most sweeping federal legislation in a generation, *the Patient Protection and Affordable Care Act* of 2010 (PPACA). The Commonwealth's landmark achievements are grounded in its Section 1115 Demonstration agreement with the Centers for Medicare and Medicaid Services (CMS). The Commonwealth's first 1115 Demonstration Waiver was approved in 1995 for the waiver period beginning in July 1997. The initial waiver period ran from State Fiscal Year (SFY) 1998 to SFY 2002. The Demonstration expanded eligibility for pregnant women, infants, children, disabled individuals and to certain non-categorically eligible populations, including certain unemployed adults and non-disabled individuals with HIV disease. It also mandated enrollment in managed care for most Medicaid members in the community 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; 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 December 2001 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 to ensure access to care for Medicaid enrollees during the transition from fee for service to a 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.

In 2006, Massachusetts amended its 1115 Demonstration Waiver to reflect the landmark legislation signed into law in April 2006, 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. Chapter 58 was 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. Most recently, CMS approved another Demonstration extension in December 2008, for a three year term, expiring June 30, 2011, to continue to build on the successes of health care reform.

Since the implementation of Massachusetts' reform plan on July 1, 2006, 364,000 additional people have obtained health insurance coverage; and Massachusetts has the highest rate of insured of any state in the nation.¹ Massachusetts' recognized success has made it the model for the historic and recently enacted federal health care reform legislation, the *Patient Protection and Affordable Care Act*.

The Demonstration agreement to the Massachusetts reform model, because it authorizes and funds the Commonwealth's health reform programs and their service delivery models. The Commonwealth looks forward to continuing to work collaboratively with CMS to extend this important federal – state partnership that is central to the continuation and success of health reform in Massachusetts.

Section 2 Structural Components of Massachusetts' Health Insurance Model

Massachusetts expanded the availability of public health insurance programs, first through increased eligibility under MassHealth and related programs, and later through the creation of Commonwealth Care. Within these programs, Massachusetts supports vulnerable populations with subsidized benefits for low-to-moderate income individuals and families, while simultaneously promoting the use of private and employer sponsored health insurance. Additionally, Massachusetts requires residents to obtain and maintain health insurance and employers to contribute to employee health insurance premiums. The expanded eligibility for publicly funded programs, combined with the individual and employer mandates established the shared responsibility among individuals, employers and public entities in ensuring health care coverage for residents of the Commonwealth. This new model for promoting access to health insurance, pioneered in the Commonwealth under the 1115 Demonstration, is now the basis for the reforms enacted under the *Patient Protection and Affordable Care Act* (PPACA).

2.1 MassHealth

MassHealth provides access to health care benefits through nine separate programs, listed in Table 1. MassHealth members under the age of 65 who do not have access to other health insurance typically receive benefits through either a managed care organization or the Primary Care Clinician Program. In general, the Commonwealth will purchase employer sponsored health insurance (ESI) for MassHealth members if it is available and cost-effective to do so. Members for whom MassHealth purchases ESI may receive additional services through managed care or fee-for-service delivery systems if such services are necessary to ensure that the members are receiving the benefits that they are entitled to under their MassHealth coverage type.

Through MassHealth programs, the Commonwealth covers approximately 1.4 million members, which includes members over the age of 65 and members covered through CHIP, as well as members covered under the 1115 Demonstration. At the same time, the MassHealth Insurance Partnership has enrolled more than 4,628 employers, by providing incentives to promote employer-sponsored health insurance at significant employer contribution levels. CMS's continuing support of the Insurance Partnership has resulted

¹Sharon K. Long, Karen Stockley, "Health Reform in Massachusetts: An Update as of Fall 2009." June 2010. Blue Cross Blue Shield Foundation. See also <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur2010006.pdf>

in the program reaching more than 13,369 individuals, low-income workers and their family members.

2.2 Commonwealth Care

The hallmark of Chapter 58 is the Commonwealth Care premium assistance program, which is administered by the Massachusetts' Commonwealth Connector Authority (the Connector). Commonwealth Care makes health insurance products affordable by subsidizing the premiums for low-income individuals not eligible for MassHealth, and serves as the model for the refundable premium tax credits and standardized benefit package levels codified in the PPACA. Continued federal financial contribution to MassHealth and Commonwealth Care programs is critical to the success of the overall Chapter 58 initiative. Commonwealth Care subsidizes insurance, offered through 5 managed care organizations, for adults with incomes at or below 300% of FPL who do not qualify for Medicare or Medicaid and who do not have access to employer sponsored coverage where the employer pays at least 20% of the premium for a family plan or 33% of the premium for an individual plan. People with a family income below 150% FPL and no other source of insurance may choose a plan with no premiums and low cost sharing. The premiums of eligible people between 150-300% FPL are determined on a sliding scale. Plans are currently available for as low as \$39 per month for an individual earning between \$16,261 and \$21,672 per year; \$77 per month for an individual earning between \$21,673 and \$27,096 per year; and \$116 per month for those earning between \$27,097 and \$32,508 per year.² As of March 31, 2010 there were approximately 149,000 people enrolled in Commonwealth Care.³

2.3 Health Safety Net

Massachusetts introduced the Health Safety Net (HSN) under Chapter 58 as a successor to the Uncompensated Care Pool. The Health Safety Net provides support to acute hospitals and community health centers that provide care to low-income individuals who are uninsured or underinsured and are not eligible for other public health insurance programs. Massachusetts residents with incomes up to 200% FPL are eligible for full HSN coverage. Those with incomes between 200% FPL and 400% FPL are eligible for partial HSN coverage, which includes deductibles. The HSN does not provide insurance, but is designed to help acute hospitals and community health centers defray the cost of providing safety net care. Unlike the former Uncompensated Care Pool, the Health Safety Net pays providers based on eligible claims.

²Commonwealth Connector Authority. "Health Reform Facts and Figures," April 2010. Available at: <https://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0c/?fiShown=default>. Accessed on 7 May 2010.

³This is down from a peak of 177,000 Commonwealth Care enrollees at the end of SFY 2009. Commonwealth Connector Authority. "Report to the Massachusetts Legislature. Implementation of Health care Reform. Fiscal Year 09." October 23, 2009. The change in enrollment in Commonwealth Care between SFY 2009 and April 2010 came as a result of legislative action that required shifting legal immigrants from Commonwealth Care into the fully state funded Bridge Program. Enrollment in Bridge occurred between September and December of 2009.

Table 1 MassHealth Programs

<u>Name</u>	<u>Description</u>	<u>Income Limits</u>
MassHealth Standard	Premium assistance and direct medical benefits for low-income families	Parents, caregivers and disabled adults: at or below 133% FPL. Children ages 1-18: at or below 150% FPL. Infants up to age 1 and pregnant women: at or below 200% FPL.
MassHealth Breast and Cervical Cancer Treatment Program	Direct medical benefits for uninsured women under the age of 65 with breast and cervical cancer	At or below 250% FPL
MassHealth CommonHealth	Premium assistance and direct medical benefits for disabled individuals who are not eligible for MassHealth Standard	No income limit
MassHealth Family Assistance	Premium assistance and direct medical benefits for individuals with HIV; Premium assistance and direct medical benefits for low-income children who are not eligible for MassHealth Standard. Parents may be covered by private insurance incidental to premium assistance payments made on behalf of the child. Children may be covered through the CHIP program.	Individuals with HIV: at or below 200% FPL. Children: at or below 300% FPL. Childless Adults (premium assistance only): at or below 300% FPL.
MassHealth Basic	Premium assistance or direct medical benefits for individuals receiving state funded Emergency Assistance to Elderly, Disabled and Children (EAEDC) or are Department of Mental Health clients who are long-term or chronically unemployed.	At or below 100% FPL
MassHealth Essential	Premium assistance or direct medical benefits for individuals who are long-term or chronically unemployed and who are not eligible for MassHealth Basic.	At or below 100% FPL
MassHealth Limited	Emergency services for individuals whose immigration status makes them ineligible for other MassHealth programs	Same as MassHealth Standard
MassHealth Prenatal	Short-term outpatient prenatal care for pregnant women who have applied for standard and are awaiting eligibility approval.	Below 200% FPL.
MassHealth Insurance Partnership	Premium assistance payments for MassHealth members and qualified employers.	Below 300% FPL

2.4 Medical Security Plan

The Medical Security Plan (MSP) provides premium assistance or direct medical benefits to individuals who are receiving unemployment compensation benefits under Massachusetts General Law Chapter 151A. Under the premium assistance provisions of the MSP, individuals can receive a subsidy toward their premiums for continuation of qualified employer sponsored insurance that began while the individual was still employed. Not surprisingly, Massachusetts has seen a significant increase in enrollment in this program during the current waiver term. The Commonwealth is currently exploring whether it would be more efficient to serve these individuals in the Commonwealth Care program. There are a number of obstacles to doing so, including the current maintenance of effort requirement in the American Recovery and Reinvestment Act of 2008, because of the differences in eligibility criteria between the two programs. The Commonwealth will work with CMS on any proposal it develops to merge the two programs.

2.5 Commonwealth Choice

Commonwealth Choice makes a range of unsubsidized private plans available to individuals and businesses with 50 or fewer employees. The plans have received the Connector's "Seal of Approval" to offer a range of benefits and options, grouped by level of benefits and cost sharing at the Bronze, Silver and Gold levels. There is also a Young Adults Plan product offered from the same carriers for individuals between the ages of 18 and 26. Unlike Commonwealth Care, the Commonwealth Choice program does not rely on any federal funding or specific Demonstration authority. Its purpose is to provide affordable health insurance options, not subsidized coverage. A procurement process is used to solicit health plans offered through the Commonwealth Choice program. The Board of the Connector awards the Seal of Approval to plans it deems to be of good quality and value. All plans have to meet the Minimum Creditable Coverage standard.⁴

2.6 Employer Contribution

Employers with more than 11 full-time equivalent employees must facilitate pre-tax availability of health insurance to their employees. Additionally, employers with 11 or more full-time equivalent employees are required to make a fair and reasonable contribution toward employee health insurance premiums or be charged a per employee fee. An employer is considered to offer a "fair and reasonable" contribution if for employers with 50 or more employees 25% of the employees are enrolled in the employer's group health plan *and* the employer contributes at least 33% of the individual premium. For employers with 11-50 employees, an employer is considered to offer a "fair and reasonable" contribution if 25% of the employees are enrolled in the employer's group health plan *or* the employer contributes at least 33% of the individual premium. The fee for failing to provide a fair and reasonable contribution is \$295 per employee, per year.

2.7 Requirement to Obtain and Maintain Health Insurance

Until recently the most distinct feature of the Massachusetts model and arguably the most effective in increasing coverage is the requirement that all residents of the Commonwealth 18 years of age and older obtain and maintain a minimum level of health

⁴See Section 3.5

insurance.⁵ Those who do not enroll in a qualified health insurance program face penalties if insurance coverage is deemed affordable for them. The individual mandate is enforced through the Connector and the state Department of Revenue. Taxpayers are required to include a schedule HC as a component of filing state tax returns.

2.8 Massachusetts is the Model for Federal Health Reform

The Patient Protection and Affordable Care Act (PPACA) is structured similarly to the Massachusetts model for health insurance coverage. As in Massachusetts, the PPACA includes the creation of a health insurance exchange, subsidies for low and moderate income individuals to purchase health insurance, an individual mandate to purchase insurance, shared responsibility requirements for employers, and expansions of public health insurance programs.

Section 3 Massachusetts' Successes

Health reform in Massachusetts, with the support and partnership of CMS, has been an unrivaled success. Since the implementation of Chapter 58 on July 1, 2006, 364,000 additional people have obtained health insurance.⁶ From June 2006 to June 2008, the number of people with health insurance coverage increased by 425,000.⁷ During this time period, individuals newly covered in either employer sponsored insurance (ESI) or non-group private plans represented nearly half (45%) of the newly insured. The count of the newly insured declined by 61,000 midway through 2008, likely due to the effects of the national economic downturn. Estimates of the impact of a recession on insurance coverage, based on national data, suggest that the 3% increase in the unemployment rate in Massachusetts between fall 2008 and fall 2009 should have resulted in a drop of employer sponsored insurance coverage of 2.8% and an increase in public and other coverage of 1.0%. On net, there would have been an increase in uninsurance of 1.8%. However, relative to national patterns, the drop in employer sponsored insurance coverage in Massachusetts was smaller and the gain in public and other coverage greater over this period. The strong system of employer sponsored and public insurance in place in Massachusetts appears to have provided more of a safety net to newly unemployed adults than is available in the nation as a whole.⁸ This has, no doubt, meant that the Commonwealth's residents encountered less unmet health care needs than Americans in other states during this recession.

⁵Amy Lischko and Anand Gopalsami, "An Interim Report Card on Massachusetts Health Care Reform: Part 1: Increasing Access." A Pioneer Institute White Paper, NO. 49, January 2010, p. 2-3

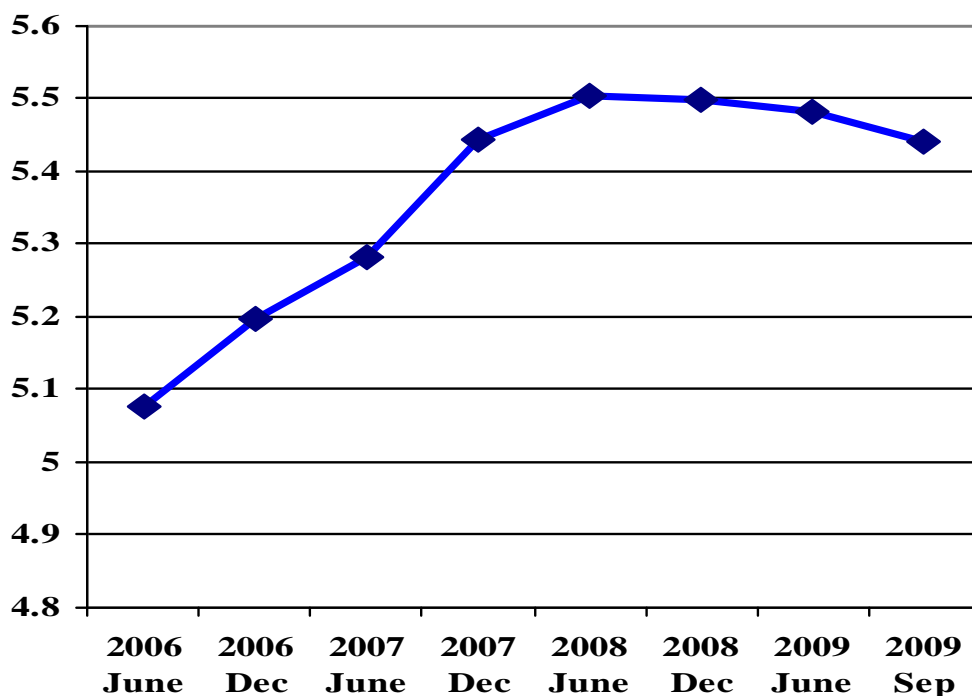
⁶Massachusetts Division of Health Care Finance and Policy, "Health Care in Massachusetts: Key Indicators," February 2010. (Available on line at www.mass.gov/dhcfp)

⁷This number could be as high as 431,000 but the exact count of newly insured individuals at a given point in time has changed over time, as health plans revise enrollment information due to retroactivity. Commonwealth Health Insurance Connector Authority. "Report to the Massachusetts Legislature: Implementation of Health Care Reform Fiscal Year 2009." Available at:

<https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%20Us/News%20and%20Updates/Current/Week%20Beginning%20October%2018%202009/Connector%20Annual%20Report%202009.pdf>

⁸Sharon K. Long, Karen Stockley, "Sustaining Health reform in a Recession: An Update on Massachusetts as of Fall 2009." Health Affairs 29, No. 6 (2010).

People with Insurance, 2006-2009
(In Millions)



3.1 The Rate of Uninsured and Coverage Gains

The most recent survey indicates that the overall rate of residents without health insurance in Massachusetts remains below 3%, where it has been since 2008.⁹ This corresponds to roughly 171,000 uninsured people in 2009 and 165,000 in 2008. The overall rate of uninsured for the Commonwealth fell by 58% between 2006 and 2009. These gains have proved relatively recession proof, as Massachusetts has continued to report record-low levels of uninsured.¹⁰

Significant gains in insurance coverage among lower-income adults, with incomes less than 300% of the FPL, have been achieved with the uninsured rate for this population dropping from 23.2% in fall of 2006 to less than 9.1% in the fall of 2009.¹¹ Among lower-income residents, rates of uninsured individuals have been reported to be as low as 4.3% and 5.0%.¹² There have also been gains among higher-income adults as well. By

⁹Sharon K. Long, Lokendra Phadera, and Karen Stockley, "Health Insurance Coverage in Massachusetts: Results from the 2008 and 2009 Massachusetts Health Insurance Surveys," Massachusetts Division of Health Care Finance and Policy, October 2009.

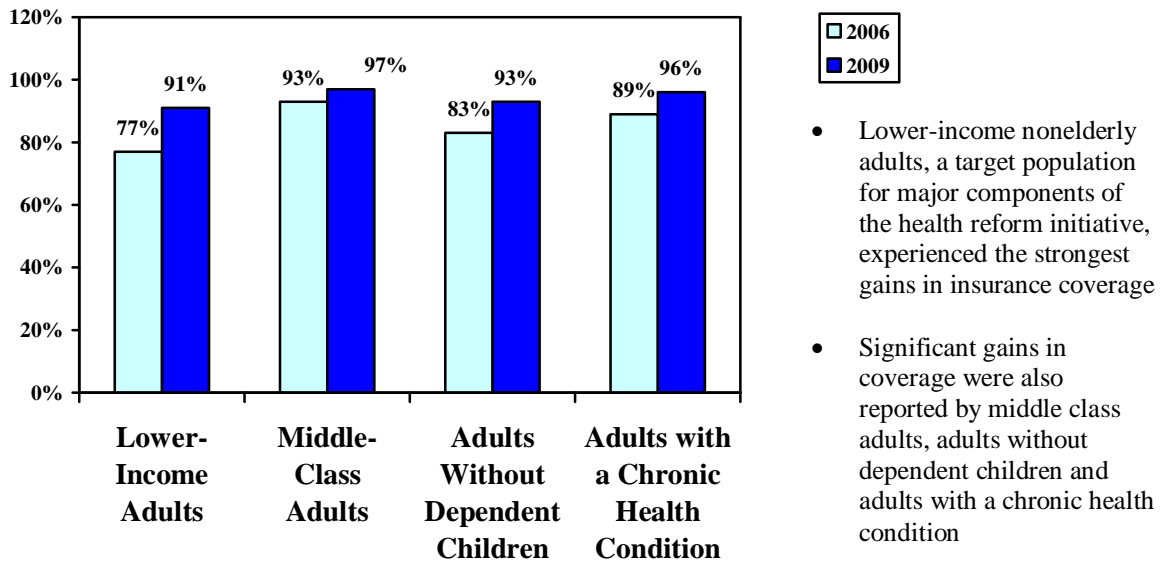
¹⁰Sharon K. Long, Karen Stockley, "Sustaining Health Reform in a Recession: An Update on Massachusetts as of Fall 2009." Health Affairs 29, No. 6 (2010).

¹¹Sharon K. Long, Karen Stockley, "Health Reform in Massachusetts: An Update as of Fall 2009." June 2010. Blue Cross Blue Shield Foundation.

¹²Massachusetts Division of Health Care Finance and Policy, "Health Insurance Coverage in Massachusetts," October 2009.

the fall of 2009, only 4% of middle class adults in Massachusetts were uninsured, down from 7% in fall of 2006.¹³

**Insurance Coverage for Population Subgroups,
2006 to 2009**
Percentage Reporting Coverage at the Time of Survey



The rate of uninsurance among working-age adults dropped by more than 60% between 2006 and 2009, demonstrating the success of the Massachusetts’ reform in encouraging employer sponsored coverage. Experts estimate that 5% of working-age adults in Massachusetts were uninsured in fall of 2009, compared to a national rate of 19.7% for non-elderly adults.¹⁴ In 2009, lack of health insurance was highest among non-elderly adults, compared to a rate of 1.9% for children and 0% for elderly adults. In addition to the reduction in uninsured individuals at a point in time, there were also reductions in persistent lack of insurance - lasting 12 months or more. By fall of 2009, the share of adults in the state who reported being long-term uninsured had dropped by nearly 70%, down to only 2.5% from 8.5%.¹⁵

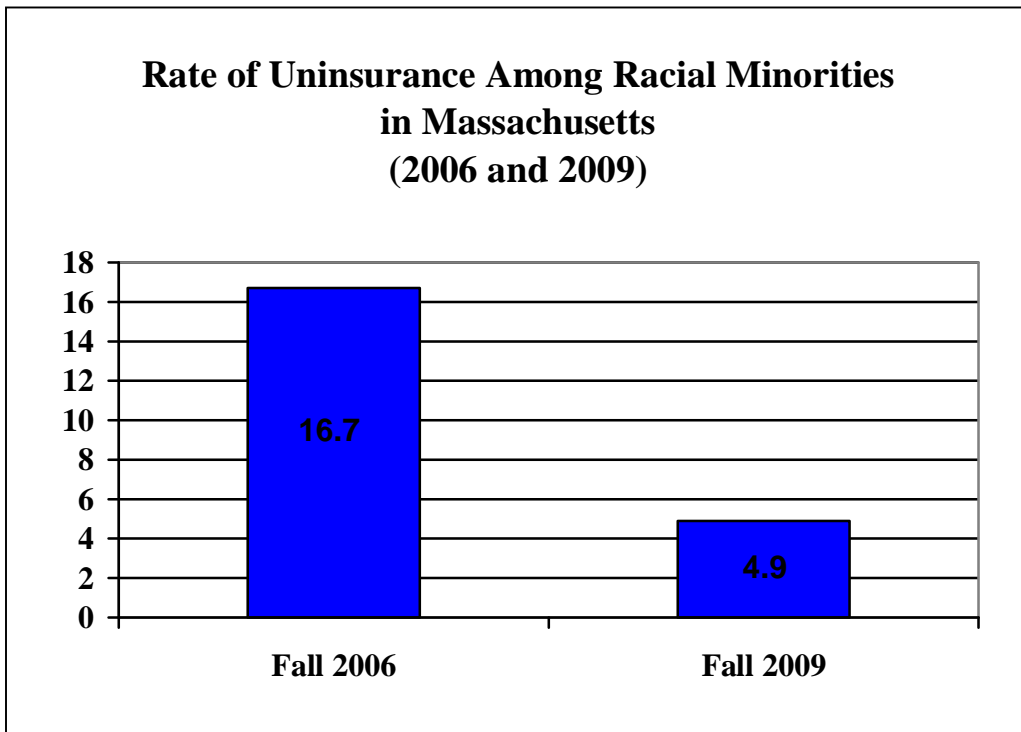
Minority adults also experienced strong gains in insurance coverage, access to and use of care, and the affordability of care between fall 2006 and fall 2009. Most notably, the rate of uninsurance fell by 11.8% between fall 2006 and fall 2009 for minority adults. By fall 2009, there was no difference in the share of minority and white adults with insurance

¹³Middle class adults are defined as those with incomes above 300% FPL. Sharon K. Long, Karen Stockley, “Health Reform in Massachusetts: An Update as of Fall 2009.” June 2010. Blue Cross Blue Shield Foundation.

¹⁴Sharon K. Long, Karen Stockley, Urban Institute, “Health Reform in Massachusetts: An Update on Insurance Coverage and Support for Reform as of Fall 2008,” Massachusetts Health Reform Survey, Policy Brief, September 2009. Sharon K. Long, Karen Stockley, “Health Reform in Massachusetts: An Update as of Fall 2009.” June 2010. Blue Cross Blue Shield Foundation.

¹⁵Long, Stockley, Urban Institute “Health Reform in Massachusetts,” September 2009.

coverage, after controlling for differences in health status and other factors.¹⁶ The largest gains in insurance were among Hispanic residents, with uninsurance rates among Hispanic residents falling from 10.2% in 2007 to 5.1% in 2009. Minority adults also gained ground in terms of the affordability of health care. Between fall 2006 and fall 2009, minority adults reported stronger reductions in the percentage of people paying medical bills over time and in unmet need for preventive care due to costs than white adults. In fall 2009, minority adults were less likely to report unmet need for care because of costs than were white, non-Hispanic adults, likely reflecting the strong gains in public and other coverage among minority adults under health reform.¹⁷



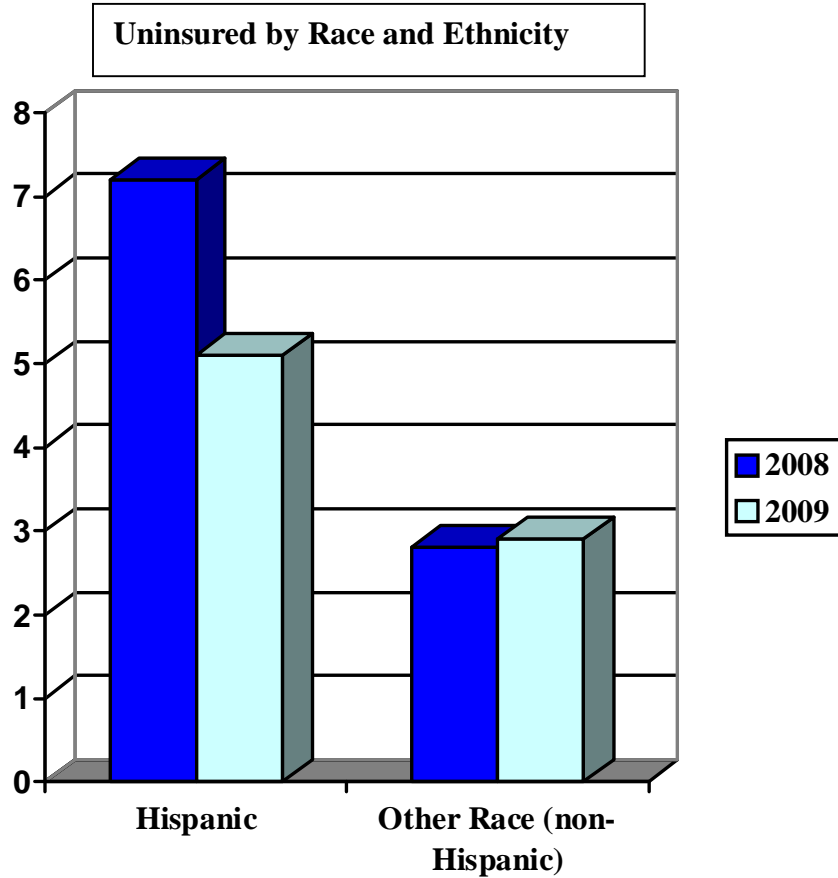
Gains in insurance coverage have been achieved through employer sponsored insurance and the expansion of public coverage. Private group and individual purchase make up more than 86% of the insured. Since implementation of health reform, enrollment in private group insurance has grown by 41,000 and individual purchase has more than doubled, adding 50,000 new individual purchase enrollees since 2006.¹⁸ As of 2009, 32% of the newly insured obtained insurance through an employer or in the individual non-group market.¹⁹

¹⁶Sharon K. Long, Karen Stockley, “Health Reform in Massachusetts: An Update as of Fall 2009.” June 2010. Blue Cross Blue Shield Foundation.

¹⁷Sharon K. Long, Karen Stockley, “Health Reform in Massachusetts: An Update as of Fall 2009.” June 2010. Blue Cross Blue Shield Foundation

¹⁸Massachusetts Division of Health Care Finance & Policy: “Health Care in Massachusetts: Key Indicators,” February 2010. (Available on line at www.mass.gov/dhcfp)

¹⁹Michael T. Doonan and Katharine R. Tull. “Health Care Reform I Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate.” *The Millbank Quarterly*, Vol 88, No.1, 2010 (pp. 54-80).



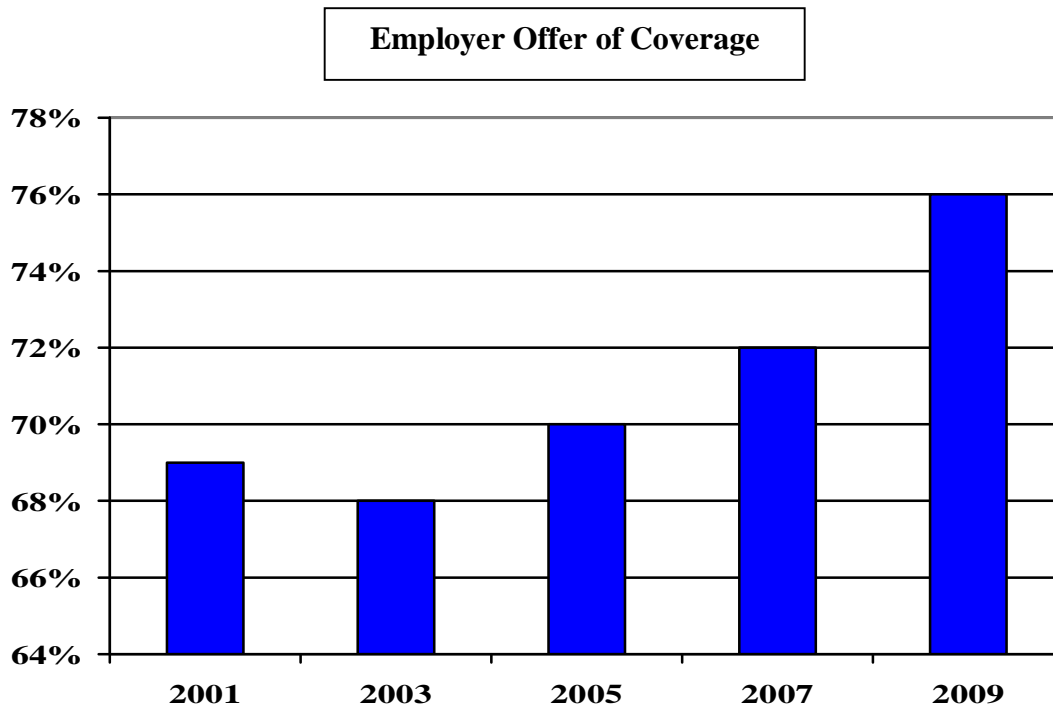
Other Race, Non-Hispanic includes black and Asian in addition to other races. Massachusetts Division of Health Care Finance and Policy, Key Indicators, February 2010, February 2009.

3.2 Expansion in Employer Sponsored Insurance

Perhaps the most encouraging indicator of success in the Massachusetts model is the percentage of employers offering health insurance in Massachusetts, which has increased to 76% in 2009, from 69% in 2001. The national rate of employers offering health insurance declined to 60% from 68% during the same time period.²⁰ Among Massachusetts residents with insurance coverage, the majority of children (75%) and non-elderly adults (80%) had employer sponsored insurance coverage (ESI). There is no evidence of public coverage “crowding-out” employer-sponsored insurance coverage for non-elderly adults in Massachusetts. In fact, employer sponsored coverage increased by

²⁰Massachusetts Division of Health Care Finance & Policy: “Health Care in Massachusetts: Key Indicators,” February 2010. (Available on line at www.mass.gov/dhcfp)

2.7% between fall of 2006 and fall of 2009, along with a 5.0% increase in public coverage.²¹



3.3 Improvements in Care

Improving insurance coverage in Massachusetts has also led to improvements in access to care.²² After the enactment of Chapter 58, working-age adults were more likely to report that they had a usual place to go when sick or in need of advice about their health, a measure of continuity of health care (up 2.9% between fall 2006 and fall 2009).²³ The likelihood of having any doctor visit rose (up 5.7%) as did the likelihood of having a preventive care visit (up 6.7%) by fall 2009.²⁴ Adults were also less likely to have an unmet need for care - down 5.4% overall and down about 2 to 3% for each specific type of care examined, such as doctor care, specialist care, medical tests, treatment or follow up, prescription drugs and dental care.²⁵ Although there were gains in health care use in the first year, many of the gains in doctor visits occurred in the second year (between fall 2007 and fall 2008), when people were more likely to have continuous insurance coverage. During the second period, there were significant increases in the likelihood of any doctor visit in the past twelve months (up 4.6%) and multiple doctor visits (up 6.5%). Lower-income adults experienced the strongest gains in reported health care quality -

²¹Sharon K. Long, Karen Stockley, "Health Reform in Massachusetts: An Update as of Fall 2009." June 2010. Blue Cross Blue Shield Foundation.

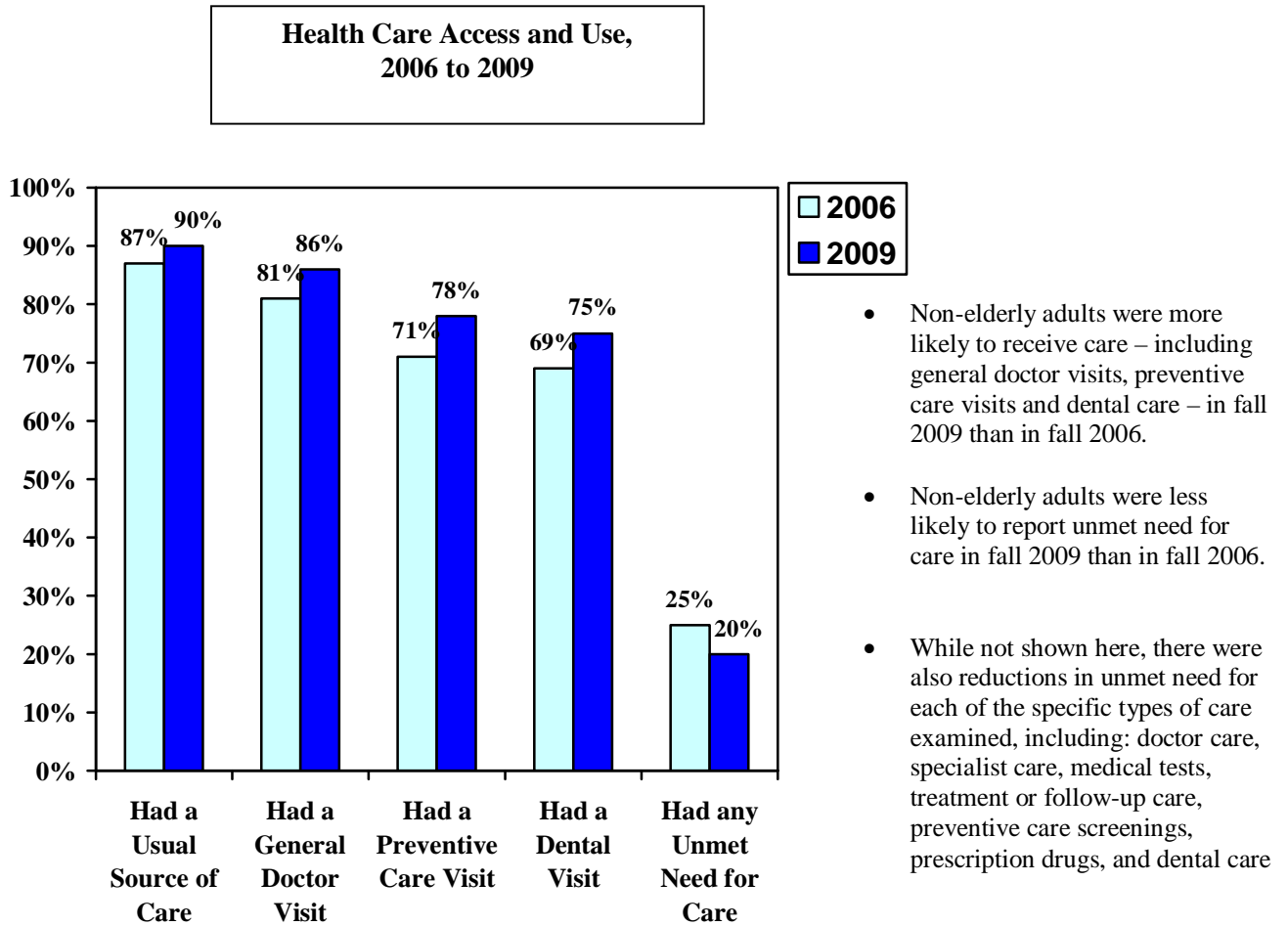
²²Sharon K. Long, Paul Masi, "Access And Affordability: An Update On Health Reform In Massachusetts, Fall 2008" Health Affairs, 28, no 4 (2009) w578-587 (published online 28 May 2009)

²³Sharon K. Long, Karen Stockley, "Health Reform in Massachusetts: An Update as of Fall 2009." June 2010. Blue Cross Blue Shield Foundation.

²⁴Sharon K. Long, Karen Stockley, "Health Reform in Massachusetts: An Update as of Fall 2009." June 2010. Blue Cross Blue Shield Foundation.

²⁵Sharon K. Long, Karen Stockley, "Health Reform in Massachusetts: An Update as of Fall 2009." June 2010. Blue Cross Blue Shield Foundation.

they were more likely to rate the quality of care they received as very good or excellent after enactment of Chapter 58 (62.7% in fall of 2009 compared to 53.2% in fall of 2006).



3.4 Successful Implementation of the Individual Mandate

Massachusetts requires that individuals obtain and maintain health insurance if it is deemed affordable for them. The penalties for failure to have health insurance first went into effect in 2007. Individuals who were deemed able to afford health insurance, but failed to comply as of December 31, 2007, were subject to the loss of their personal tax exemption, which was \$219 for an individual. For 2008 and beyond, adults who are deemed able to afford health insurance have been required to have coverage for each month of the tax year. There is no penalty in the case of a lapse in coverage of 63 days or less.

Individuals who can afford to purchase health insurance, but fail to comply are subject to penalties for each month of non-compliance in the tax year. The penalties may not exceed one-half of the least expensive monthly premium for which an individual would

have qualified through Commonwealth Care or Commonwealth Choice. The penalty is calculated weighing the individual's age, income and number of months they are uninsured. In tax year 2008, the highest individual penalty for remaining uninsured for twelve months was \$912. For tax year 2009, the comparable penalty was \$1,068. Compliance among Massachusetts tax filers has been high. As of December 2009, the Department of Revenue reported that 98.3% of tax filers required to file health insurance information with their tax returns for tax year 2008 complied.²⁶

Of the 3.8 million adult tax filers to report coverage in 2008, nearly 96% reported coverage for the full year or the entire period for which the insurance mandate applied to them. The Department of Revenue assessed \$16.4M in penalties on the 44,935 adult tax filers who lacked insurance for all or part of 2008, who were deemed able to afford health insurance. This is slightly less than the total collections of 2007 health care tax penalties.²⁷ Among those without health insurance, approximately 58% (about 118,000) were deemed able to afford insurance. Among those deemed able to afford insurance, 43% (about 51,000) had sufficiently low incomes to qualify for No Tax Status or Limited Income Credit, nullifying or reducing the penalty for tax filers in these categories. About 9,000 (5.5%) of those without insurance indicated they had a religious exemption. Only about 7,200 tax filers indicated an intent to appeal the penalty, and about 2,300 actually completed their appeals.²⁸

3.5 Establishment of the Minimum Creditable Coverage Standard

Massachusetts has succeeded in ensuring high rates of insurance take up, while requiring a comprehensive benefit package through the establishment of the minimum creditable coverage (MCC) standard. As of January 1, 2009, individuals were required to have health plans that provided the following benefits in order to be considered insured:

- A comprehensive set of services (e.g. doctors visits, hospital admissions, surgery, mental health and prescription drug coverage).
- Doctor visits for preventive care not subject to a deductible.
- A cap on annual deductibles of \$2,000 for an individual and \$4,000 for a family.
- For plans with up-front deductibles or co-insurance on core services, an annual maximum on out-of-pocket spending of no more than \$5,000 for an individual and \$10,000 for a family.
- No caps on total benefits for a particular illness or for a single year that make the patient responsible for all other charges.
- No caps on the dollar amount per day or stay in the hospital that make the patient responsible for all other charges.

²⁶Massachusetts Department of Revenue, "Individual Mandate 2008 Preliminary Data Analysis," December 2009. Data for the 2009 tax year is not yet available.

²⁷Massachusetts Department of Revenue, "Individual Mandate 2008 Preliminary Data Analysis," December 2009.

²⁸Commonwealth Health Insurance Connector Authority, "Report to the Massachusetts Legislature: Implementation of Health Care Reform Fiscal Year 2009."

- For policies that have a separate annual deductible for prescription drugs, it cannot exceed \$250 for an individual or \$500 for a family.

As of August 1, 2009, the Connector had received approximately 475 plans for review, granting MCC certification to 377 and denying certification to 12. Eighty-four (84) additional plans contained no apparent deviation from the MCC standard and required no review by the Connector.²⁹

3.6 Steady Public Support

Perhaps the greatest achievement of the coalition supporting Massachusetts health reform, and currently the biggest distinction between the Massachusetts model and the federal legislation, is the amount of public support for the Massachusetts reforms. Public support for the 2006 reforms, even after the enforcement of the individual mandate and the establishment of the minimum creditable coverage standard, has remained strong and widespread. Public support crosses all demographics and includes men and women, younger and older adults, higher and lower income adults, and working and non-working adults across the state.³⁰ Almost three out of four households (73%) in Massachusetts supported health reform in 2008 and 2009.³¹ This is up from the 64% supporting health reform in its infancy in 2006.³²

3.7 Eligibility Processes

Part of the reason the Commonwealth has been so successful in insuring a high percentage of its residents is its efforts to enroll all those who are eligible for public programs. These efforts are undertaken in recognition of the fact that making affordable insurance options available to all a state's residents is not the same as covering all its residents. This commitment has only deepened during the current waiver term, despite the economic downturn presenting a clear incentive to let that commitment lapse. The following are activities underway that serve to make it easier to enroll and remain enrolled in subsidized insurance in Massachusetts.

Sustained Commitment to Outreach and Enrollment: The Office of Medicaid manages grants made to community-based organizations that conduct outreach, enrollment and retention work with Massachusetts residents for all health insurance programs available through health care reform. MassHealth has awarded at least \$2.5 million in funding to community organizations through this program each year since the passage of Chapter 58. The grant recipients use multiple venues that are linguistically and culturally appropriate to engage individuals, families, and children. Examples include: career centers, local teen centers, public housing authorities, food pantries, adult education centers, chambers of commerce and public libraries. With this funding, grant

²⁹ Commonwealth Health Insurance Connector Authority. "Report to the Massachusetts Legislature: Implementation of Health Care Reform Fiscal Year 2009." Updated by Commonwealth Connector Staff June 28, 2010.

³⁰ Sharon K. Long, Karen Stockley, Urban Institute, "Health Reform in Massachusetts: An Update on Insurance Coverage and Support for Reform as of Fall 2008," September 2009, Massachusetts Health Reform Survey Policy Brief.

³¹ Sharon K. Long, Lokendra Phadera, and Karen Stockley. Urban Institute. "Health Insurance Coverage in Massachusetts: Results from the 2008 and 2009 Massachusetts Health Insurance Survey," Massachusetts Division Health Care Finance and Policy, October 2009.

³² Blendon, RJ T Buhr, C Flesichfresser, and FM Benson. "The Massachusetts Health Reform Law: Public Opinion and Perception November 2006. available at: http://www.bcbsmafoundation.org/foundationroot/en_US/documents/2006ReformPollingreport.pdf

organizations have enrolled 253,474 individuals into MassHealth, Commonwealth Care and Commonwealth Choice since 2006. Grantees have also assisted 104,619 members in retaining their health insurance benefits by helping them complete and submit their annual renewal paperwork.

Enhanced Customer Service: MassHealth is working to improve the ways it interacts with its members to find efficiencies in customer service expenditures and to enhance members' ability to access the information they need. MassHealth has implemented the use of a new interactive voice tool, "MAP IVR" to allow any MassHealth, Commonwealth Care or Health Safety Net member to hear by phone details about their case without having to speak to a person, including: key eligibility dates, outstanding items needed to finalize a redetermination and examples of forms that can be used to satisfy those requirements. MassHealth and Commonwealth Care members who are heads of household – the individuals who signed the original application for benefits – can now view their accounts online and submit certain information electronically. In addition, individuals who are receiving cash or food assistance through the Department of Transitional Assistance can now also view and edit their information using My Account Page. The Office of Medicaid has undergone a thorough analysis of its customer service operations by COPC (Customer Operations Performance Center Inc.), including extensive focus groups with both members and providers, in order to learn what could be done better. The evaluation and recommendations are now complete and the Commonwealth is working to develop a new customer service platform that incorporates these recommendations before the conclusion of this waiver term.

Facilitating Enrollment and Preventing Unnecessary Disenrollment: Medicaid programs across the country face complaints that eligible individuals are often disenrolled for administrative reasons. The Commonwealth is actively working to address this issue, known as "churn," while maintaining and enhancing its program integrity measures. Massachusetts already scores above average for the portion of the year that eligible members are continuously enrolled. The national average is 78%; the Massachusetts figure is 82%, among the best in the nation. Massachusetts' score in this area exceeds the national average for all populations.³³ One way that Massachusetts is looking to improve further is through its Robert Wood Johnson "Maximizing Enrollment for Kids" Grant. This 4-year, \$1 million grant (awarded to only 8 states, out of 25 that applied) provided the Commonwealth with an independent, diagnostic assessment of its policies and procedures to help the Commonwealth better understand how to increase enrollment and retention in the Children's Health Insurance Program. In Massachusetts, CHIP is fully integrated with the Medicaid program, so improvement efforts will, and are intended to benefit all populations. The opportunities for improvement that were identified as part of this grant that the Commonwealth is actively pursuing, in addition to the customer service improvements described above, include:

- Administrative renewals—The annual eligibility renewal process often contributes to caseload volatility, because members are required to submit a lengthy form and verification documents. Failure to submit the form or

³³Robert Seifert, Garrett Kirk and Margaret Oakes, "Enrollment and Disenrollment in MassHealth and Commonwealth Care," UMass Center for Health Law and Economics and the Massachusetts Medicaid Policy Institute, April 2010.

verifications are the main reasons members are disenrolled. On April 15, 2010, the Commonwealth moved to an “administrative renewal” process for single elders in nursing facilities, about 11,700 people. With administrative renewal, the Commonwealth uses data it already has to determine if the member is still eligible, and then sends the member a personalized letter stating that fact, which does not require them to do anything further unless their circumstances have changed. The Commonwealth is currently analyzing other population groups with stable circumstances as candidates for administrative renewal.

- Ex Parte Renewal—This process, which the Commonwealth is actively investigating, allows Massachusetts to use data from food stamps, the Department of Revenue and other sources to determine ongoing eligibility, thus obviating the need for the forms and the administrative disenrollment that can result.
- Electronic Document Management (EDM)—This will substantially improve the speed and accuracy of the re-determination process and therefore reduce unnecessary disenrollment. The Commonwealth will complete an EDM pilot at one of its enrollment centers by the end of 2010, and expects to roll out EDM across all of MassHealth during 2011.

Section 4 The Next Phase of Health Reform: Health Care Cost Containment

The Commonwealth has achieved its goal of implementing nearly universal health care coverage. Massachusetts must now turn its focus to reducing both the actual costs of medical care and health insurance and the slope of the increases in costs to ensure that affordable care remains available for all residents. The Commonwealth seeks to evolve its partnership with the Centers for Medicare and Medicaid Services to promote health care system redesign through payment reform that rewards high-quality, efficient care and that is accountable and transparent.

Critics of state and federal health reform, in expressing skepticism about 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.”³⁴ 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.³⁵ The authors found that because government costs for uncovered services declined sharply, government’s share of total payments was similar to

³⁴Massachusetts Taxpayers Foundation, “Massachusetts Health Reform: The Myth of Uncontrolled Costs,” May 2009, pg 2. (Available on line at www.masstaxpayers.org)

³⁵Robert Seifert and Paul Swoboda, “Sharing the Cost of Health Care Reform” 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)

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.

Most states in this deep recession are struggling to balance their budgets and maintain their Medicaid obligations. Massachusetts has remained steadfast in its commitment to universal access while the worst economic downturn in more than 70 years has resulted in more Massachusetts residents relying on safety-net programs.

However, Massachusetts, like states around the country, the federal government, the private sector, and individuals, is burdened by health care cost inflation and a fee-for-service payment system that rewards volume of services provided through fee-for-service payment rather than improvements in the health outcomes of the population. The Division of Health Care Finance and Policy's recent Cost Trends Report found that the health care system in Massachusetts is 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.³⁶

Massachusetts health care costs are currently projected to rise by an average of 6% annually during the next decade, while GDP is projected to grow at less than 4%.³⁷ While the MassHealth program has aggressive utilization management and cost controls that have been in place since the first waiver period, Massachusetts overall health spending was 15% higher than the US average in 2004.³⁸ The difference between the rate of growth in health care spending and the rate of growth of the national GDP is expected to cost the Commonwealth a cumulative \$90 billion between 2011-2020.³⁹ A study of preventable hospitalizations indicated that 13% of inpatient admissions in Massachusetts were potentially preventable and that they accounted for an estimated \$639 million in hospital costs in 2008 alone.⁴⁰ Some reports indicate that nearly 50% of emergency room visits in Massachusetts were potentially preventable, as were nearly 10% of hospital admissions and re-admissions.⁴¹

³⁶The Division of Health Care Finance and Policy, pursuant to Chapter 305 of the Acts of 2008, is required to compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The Division held public hearing and conducted research to better understand the sources of escalating health care costs in Massachusetts.

³⁷Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health Care Spending Baseline Trends and Projections," February 4, 2009. Massachusetts Health Care Quality and Cost Council, "Roadmap to Cost Containment," page 1, October 2009.

³⁸Massachusetts Division of Health Care Finance & Policy: "Massachusetts Health Care Cost Trends Part 1: The Massachusetts Health Care System in Context." February 2010.

³⁹Massachusetts Division of Health Care Finance & Policy. "Massachusetts Health Care Cost Trends 2010 Final Report," April 2010. Massachusetts Health Care Quality and Cost Council, "Roadmap to Cost Containment," October 2009.

⁴⁰Massachusetts Health Care Quality and Cost Council, "Roadmap to Cost Containment," October 2009.

⁴¹Massachusetts Health Care Quality and Cost Council, "Roadmap to Cost Containment," October 2009. Massachusetts Division of Health Care Finance and Policy, "Massachusetts Health System Data Reference," 2009. Massachusetts Division of Health Care Finance & Policy: "Massachusetts Health Care Cost Trends 2010 Final Report." April 2010.

These are problems for all payers: the state, businesses, families, local governments, and the federal government. With the passage of the federal health reform, this becomes a national issue as well, as insurance coverage gains will bring health care cost containment questions to the forefront for all states. The good news in Massachusetts is that the forces that came together to pass the 2006 reforms are also at the table to craft and implement state-wide payment reform solutions. (This is discussed in more detail in section 4.4)

Fee-for-service reimbursement, currently the dominant method of paying for care in Massachusetts, encourages overuse of many costly specialty services while short-changing important, but less lucrative areas of care, such as primary care.⁴² Fee-for-service reimbursement offers little incentive to account for quality of care or improved health outcomes, or to coordinate care across a range of providers and settings. In a fee-for-service model, physicians and other providers are paid more for doing more, rather than for achieving or maintaining valued outcomes in their patients. Massachusetts' Demonstration initially addressed the cost growth associated with the fee-for-service payment methodology by moving to a managed care delivery system. The Commonwealth intends to build off of that experience to restructure payment mechanisms to promote low-cost health care that is focused on improved outcomes.

It is clear that the current system is unsustainable and incompatible with the Commonwealth and the federal government's goals to provide affordable coverage to all, but the path to payment reform is less clear and filled with challenges. Providers are invested and entrenched in the current system, and in many cases, lack the resources to conduct the organizational transformation necessary to accommodate a new way of doing business. There are also many difficult and complex questions to resolve to build a system that promotes quality and efficiency, while ensuring equity, accountability and transparency. Nonetheless, the Commonwealth is deeply committed to implementing state-wide payment reform and is heavily engaged in building the consensus and foundation necessary to proceed with state-wide payment reform, while taking action in the near term to provide relief to small businesses, individuals and essential safety net providers struggling under the current system.

4.1 Near Term Solutions to Control Costs

Small businesses have been hit hard by the rising cost of health insurance. Businesses are restricted in their ability to afford to hire new workers because the cost of health benefits consumes so much of their revenue. To mitigate increased spending on health insurance benefits, employers have been shifting costs of care to employees through increased levels of co-payments, coinsurance and deductibles, as well as increases in the portion of individual and family premiums for which employees are now responsible.⁴³ The Connector launched a new group health insurance product called Business Express in February of 2010 to help make covering workers more affordable for small employers by making products available without a membership fee and with significantly reduced administrative costs. Business Express is open to businesses with 50 or fewer employees, and all of its products carry the state's Seal of Approval for quality and value. The

⁴² Robert E. Mechanic and Stuart H. Altman, Health Affairs, "Episode Payment, Commentary" 27 January 2009, w.263.

⁴³ Massachusetts Health Care Quality and Cost Council, "Roadmap to Cost Containment," October 2009.

administrative savings mean that businesses with 5 or fewer employees could save more than \$300 per employee per year.

Recognizing that comprehensive reform will take time, Governor Patrick filed legislation to implement interventions that in the short term can reduce health care costs for small businesses. The legislation provides more regulatory oversight over the annual increase in health insurance premiums charged to the state's businesses and new authority to review the rates providers charge insurers. Regulating rates will not address the systemic issues that need to change to effect a comprehensive health system reform, but it may provide temporary relief. The bill also includes other proposals that will help reduce the cost of health care, including requiring health plans to offer at least one product with selective networks that do not include some higher-cost providers; establishing a reinsurance pool for high-risk claims and limiting new enrollment in individual plans to two periods a year to prevent people from only seeking insurance when they need an expensive procedure and then dropping the plan. The state Senate enacted a bill to address health care costs that includes many of Governor Patrick's proposals as well as additional proposals. The state House of Representatives is considering a version of a health care cost reduction bill and is expected to take action before the legislature adjourns for the year on July 31st. These bills are seen as providing tools for addressing costs in the current structure of health care delivery and not as a replacement for comprehensive system and payment reform.

4.2 Comprehensive Payment Reform

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 conducted 9 public meetings between January and July 2009 to create a set of principles to guide the development of payment policy recommendations, elicit and consider input from key stakeholders, assess and debate alternative payment approaches, and arrive at recommendations for payment policy. Additionally, the Commission conducted approximately 25 stakeholder meetings between January and May of 2009 in which it met repeatedly with health plans, physicians, community hospitals, teaching hospitals and safety net hospitals, consumer advocates, organized labor, employers, community health centers, and the Commonwealth's Connector Authority.

On July 16, 2009, the Commission released a unanimously-approved final report,⁴⁴ which recommended a gradual transition by all payers to a system of global payments, through a framework of accountable care organizations (ACOs). The Special Commission defined ACOs as organizations that accept responsibility for all or most of the care that enrollees

⁴⁴"Recommendations of the Special Commission on the Health Care Payment System," July 26, 2009. Available at www.mass.gov/dhcfp

need, including primary and specialty care, hospital care, therapy services, home care, and prescription drugs. In addition, an ACO must be of sufficient size to accurately measure performance against uniform quality metrics.⁴⁵ ACOs could be composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need. ACOs could be real (incorporated) or virtual (contractually networked) organizations—potentially including, for example, a large physician organization that would contract with one or more hospitals and ancillary providers. Providers may decide to use established relationships to create an ACO, or could enter into new relationships that they view as beneficial to their patients.⁴⁶

The Commission, relying on well established research in the field, emphasized that primary care practices operating as patient-centered medical homes (PCMHs) are a fundamental part of an ACO delivery system.⁴⁷ The Special Commission recommended that the primary care practices in each ACO undergo the necessary practice redesign to become effective patient-centered medical homes and that payment support their operation as PCMHs.

When implemented, this payment system will reduce the financial advantage that accompanies inpatient services and tertiary care at the expense of primary and preventive care, expand effective primary and preventive services, and encourage coordination of care among and between providers because payments will be aligned to promote the highest quality care in the most efficient manner. High-cost providers will be at a disadvantage.

In October of 2009, the Massachusetts Health Care Quality and Cost Council approved the Roadmap to Cost Containment. The Roadmap contains discreet strategies, which with strategic implementation, will allow the Commonwealth to meet its goal of sustainably containing cost growth in health care.

The roadmap recommends eleven strategies:

1. Comprehensive payment reform
2. Support of system-wide redesign efforts
3. Widespread adoption and use of health information technology (HIT)
4. Implementation of evidence-based health insurance coverage informed by comparative effectiveness research (CER)
5. Implementation of additional health insurance plan design innovations to promote high-value care
6. Development of health resource planning capabilities

⁴⁵“Recommendations of the Special Commission on the Health Care Payment System,” July 26, 2009. Available at www.mass.gov/dhcfp

⁴⁶The Special Commission termed these organizations ‘Accountable Care Organizations’ (ACOs) because certain members of the Special Commission were familiar and identified with this terminology. However, the Special Commission’s definition of an ACO differs slightly from the original conception of the term, which defines an ACO as extended hospital medical staff (Fisher et al. 2007) and presumes that physicians practicing within an ACO are owned or directly contract with a provider entity such as a hospital. The Special Commission did not extend its definition of an ACO this far, allowing for other forms of provider organization.

⁴⁷“Recommendations of the Special Commission on the Health Care Payment System,” July 26, 2009. Available at www.mass.gov/dhcfp

7. Enactment of malpractice reform and peer review statutes
8. Implementation of administrative simplification measures
9. Consumer engagement efforts
10. Emphasis on the prevention of illness and the promotion of good health
11. Increased transparency

Health care spending is a product of the price of health care services and the amount of health care patients use. Use is affected by both consumers and providers. The proposed strategies are intended to reduce care that is unnecessary, duplicative, and of no (or marginal) benefit as well as to reduce the price for that care over time, thereby increasing the efficiency of the health care system and reducing the rate of cost growth. Each of the strategies has been shown to be effective in reducing health care costs, or cost growth, on a limited basis. Small-scale examples exist in Massachusetts and in other states. Full-scale, integrated implementation of the combined strategies will have the maximum impact on controlling costs in the Commonwealth.

A number of the strategies are already underway. Current system-wide efforts to adopt and use HIT, simplify administrative processes and increase transparency are in progress. Massachusetts' State Medicaid HIT Plan to encourage Medicaid health care providers to adopt and use electronic health record (EHR) technology is currently in process. Moving Medicaid health care providers to adopt health information technology is a critical element of payment reform by allowing clinical data to be aggregated and shared across different settings of care to support efficiencies, collaborative decision making and practice transformation across the spectrum of health care settings, both within a single practice setting as well as across large care health payment systems. Additionally, the Department of Public Health is working diligently to implement strategies that promote wellness and prevent chronic illness. Ultimately, the implementation of a multi-payer medical home model will set the foundation for payment reform in the Commonwealth.

4.3 Building the Foundation for State-Wide Payment Reform: The Patient-Centered Medical Home Initiative

Many of the most important opportunities for controlling costs can and should be addressed through effective primary care. There is growing evidence of the potential role that a strengthened primary care system can play in reducing health care costs.⁴⁸ Some examples of the opportunities for reducing costs through the efforts of primary care providers include:

- Expanding access to care by using teams that include physician extenders, email and phone calls, same-day appointments, group visits, and urgent care centers can reduce costs and improve patients' access to effective primary care.
- Many illnesses can be prevented through interventions such as immunizations, weight management, and increased physical activity, and the severity of other illnesses can be reduced through regular screenings that lead to early diagnosis and treatment at the earliest stages of disease.

⁴⁸Miller H. "How to Create Accountable Care Organizations." Center for Healthcare Quality and Payment Reform. 2009

- Use of evidence-based treatment guidelines and shared decision-making tools can reduce unnecessary or potentially harmful tests, interventions, and misuse of medications.
- Use of generic drugs or lower-cost alternatives can reduce expenditures on pharmaceuticals and increase patient adherence to treatment regimens that prevent the need for more expensive services.
- Rates of emergency room visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced through improved patient education, self-management support, and access to primary care.

Primary care practices functioning as Patient Centered Medical Homes can form the foundation of ACOs, with the goal of improving prevention and chronic care management, reducing unnecessary testing and referrals, and reducing unnecessary admission, readmissions and unnecessary emergency department visits. Primary care practices and specialists who provide care for the most frequently presenting conditions outside of the primary care provider's domain, working together can further improve the quality and efficiency of care by focusing on prevention and improvement of care for ambulatory care-sensitive conditions and common specialty procedures. Primary care practices, specialists and hospitals, collaborating through an integrated delivery system have great potential to focus on all or most opportunities for cost reduction and quality improvement. Primary care providers, especially those in community health centers, public health agencies, safety net or disproportionate share hospitals, and social service organizations working jointly can improve outcomes for vulnerable populations. The Commonwealth's goal is to build these opportunities in sequence over time.

Payment reform is necessary to promote the transformation of health care to achieve improved quality and efficiency. Fee-for-service payment fails to provide incentives for delivering the right services in the least expensive setting at the time that is best for the patient, does not provide incentives to avoid unnecessary testing and other services, and pays providers the same regardless of the quality of care. The primary tool that payers have to control costs is to reduce payments.

An alternative to fee-for-service reimbursement, at the other extreme of the payment continuum, is capitation. Under many traditional capitation systems, payers provide health care providers a fixed amount of money for every patient. These types of capitation payment systems transferred risk to the capitated provider. The capitated provider has the flexibility to decide which services to deliver. If the provider keeps a patient healthy, the payment does not decrease. However, under a capitated system, providers are at a disadvantage if they serve sicker patients, and can benefit financially from delivering fewer services than a patient needs. Between the extremes of pure fee for service and pure capitation is a range of payment options that may provide a balance between these extremes. These include shared savings, episode/bundled payment, and comprehensive care payment or global payment. As the Commonwealth moves forward with payment reform it will explore using these payment methodologies beginning with Patient Centered Medical Homes and then with PCMH and hospital system integration.

A Patient-Centered Medical Home (PCMH) is a community-based primary care setting that provides and coordinates high quality, planned, patient and family-centered health

promotion, acute illness care, and chronic condition management.⁴⁹ The PCMH concept is rooted in the early work of the American Academy of Pediatrics on medical homes for children with special health care needs and in Dr. Ed Wagner's heavily evaluated Chronic Care Model, which focuses on transforming primary care practices to provide more effective care to patients with chronic conditions.⁵⁰ It is a dynamic concept that is likely to continue to evolve, even while, and perhaps as a result of, national activity to implement and test the concept.⁵¹

The PCMH represents a new way of delivering and paying for primary care. While the current models and approach to the PCMH are new in the last few years, they are informed by and based upon earlier work. Dr. Barbara Starfield of Johns Hopkins University and many others have researched the impact of a primary care-oriented health care system on health care outcomes, costs, and equity. Dr. Starfield's research has found that a greater orientation towards primary care results in lower per-capita health care costs and better outcomes. Conversely, a specialist-oriented health care system (like that of the U.S.) is associated with higher costs and poorer outcomes. The PCMH model also recognizes the advances that have been made in preventing and managing chronic diseases such as diabetes. More than 30 years of research has demonstrated the value of early identification of diabetes, effective mechanisms to accurately monitor the progression of diabetes, and effective treatments to prevent heart disease, stroke, kidney failure, blindness, and peripheral vascular disease. Advances like these have also been made for other chronic diseases, yet the practice of primary care has not changed significantly, as it is still focused on time-limited patient appointments with an individual clinician, usually a physician. Physicians are paid according to how many appointments they can generate.

Many medical home pilots and initiatives are underway, and some of the evaluations have appeared in peer-reviewed journals. The findings to-date have been consistent in demonstrating improved quality and decreased acute care utilization and/or cost savings.

The Medical Home model promotes a team-based approach to care of a patient through a spectrum of disease states and across the various stages of life. Overall coordination of care is led by a primary care clinician, with the patient serving as the focal point of all medical activity.

In June 2009, the Secretary of the Executive Office of Health and Human Services (EOHHS), Dr. JudyAnn Bigby, convened a large group of consumer, physician, nurse practitioner, hospital, insurer, state agency and other interested stakeholder representatives to form the Council of the Massachusetts Patient-Centered Medical Home Initiative (PCMHI). The purpose of the Council is to advise EOHHS in its role as

⁴⁹Center for Medical Home Improvement, 2008.

⁵⁰Wagner EH, Austin B, and Von Korff M, "Improving Outcomes in Chronic Illness," *Managed Care Quarterly* 4, no. 2 (1996): 12–25 and Wagner EH, Austin B, and Von Korff M, "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly* 74, no. 4 (1996): 1–34

⁵¹The Chronic Care Model (CCM) and PCMH share much in common, including population-based care management supported by use of information systems, and a proactive, team-based approach to patient-centered care. The PCMH focuses on primary care for all patients (not just those with chronic illnesses), and tends to be physician-centric (although does not have to be). The CCM also focuses on patient self-management and the mobilization of community resources to meet the needs of patients. Less emphasized by the CCM are around-the-clock access to services and patient-centered concepts, such as caregiver cultural competence.

convener and overseer of the PCMHI. The Council developed a framework to clearly define the roles and responsibilities for primary care practices in transforming into medical homes and to support the transformation of primary care practices into medical homes through the provision of financial and technical assistance support to practices in their transformation efforts. The objectives of the PCMHI are:

1. To implement and evaluate the PCMH model as a means to achieve accessible, high quality primary care;
2. To attract and retain primary care clinicians into practice in Massachusetts by increasing resources available to practices and improving their quality of work life; and
3. To demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model.

The Massachusetts Patient-Centered Medical Home Initiative (PCMHI) is intended to address a series of problems including:

- fragmented, discontinuous care that harms patient health status and increases costs;
- increasing prevalence of chronic disease, and suboptimal management of chronic disease among patients with such illness; and
- a growing shortage of primary care providers.

The first stage of implementation will be a three-year, multi-payer initiative to transform selected primary care practice sites into the PCMH model. The PCMH is an alternative approach to the delivery of primary care services that promises better patient experience and better results than traditional care.⁵²

EOHHS hopes to test the medical home model for a variety of patients, and in a variety of provider types and sizes. Because the implementation of a medical home model of care requires fundamental changes in how providers care for all their patients and how they run their entire practices, Massachusetts has pursued a multi-payer approach to the PCMHI. Participation by multiple payers helps ensure that practices are compensated for these changes across as many patients as possible, which increases the likelihood of successful practice transformation and sustainability of the new model over time.

Although this has been a challenging financial time for private payers to invest in new initiatives, EOHHS has been successful in building a multi-payer approach to the PCMHI, and Massachusetts is hopeful that the first wave of PCMHI practices will produce evidence that PCMH investment offers a positive return to payers.

To date, the Commonwealth has secured the participation of Blue Cross Blue Shield of Massachusetts (BCBSMA) and Neighborhood Health Plan (NHP) for their commercial members to participate. MassHealth's newly reprocurd MCO plans (BMC HealthNet Plan, Fallon Community Health Plan, Network Health, Neighborhood Health, and Health New England) will also participate in the initial roll-out of the PCMHI alongside MassHealth's Primary Care Clinician (PCC) Plan. The Commonwealth also anticipates

⁵²For more information on the PCMH, see www.pcpcc.net/files/PCMH_Vision_to_Reality.pdf.

that the Connector's Commonwealth Care Plans (BMC HealthNet Plan, Fallon Community Health Plan, Network Health, Neighborhood Health, Celticare) will participate as well. EOHHS is also in discussions with the Group Insurance Commission (GIC), the agency that purchases state employees' health care benefits, to include GIC-contracted payers in this first group of participating payers. Although the GIC is fully in support of participating in the PCMHI, the GIC contracts with multiple payers using different arrangements (e.g., self-insured plans and HMO risk-based contracts). Bringing all of their payers into the PCMHI is a complicated undertaking that may require additional time to achieve. Finally, in August 2010, EOHHS plans to submit an application in response to CMS' Medicare Advanced Primary Care Practice Demonstration to seek Medicare's involvement in the initiative, in collaboration with these other participating payers in the Commonwealth who will be partnering with EOHHS.

In SFY 2011, EOHHS will undertake a competitive procurement to select the first group of primary care practice sites for the PCMHI. The Commonwealth expects that several of these practices will be current participants in the MassHealth PCC. EOHHS will amend existing provider contracts with PCC practice sites to clarify PCMHI requirements and related payments.

The selected primary care practice sites will initially participate in a learning collaborative and will work with a medical home facilitator to support their efforts to transform into a medical home.⁵³ Continuing education will be available to clinicians from participating practices, and payers will be aggregating data from participating practice sites to share analysis and initiative trends with the practices. Practices will be required to transform internal processes for planning, delivering and measuring the impact of care on their patients, using a patient registry and other mechanisms. They will also be required to obtain National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) recognition within 18 months from the start of their participation.

The PCMHI Council expects that PCMHI payment will evolve over time towards a payment approach consistent with a system of global payment. The initial payment system will be a hybrid model that builds on the predominant fee-for-service payment system, but contains elements that will support movement to comprehensive payments, and align with state-led efforts for broader payment reform.

The PCMHI will start by selecting two groups of participating practices. One group, the Technical Assistance-Plus group, will be comprised of participating practices for which MassHealth, its contracted MCOs and the Health Safety Net represent a significant proportion of practice revenue. This group of approximately 25-30 primary care practices, which the Commonwealth anticipates will include a significant number of community health centers, will receive additional payments as described below, as well as the technical assistance elements noted above. A second group of approximately 20 practices, the Technical Assistance-Only Practices, will not receive any additional

⁵³A learning collaborative is a process pioneered by the Institute for Healthcare Improvement whereby clinical teams join clinical teams from other organizations to learn in order to generate performance improvement. Practice teams meet a few times face-to-face over the course of at least 12 months and learn from teachers and from one another.

compensation for their participation in the PCMHI, but will receive technical assistance. Practices in this second group will need to show that they have the capacity to invest in their transformation, using either their own resources or those they may already be receiving through alternative payment streams (e.g, infrastructure payments from payers or grants) that support medical home activities. Through the PCMHI they will have the additional support of technical assistance and guidance as they evolve.

The Technical Assistance-Plus practices will receive the following additional payments from participating payers:

- Start-up Payments: Payment per practice site, pro-rated across participating payers, for start-up costs incurred by practices in the first and second years of their participation. Start up payments are intended to compensate practices for expenses incurred in activities designed to prepare each participating practice for transformation into a medical home, including populating patient registries, creating care transformation teams in the practice, and preparing for participating in the learning collaborative.
- Medical Home Activities Payments: A per member, per month (PMPM) payment for activities including, but not limited to, development of patient care plans, managing care transitions, provision of care coordination, provision of patient self-management education and self-management support, and other activities to be taught in the course of the learning collaborative sessions.
- Clinical Care Management Services Payments: A PMPM payment for services provided by a care manager who has been hired or contracted by the practice, either alone or in partnership with one or more other practices.
- Shared Savings and Quality: If EOHHS or its agent determines that a grouping of EOHHS-determined like practices has 1) generated cost savings relative to a control group of primary care practices, after subtracting payment amounts for start-up, otherwise non-covered services, and clinical care management services, and 2) if the practices meet quality of care performance thresholds to be determined by EOHHS, the practices shall share with EOHHS in the cost savings consistent with a methodology to be defined by EOHHS.

The goal of the Patient-Centered Medical Home Initiative is to expand to all primary care practice sites throughout the Commonwealth by 2015. The Commonwealth will apply the experience it gains in administering and monitoring the Patient Centered Medical Home Initiative to crafting the ACO structure for state-wide all payer reform. The transformation that will have occurred at primary care practice sites around the state as a result of this initiative will facilitate the transition to the ACO structure by ensuring that the primary care management piece is already in place for the Commonwealth's residents.

Cambridge Health Alliance PCMHI

While the Commonwealth has been developing this Patient-Centered Medical Home Initiative, Cambridge Health Alliance (CHA), has been advancing a patient centered medical home/ neighborhood (PHMHN) model. As part of that effort, CHA and its affiliated health plan, Network Health, have jointly initiated a program of managing cost and quality of a shared cohort of 2,000 primary care patients with at least two chronic

diseases and high health care utilization. About 50% of the adults in this cohort had significant inpatient and outpatient mental health utilization. The program includes extensive PCP training and introduction of case managers, including nurse practitioners and community health workers to augment and extend the reach and capacity of the primary care team. It provides additional resources to help engage members in care, monitor and encourage medication and treatment plan compliance, and serve as the first call for a member experiencing health issues. The goals include integrating additional support into the primary care setting, improving health outcomes, and lowering cost, such as by reducing preventable emergency room visits and avoidable admissions through coordination with primary care, directing necessary care and admissions to CHA providers wherever appropriate, and engaging patients in managing their care through regular connections with health outreach workers and case managers. CHA would like to build on this model to apply it to other public payer populations. These upcoming initiatives at CHA and Network Health will be an important complement to the PCMHI, and will likely pave the way for the Commonwealth's transition to a reformed payment system.

4.4 Building the Consensus for State-Wide Payment Reform

It is critical that all Massachusetts health care payers and providers embrace the path to payment reform. Without the participation of all payers, the payment system cannot be thoroughly reformed at all providers and practice sites. However, as the federal government learned in the development of the federal reform legislation, a transformation of this magnitude is not easy. It is easier to gain consensus to expand access than it is to get a universal commitment to re-making the health care reimbursement system. Fortunately, Massachusetts has a strong coalition of constituencies - leaders from state government, business, hospitals, physicians, consumer advocacy groups and health policy experts - that came together to push for the 2006 reforms, who have stayed engaged throughout implementation and are committed to ensuring the long-term success and sustainability of those reforms.

Starting in January 2009, Secretary Bigby reached out to this group and others to begin a series of meetings to develop a shared consensus vision for health system payment reform. The Secretary brought in several health policy experts from around the country to brief this group on the possible elements of payment reform, including the formation of Accountable Care Organizations, the transition to global payment, and the impact on particular providers, patients and businesses. The group met every two weeks for several months. Later in the process, the Secretary met with distinct groups of stakeholders to discuss an outline of payment reform legislation that the administration is drafting. The level of engagement and commitment from this group has been very encouraging and productive.

The draft legislation would phase in a global payment system statewide within five years, in keeping with the Special Commission's recommendations, and anticipates that when fully implemented, global payments in Massachusetts would include the following key features:

- A global payment system in which providers would receive a payment per person, adjusted for patients' health status and other factors to ensure that they are

compensated fairly for their patients' health care needs. Payments would also be based on meeting common core performance measures to ensure high quality care.

- An emphasis on patient-centered medicine, with doctors and other providers providing coordinated, evidence-based, high-quality care for patients. In addition to providing more effective care for patients, this approach will also help to reduce health care costs in the longer term.
- A careful transition to global payment within five years, during which "shared savings" would serve as an interim payment model to help some providers become more familiar with global payment with no or reduced exposure to risk. There would also be infrastructure support for providers to facilitate the transition to global payments, including technical assistance, training, and information technology.

EOHHS, with the collaboration of Massachusetts health reform's stakeholders and legislative leadership, will finalize a draft of legislation to implement for consideration at the beginning of the next legislative session in January 2011.

At the same time, the Patrick administration is committed to advancing payment reform using opportunities in the Medicaid program, as described in Section 5, and opportunities available through PPACA to involve Medicare in payment demonstrations. Medicaid and Medicare together serve nearly one third of the people in the Commonwealth and pay for approximately 37% of all personal health care expenditures in Massachusetts.^{54,55,56} The Commonwealth is seeking the partnership of the federal government early in this reform effort to help demonstrate to resistant constituencies that these changes are coming and are inevitable to sustain access to high quality care for all. The combined purchasing power and clout of Medicare and Medicaid in the health care market will provide crucial leverage to enable the Commonwealth to require that all payers and providers participate in this transformation. The partnership of the federal government will underscore that these system-wide changes are necessary for the country and require the participation of all stakeholders.

Section 5 Requested Changes to the Demonstration

The Commonwealth is seeking to evolve its partnership with the federal government through the 1115 Demonstration to support payment reform initiatives, both short and long term that will lead to improved health for members, enhance quality of care and patients' experience, permanently alter the trajectory of health care costs, and promote transparency in the delivery of health care. To decrease fragmentation in care and

⁵⁴ CMS reported 1,021,479 Medicare members in Massachusetts in 2008. CMS Data Compendium: State Data. Medicare Part D Enrollment by State (Total Medicare Enrollees).

http://www.cms.hhs.gov/DataCompendium/16_2008_Data_Compendium.asp#TopOfPage

⁵⁵ The Census Bureau estimated 6,497,967 people in the Commonwealth on July 1, 2008. U.S. Census Bureau: Annual Estimates of the Resident Population for the United State, Regions, State, and Puerto Rico. December 22, 2008.

<http://www.census.gov/popest/states/tables/NST-EST2008-01.xls>

⁵⁶ CMS National Health Expenditure Data.

<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatespecific2004.pdf>

effectively control costs, Massachusetts must reform the organization of the health system to promote collaboration and efficiency, as well as reform the payment system to align high quality outcomes with financial incentives. As Massachusetts focuses on health care quality improvements and cost containment – through Medical Homes, integrated care for high risk populations and long-term payment reform - the Commonwealth’s partnership with CMS through the Demonstration remains central to its continued success. Reforming Massachusetts’ system from a fractured delivery system into an integrated delivery system will manifest savings over the long term. Care coordination and integrated care for high risk populations and health care payment reform are fundamental to ensuring consistent quality of care, reducing errors, decreasing health care disparities, and reining in overall health care costs and thereby sustaining near-universal health insurance coverage.

A critical component of improving health care quality and curtailing costs will be integrating care to ensure that providers work collaboratively to meet patient care needs and do so in the most appropriate setting. Moving toward using the right care at the right time in the right place will be a significant behavioral change both for providers and for health care consumers, but it is also a pivotal building block in the long-term systemic transformation Massachusetts envisions.

5.1 Maturing of the Patient Centered Medical Home Initiative (PCMHI)

While the PCMHI initiative will begin during the current Demonstration term, the renewal provides the opportunity for this project to grow and expand beyond its initial implementation in SFY 2011.

Payments to selected practices will begin in SFY 2011, but bonus payments based on shared savings and quality will not begin until the second year of the initiative. In SFY 2012, EOHHS will calculate shared savings based on practice performance in the first two years of the PCMHI, and will issue these payments to the participating practices, if appropriate.

EOHHS is hopeful that initial results from the original practice sites will provide an incentive for additional private payer participation in the PCMHI’s expansion efforts, with the goal of transforming all primary care practices in Massachusetts into PCMH’s by 2015. Plans to move the PCMHI forward during the waiver term include further expansion to additional public payer dominant practices, including transformation of all Massachusetts Community Health Centers.

5.2 Integrated Care for Dual Eligibles

Improving care coordination for beneficiaries who are dually eligible for MassHealth and Medicare focuses on a population that often experiences fractured care, does not receive the care management necessary to address co-morbid conditions, and experiences frequent emergency department visits and readmissions that drives a disproportionate share of health care expenditures. In SFY 2009, EOHHS projected that 43.5% of Medicaid SFY 2010 funds would be spent on the 20% of members who are Dual Eligibles. These Dual Eligible individuals include those with chronic disease, disabilities, or other long-term illnesses, and are often in socio-economically vulnerable populations that may require the greatest assistance in accessing medical care in the most appropriate and cost-effective venue.

Massachusetts has been examining ways to improve care delivery, quality, and outcomes for residents with Dual Eligibility. Most younger adult Dual Eligible individuals (ages 22-64) in Massachusetts currently do not have access to an integrated model of care, unlike the Commonwealth's Seniors who may choose the Senior Care Option (SCO) program, or those ages 55 and older who may qualify for the Program for All-Inclusive Care for the Elderly (PACE) program. This younger adult Dual Eligible population, approximately 110,000 members, is limited to receiving their Medicaid services in the fee-for-service (FFS) environment which is often recognized as defaulting to fragmented, uncoordinated care that can lead to poor clinical outcomes and potentially avoidable expenditures. Financial incentives for individual service providers and for Medicaid and Medicare as payers in a FFS system are misaligned and at odds with the goal of providing the right care in the right place at the right time. Massachusetts' goal is to create a fully capitated integrated model of care that meets the needs of the 22-64 year old Dual Eligibles and integrates services and care coordination similar to the SCO program, but takes the SCO model a step further by also integrating Medicare and Medicaid financing at the state level to align financial incentives and provider accountability in a new way.

Massachusetts plans to expand on its longstanding managed care program architecture in two ways for Dual Eligibles. First, the Commonwealth would add long-term care state plan services and potentially Home and Community Based Waiver Services to the scope of services that would be included in a capitated arrangement. Additionally, Massachusetts would modernize the care management in order to offer a new integrated care product to younger, dually eligible members.

Massachusetts has recently required the MCOs to provide complex care management for disabled persons in the managed care program. The goal is to improve coordination of care and quality of care and maintain functional status. The outcomes we are tracking in this program include functional and ambulation status as well as primary diagnoses and comorbidities. We will build on this experience with disabled adults as we build the program for Dual Eligibles.

Massachusetts plans to seek authority under the Center for Medicare and Medicaid Innovation (CMI) created by section 3021 of the PPACA within CMS to grant the Commonwealth the funds that Medicare would have spent for Dual Eligibles. Massachusetts would then administer the Dual Eligibles' Medicare and Medicaid benefits jointly, such that the Dual Eligibles would experience their Medicare and Medicaid coverage as a single, integrated care program.

The Commonwealth has been in discussions with CMS about these ideas, and plans to continue this engagement over the next several months. The Commonwealth proposes using the 1115 Demonstration as the vehicle to offer managed Medicaid services to Dual Eligible members as part of this new fully capitated, integrated care product. It is significant that this managed care product would also incorporate Medicaid long-term care services that have not previously been available in a managed care product for most of the MassHealth population under age 65.

Massachusetts intends to use its existing freedom of choice waiver authority under the 1115 Demonstration to enroll Dual Eligibles ages 22-64 in this new Medicaid managed care product. As two-thirds of the Commonwealth's Home and Community-Based Waiver participants under age 65 are also dually eligible, Massachusetts plans to bring these currently excluded members into the 1115 Demonstration in the new term (this is explained in further detail under "Managed Care for Excluded Groups"). The Commonwealth further proposes removing the eligibility exclusion for individuals who are receiving inpatient care in medical facilities, so that Dual Eligibles who reside in these settings may choose to participate in a managed care product; Massachusetts is optimistic that this may better facilitate transitions to community settings. Bringing these two groups into the Demonstration ensures that the Commonwealth can offer managed care to all Dual Eligibles in the target group via the Demonstration. Massachusetts will also plan for the Demonstration to offer a fully capitated integrated care plan as a new managed care option that will be available for Dual Eligible members ages 22-64.

5.3 Managed Care for Excluded Groups

Massachusetts intends to expand on its successful development of a mature managed care system by offering previously excluded groups access to managed care products. Historically, specific populations have been excluded from the 1115 Demonstration Waiver, and therefore from participating in MassHealth's managed care products. For certain groups on this list, this exclusion no longer makes sense, and would in fact be a barrier to the Commonwealth's broader integrated care policy goals. Massachusetts proposes making managed care products available to members who would otherwise have access to them if not for the exclusion. Specifically, MassHealth members would no longer be categorically excluded from enrollment in managed care because they are participants in a Home and Community Based Waiver (HCBW), children who are eligible under TEFRA section 134 (the Kaileigh Mulligan program) or children who are receiving Title IV-E adoption assistance. Beyond accessing managed care, these members may benefit from and should be included in the many important reform initiatives the Commonwealth is embarking upon.

Approximately 3,400 (27%) of HCBW participants under age 65 (based on SFY 2009 data) did not have any additional health insurance, including Medicare, other than Medicaid. This group of HCBW participants would be able to participate in MassHealth's managed care programs. The PCC and MCO plans have been providing high-quality care for years to much of MassHealth's complex, disabled membership.

Effective July 1, 2010, MassHealth has re-procured its MCO contracts to include the specific Complex Care Management (CCM) requirements that all contracted MassHealth Managed Care Organizations MCOs must meet. The goal of CCM is that all MCO enrollees with special health care needs receive appropriate services to maintain optimal health and functional status. The MCOs will be required to adopt a patient-centered approach to care, with enhanced care coordination, and comprehensive case management services that are tailored to individual needs with the ultimate goal of getting the patient to his or her optimal level of overall health and function. Members identified as having CCM needs will be paired with a Designated Care Management Coordinator (CMC), typically a registered nurse, who is responsible for coordinating all aspects of an enrollee's needs across the continuum of care, including collaboration with providers,

patients, families, and community-based partners. The CMC is responsible for managing both the clinical and non-clinical needs of the member to include medical, behavioral, and social care management. Specific services may range from intensive clinical care to telephonic or face to face care management, ongoing long-term care, providing linkages with community resources or other suitable social safety networks, and appropriate transition to independent community-based.

Particularly with these new enhancements to the MCO program that will most benefit people with complex care needs, it no longer makes sense to exclude this group of complex members from managed care plans that are well-equipped with tools to manage HCBW participants' health care needs. Massachusetts does not intend to make any changes to the services delivered under the HCBWs, or to their purchasing or delivery arrangements. The Commonwealth instead envisions simultaneously enrolling HCBW participants in the 1115 Demonstration while maintaining enrollment in their current respective HCBWs. Massachusetts also does not intend to make any changes to the rules governing these individuals' financial eligibility.

Massachusetts would also like to offer children who are currently excluded from the Demonstration the opportunity to enroll in managed care. To do this, the Commonwealth would remove from the list of populations excluded from the Demonstration children who are eligible for the Kaileigh Mulligan program and children who are eligible for the Title IV-E adoption assistance program. By including these previously excluded populations in the Demonstration, Massachusetts would be able to give these children access to the same high-quality managed care products as other MassHealth children have.

Individuals who are residing in long-term care facilities are also disproportionately dually eligible for both Medicare and Medicaid, and have historically been excluded from Medicaid managed care products. By bringing members who are under the age of 65 and living in a long-term care placement into the Demonstration, the Commonwealth will lay the foundation for providing integrated care to a new cohort of dually eligible members.

Massachusetts proposes removing the following populations from the list of Eligibility Exclusions for the 1115 Demonstration:

- Individuals who are institutionalized
- Participants in a Home and Community Based Waiver
- Children eligible under TEFRA section 134 (Kaileigh Mulligan kids)
- Children receiving Title IV-E adoption assistance

These changes will bring all MassHealth members under the age of 65, with the exception of PACE (Program of All-Inclusive Care of the Elderly) participants and Refugees who are 100 percent federally funded, under the authority of the 1115 Demonstration. This new alignment will facilitate the Commonwealth's progress toward more integrated care for its members. Specifically, these changes bring all MassHealth members ages 0-64 under the umbrella of the 1115 Demonstration to better enable Massachusetts' progress toward adopting state-wide payment reform. While Massachusetts doesn't propose any changes for members aged 65 and older at this time,

the Commonwealth expects that if Medicare agrees to participate in this all-payer reform, then most of these older MassHealth members would join the reform when Medicare joins the effort.

5.4 Global Payment Pilot Projects

While the Patrick Administration is building the support necessary for legislation to mandate the participation of all payers in statewide payment reform, the Commonwealth is committed to leveraging the buying power of the Demonstration programs to begin the transition from fee for service to integrated delivery and payment systems through global payment pilots. The projects will require the partnership of the federal government to authorize non-traditional forms of payment.

MassHealth and the Division of Health Care Finance and Policy are actively pursuing pilot projects with hospitals and provider groups to put global and bundled payment systems into practice. The first pilot project of this kind is a partnership with Boston Children's Hospital to expand their Community Asthma Initiative, which was recently selected to receive the U.S. Environmental Protection Agency's (EPA) 2010 *National Environmental Leadership Award in Asthma Management* for their exemplary efforts to deliver high-quality pediatric asthma care that includes environmental controls. By utilizing case management and traditionally unreimbursed services, such as home visits and environmental interventions, the initiative was able to reduce asthma admissions by 81% and ER visits for asthma by 65% in just one year. The Commonwealth aims to reach agreements with providers on additional pilot projects before the start of the Demonstration renewal and will update CMS on those agreements as they occur during the course of Demonstration negotiations.

5.5 Transition Support Payments for Cambridge Health Alliance

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 is also distinguishable from all other Massachusetts hospitals by the following:

- CHA has the greatest concentration of patients participating in Demonstration programs of any provider in the Commonwealth (49%), about 3 times the acute hospital average (16%) and over 2 times the average for the states disproportionate share hospitals (21.5%).⁵⁷
- CHA has the highest concentration of outpatient care for Medicaid and low-income payers in the state (56%).
- CHA operates fully integrated and owned primary care sites and health centers.
- 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 and a native language other than English.

⁵⁷ Based on data from the Massachusetts Division of Health Care Finance and Policy's 2009 403 Report.

- CHA has an employed physician base.
- CHA has an affiliated provider-sponsored MassHealth and Commonwealth Care managed care plan, Network Health.

CHA also 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 medical facilities (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.

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 relationship between the Commonwealth and CHA.

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 an 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 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 discussed in the Commonwealth's pending amendment request, submitted March 2010. CHA's reconfiguration activities have already resulted in cumulative service-line expense reductions in the range of \$185 million over hospital fiscal years 09-11, as well. CHA projects that its HFY 2011 expenses will be 16% below pre-reconfiguration trend projections.

Transformation to the ACO Model

CHA is actively planning and developing initial readiness to become an ACO in order to be able to pilot new delivery and payment models for the Commonwealth's waiver participants. CHA proposes to implement effective new health care delivery and payment models as a major public safety net health system during the Demonstration period. This new ACO delivery model would capitalize on CHA's strengths as a primary care focused system with an advancing patient-centered medical home model, extensive planned-care, chronic-disease management, employed and aligned physicians and CHA's affiliated managed care plan, Network Health. This model would introduce new global budget payment methods that address systemic volume-driven incentives in today's fee-for-service payment system.

CHA's public status, heavy concentration of Demonstration patients, a mission aligned to Demonstration participant's needs, a high concentration of out-patient, primary and behavioral health services, physicians as employees and successful reconfiguration could make it an ideal entity for the Commonwealth to work with in piloting the ACO model as the Commonwealth seeks the authority and support necessary to accomplish all payer state-wide payment reform.

Additional Payments to Support CHA's Transformation

While the reconfiguration has reduced CHA's cost trends substantially, it does not address the underlying challenges that CHA faces within the current health care payment system or provide the funds necessary to transform the system into an ACO model.

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 the Commonwealth is striving to have.

In order to support CHA through the reconfiguration and transformation to an ACO, the Commonwealth is proposing an additional \$163 million in payments to CHA for SFY 2012, \$166 million for SFY 2013 and \$169 million in payments for SFY 2014 relative to currently approved levels of funding. These amounts represent an annual 1% increase in

net funding for CHA each year over the SFY 2011 funding proposed in the pending waiver amendment (which is itself 9% lower than the requested amount for SFY 2010). The 1% increase represents a very modest projection for medical inflation, recognizing the Commonwealth and CHA's commitment to bending the trend in health care costs. Like the prior payments to CHA, the non-federal share of these amounts will be provided by the Cambridge Public Health Commission through permissible intergovernmental transfers.

5.6 Transition Payments for Private Hospitals

The Commonwealth, like its sister states, is faced with the challenge of maintaining access to essential hospital services for low-income individuals in a fee-for-service system that may not always reward efficiency of care or even 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 under the current reimbursement system.

As discussed in Section 4, the Commonwealth is currently developing legislation to shift all payers and all providers in Massachusetts to a global payment system statewide and is currently building the elements of a reformed system within the Massachusetts Medicaid program. To facilitate this transformation and to bridge acute hospitals until that transformation is complete, the Commonwealth is seeking the federal government's support in creating a transitional approach for hospitals that mitigates the problems inherent in the fee-for service payment system.

The Commonwealth is therefore requesting authorization to provide a total of \$135 million in additional payments to private hospitals for each year of the renewal term. This is a continuation of the request made in the pending March 2010 amendment request, with no increase for medical inflation to reflect the Commonwealth's commitment to bend the trend in health care costs and transform payers to a system where high medical inflation will no longer be tolerated.

As discussed in the amendment request, the calculation prioritizes those hospitals for which Medicaid and other state-supported programs represent a large share of total services delivered, and for which commercial insurance represents a small share, by reserving \$120 million of the proposed \$135 million for those providers (Group A). The remaining \$15 million is then distributed among all other acute care hospitals in the state (Group B). In both groups, the calculation adjusts the payments to reflect the total level of expenses for state-supported programs for low-income individuals at each hospital. (See Attachment B for a detailed description of the payment methodology.)

As soon as federal approval is granted for the transition payments, the Commonwealth will require each of the Group A hospitals, to whom \$120 million of the \$135 million would be dedicated, to undergo an analysis and reconfiguration akin to what Cambridge Health Alliance is going through to ensure not only that each hospital relying significantly on Demonstration programs is efficient as it can be, but also that it is ready to transform to an integrated system of care and to a state-wide reformed payment system built on the ACO model. The Special Commission recognized that providers will need

significant support in building the infrastructure needed to integrate care successfully, meet performance metrics/targets, and manage financial risk for performance.⁵⁸

Pursuant to the terms of the waiver amendment or renewal agreement, the hospitals would be required to hire an independent audit firm to conduct a comprehensive review of the hospital systems to:

1. Identify operational inefficiencies and opportunities for improved revenue. The firm would also make recommendations to lower costs and enhance the hospitals' ability to be cost-effective;
2. Evaluate the specific organization's readiness to perform under integrated care models and identify additional investments, operational changes, and clinical affiliations that would be required to promote primary care and facilitate the conversion of the hospital system to an integrated care organization or as a component of a larger integrated care organization; and
3. Demonstrate ongoing successes and savings.

Providers will need resources to enable them to improve their infrastructure for care management and to deliver different services in different ways. Special financing and payment arrangements may be needed for care changes where the return on investment will occur over many years. For example, installing an electronic health record system not only requires significant capital costs, but also reduces productivity initially during the training and learning process. It takes time to recruit and train nurse care managers before they can begin improving the support for chronic disease patients. Although improved payment systems may provide revenue streams to cover those costs over time, some providers who are reorganizing themselves into integrated systems of care may need transition payments to enable them to make the changes. Ultimately the hospitals will need to demonstrate that they have the ability to manage and coordinate patient care, manage financial risk, and measure cost and quality.⁵⁹

Using information obtained from the operational reviews, the hospitals and EOHHS would establish specific benchmarks and timeframes for actions hospitals would undertake to obtain operational efficiencies and to move toward an integrated delivery of care model. Such actions could include:

1. HIT/EMR enhancements and movement toward coordinated transitions with geographic area providers of care;
2. Qualifying hospital licensed community health centers as NCQA medical homes;
3. Innovative chronic disease management models;
4. Reduction in emergency department utilization; and
5. Reductions in readmissions, preventable hospitalizations, hospital acquired infections.

⁵⁸ Recommendations of the Special Commission on the Health Care Payment System, July 26, 2009. Available at www.mass.gov/dhcfp

⁵⁹ Miller H. "How to Create an Accountable Care Organization." Center for Healthcare Quality and Payment Reform. 2009. www.CHQPR.org

Funding provided to the hospitals would be disbursed in periodic intervals, provided the hospital meets the benchmarks and timelines established by EOHHS and the hospital. The Commonwealth would use its All Payer Claims Database to develop benchmarks and funding targets.

This approach to hospital relief will identify and eliminate the hospitals' current inefficiencies, rather than enabling them. It will leverage the analysis for advancing these medical facilities toward integrated care organizations, leading to a pay-for-performance and integration strategy that mitigates annual increases in health care costs, improve health outcomes and better manages utilization at the appropriate settings and right place. Perhaps most importantly from a federal perspective, it will also provide a best-practice model for other states that demonstrates how a high-public payer organization can succeed after health reform's implementation by transforming itself. Without that transformation, the nation's safety net providers will struggle enormously post-health reform, creating serious vulnerabilities in the safety net itself.

5.7 Crisis Stabilization Services

Massachusetts introduced the Children's Behavioral Health Initiative in 2007, in response to the findings of the US District court in the case of *Rosie D. v Romney* in 2006. For MassHealth children, the Children's Behavioral Health Initiative offers enhanced behavioral health screenings and assessments. For children who are eligible for Early Periodic Screening, Diagnosis and Testing (EPSDT), the Children's Behavioral Health Initiative also offers additional community-based behavioral health services. Through this 1115 Demonstration Renewal, Massachusetts also intends to enhance the clinical model of the Crisis Stabilization services. This enhanced model will include services that are not available under the Medicaid State Plan, such as Crisis Stabilization services. Crisis Stabilization is a service that is designed to prevent or ameliorate a behavioral health (mental health or substance abuse) crisis that may otherwise result in a youth being removed from their home and community environment to be admitted to an inpatient hospital or a psychiatric residential treatment facility. This service is provided for youth who do not require hospital level of care and is delivered in group care facilities (for youth under 18) and adult crisis stabilization units (for youth 18 to 21). Because the enhanced Crisis Stabilization service is delivered in a non-hospital setting, it is more cost effective than traditional institutionally based behavioral health care. This model of service delivery therefore allows the Commonwealth to provide high-quality, appropriate services in the community at a lower cost than is available under the Medicaid State Plan.

5.8 Designated State Health Programs

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 SFY 2011 late in the most recent renewal negotiations as a concession to secure the overdue Demonstration approval for SFY 2009 through SFY 2011. However, the

Commonwealth continues to appropriate funds to these important health programs and plans to continue to do so through the waiver term.

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 in SFY 2010, 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- SFY 2009, \$385M.

5.9 Rebates for Covered Outpatient Drugs Provided to CommCare Enrollees

The Commonwealth is seeking to extend rebates for Covered Outpatient Drugs to Commonwealth Care enrollees, who receive their pharmacy benefits through managed care organizations. This proposed approach is consistent with the extension of such rebates for enrollees in Medicaid Managed Care Organizations now provided for under the ACA and ensures that the benefit of rebates is extended to all individuals who receive Covered Outpatient Drugs services from Managed Care Organizations under the Demonstration Waiver.

Section 6 Budget Neutrality

Section 1115 of the Social Security Act requires that the Commonwealth demonstrate that federal Medicaid spending for the 1115 Demonstration Waiver does not exceed what the federal government would have spent in the absence of the Demonstration. Since the inception of the Demonstration, Massachusetts has met this budget neutrality test, using program savings (budget neutrality "room") to invest in significant advances, such as the Commonwealth's landmark health care reform legislation in 2006. The changes proposed in this renewal request continue to meet budget neutrality requirements during the extension period. The details of the budget neutrality calculation are presented in Attachment A.

Massachusetts' budget neutrality calculation is detailed in Section XI and Attachment D of the Special Terms and Conditions of the current Demonstration. The calculation demonstrates that gross spending under the Demonstration ("with waiver") is less than what gross spending would have been in the absence of a waiver (the "without waiver" limit). As part of the 2008 renewal the Commonwealth and CMS agreed to reset the budget neutrality calculation at zero at the beginning of SFY 2009 so that no deficit or savings was carried over from prior years. Accordingly, the budget neutrality demonstration includes "with waiver" expenditures and "without waiver" expenditure limit calculations beginning in SFY 2009. Data for prior periods is included for reference only.

"With waiver" expenditures include actual gross expenditures in SFY 2009 and projected expenditures through SFY 2014, based on the most recent MassHealth budget forecast.

Safety Net Care Pool expenditures are calculated separately and added to the other expenditures based on projections for the individual programs.

“Without waiver” expenditures are calculated by multiplying historical pre-waiver per-member per month (PMPM) costs, trended forward to the renewal period (based on trends negotiated with CMS) by actual caseload member months for the base (non-expansion) populations. The trends for the renewal period are the President's budget trends provided by CMS.

This demonstration submission contains some notable enhancements to the budget neutrality model. These changes are detailed as follows.

- First, as described in Section 5, Massachusetts proposes to include previously excluded populations. Accordingly, the expenditures for these groups are included in both the “with waiver” and “without waiver” calculations.
- Second, long-term care expenditures are included in both the "without waiver" limit and the "with waiver" expenditures.
- Third, the budget neutrality demonstration includes a new "hypothetical" population group for individuals at or under 133% FPL based on the new optional authority established in PPACA to cover these individuals under the state plan as of April 1, 2010.
- Fourth, certain new Children's Behavioral Health Expenditures described in Section 5.6 are shown as a separate adjustment to projected "with waiver" expenditures.
- Finally, the “with waiver” expenditures include the new Safety Net Care Pool costs described in Section 5 to support the Commonwealth's efforts to increase care coordination, support safety net providers, and move the entire health care system towards a reformed payment system that will help control costs in future years.

6.1 Including Previously Excluded Populations in the 1115 Waiver

As detailed in Section 5, the Commonwealth is proposing to include certain previously excluded populations in the Demonstration. Specifically, Massachusetts intends to remove from the list of excluded populations individuals who are in long-term care facilities, individuals who are participants in a Home and Community Based Waiver and children who are either eligible under TEFRA section 134 (the Kaileigh Mulligan program) or who are receiving Title IV-E adoption assistance. Individuals who are in long-term care facilities and Home and Community Based Waiver Participants, who by definition require a facility level of care, are included in the budget neutrality calculation in the Base Disabled Eligibility Group. Children who are eligible through Massachusetts' Kaileigh Mulligan program or who are receiving Title IV-E Adoption assistance are included in the Base Families Eligibility Group.

6.2 Including Long-Term Care Related Costs in the Budget Neutrality Calculation

During the Demonstration extension period, Massachusetts will move towards increased integration of care through several mechanisms such as Medical Homes and integrated care for high-risk populations. True member-centered integration of health care delivery will require coordination of both acute and long-term care services. In recognition of

this, the Commonwealth proposes including long-term care expenditures in the budget neutrality calculation.

Long-term care expenditures are currently excluded from the budget neutrality demonstration under paragraph 72(b) of the Special Terms and Conditions. In order to ensure that long-term care expenditures are accurately reflected in the budget neutrality calculation, the Commonwealth has incorporated these previously excluded expenditures into both the "without waiver" and the "with waiver" portions of the demonstration as of July 1, 2012.

To include long-term care costs in the “without waiver” calculation, Massachusetts first determined the total expenditures for long-term care services for each EG as of SFY 2009. Using member month data for the same year, the Commonwealth calculated the PMPM cost for each EG associated with the long-term care expenditures in SFY 2009.

The Commonwealth trended these SFY 2009 LTC PMPM rates forward to SFY 2012-SFY 2014 using the President's Budget Trend rate appropriate for each EG. Each EG's projected LTC PMPM was then added to the relevant "without waiver" PMPM that was otherwise calculated for each waiver year during the renewal.

For the "with waiver" calculation, total long-term care expenditures associated with each “with waiver” population group for SFY 2009 were trended using MassHealth budget forecast trend rates for long-term care expenditures. These long-term care expenditures were then added to the actual expenditures for the corresponding “with waiver” population group for SFY 2012-SFY 2014.

As would be expected, the additional PMPM for long-term care expenditures is relatively small for the Base Families, 1902(r)(2) children, and BCCTP EGs. Due to the demographics of these EGs, it is unsurprising that their LTC expenditures are relatively small. The LTC PMPMs for the Base Disabled/MCB, 1902(r)(2) disabled, and CommonHealth EGs are substantially larger, reflecting the higher utilization of LTC services among this population. The LTC PMPMs for all groups are reflected in the chart below:

Long-term care PMPM			
	SFY 2012	SFY 2013	SFY 2014
Base Families	\$ 3.12	\$ 3.12	\$ 3.12
Base Disabled/MCB	\$ 214.40	\$ 214.40	\$ 214.40
1902 (r) 2 Children	\$ 2.04	\$ 2.04	\$ 2.04
1902 (r) 2 Disabled	\$ 178.00	\$ 178.00	\$ 178.00
1902 (r) 2 BCCTP	\$ 19.51	\$ 19.51	\$ 19.51
CommonHealth	\$ 224.58	\$ 224.58	\$ 224.58

6.3 Ensuring Appropriate Treatment of Categorically Eligible Populations under PPACA
 Subsection (k)(2) of section 1902 of the Social Security Act as added by the Patient Protection and Affordable Care Act gives states the option to offer coverage to certain

individuals whose income does not exceed 133% FPL under the state plan beginning on April 1, 2010.

The Commonwealth currently offers coverage to all of these individuals under the Demonstration through Commonwealth Care, MassHealth Essential and MassHealth Basic. As indicated in an e-mail from Secretary Bigby to Cindy Mann on April 1, 2010, the Commonwealth would like to continue serving all eligible individuals under 133% in these waiver programs, while treating them as hypothetical state plan members for the purposes of Massachusetts' budget neutrality calculation. This would recognize the Commonwealth's early expansion efforts, while preventing any disruption for members and allowing the Commonwealth the time necessary to fully analyze the mandatory State Plan provision, which is effective in 2014.

The precedent for including hypothetical population expenditures as "without waiver" expenditures goes back to the 2006 renewal, when Commonwealth members were given hypothetical status. In addition, the Commonwealth currently counts the 19 and 20 year olds and parents in Commonwealth Care and MassHealth Essential on the without-waiver side of the budget neutrality calculation by considering them hypothetical state plan populations as agreed in the last Demonstration renewal (see paragraph 73(ii) and (iii) of the Special Terms and Conditions).

For the new 1902(k)(2) hypothetical population, the amount of actual expenditures to be included in the "without waiver" expenditure limit will be the lower of the trended baseline (2009) costs, or the actual per-member, per-month cost experience for these groups in SFY 2012-2014. Current hypothetical populations are treated this way for budget neutrality purposes.

6.4 Enhancing Services Under the Children's Behavioral Health Initiative

Under the Children's Behavioral Health Initiative (CBHI), Massachusetts has expanded the availability of community-based behavioral health services to children through EPSDT. Additionally, the Commonwealth has received approval through the Medicaid State Plan to provide six additional behavioral health services under EPSDT. Actual CBHI-related expenditures are included in the "with waiver" expenditures and projections, and paragraph 73(d) of the Special Terms and Conditions provides a mechanism to include new CBHI-related EPSDT expenditures in the "without waiver" expenditure limit.

As discussed in Section 5, the Commonwealth proposes to provide certain additional behavioral health services for children under the waiver. These new services are shown as a separate adjustment to the "with waiver" expenditure projections.

6.5 Safety Net Care Pool

The Safety Net Care Pool projections in the budget neutrality demonstration represent the Commonwealth's best projections for future expenditures in the Safety Net Care Pool programs. The Safety Net Care Pool programs include Commonwealth Care, the Health Safety Net Trust Fund Safety Net Care Payments, Public Service Hospital Safety Net Care Payments, Designated State Health Programs, Payments to Certain State-Owned Hospitals and to Institutions for Mental Disease, Infrastructure and Capacity-Building for

Hospitals and Community Health Centers, and Transitional Relief for Private Hospitals. Note that Commonwealth Care expenditure projections are net of projected expenditures for the hypothetical Commonwealth Care populations, which are reported in separate EGs.

The Safety Net Care Pool expenditures include the payment amounts for Cambridge Health Alliance and for the Transitional Relief for Private Hospital payments described in Section 5. Notably, the Commonwealth is no longer making hospital supplemental payments under Section 122 of Chapter 58. These payments are shown as zero in the budget neutrality demonstration.

The Safety Net Care Pool expenditures also reflect projected payments of \$30 million per year for infrastructure and capacity-building funding under paragraph 45(d) of the Special Terms and Conditions.

Given the proven success of the Safety Net Care Pool as an element of the Demonstration, the Commonwealth proposes for the renewal period to treat the Safety Net Care Pool (SNCP) spending in the same way as all other spending allowable by Expenditure Authority in the Demonstration. The requirement of budget neutrality is the core requirement for management of spending under an 1115 demonstration. SNCP spending, especially for Commonwealth Care, should no longer be artificially restricted by a Demonstration sub-cap.

When the SNCP was created the SNCP cap was conceived as a way to monitor expenditures for programs like Commonwealth Care in the absence of any experience with these programs. At the time, the available dollar amounts included the Commonwealth's annual federal disproportionate share hospital (DSH) allotment previously authorized under the Medicaid state plan and the SFY 2005 supplemental payment amounts to Boston Public Health Commission and Cambridge Public Health Commission managed care organizations. During the 2008 renewal negotiations, the SNCP cap was modified based on detailed conversations with CMS about the management of SNCP programs. As the Commonwealth enters the third full Demonstration term of the SNCP, with Massachusetts health care reform fully implemented and proven successful, the SNCP cap has become unnecessary. It is important that the STCs of the upcoming Demonstration term reflect the maturity of the SNCP concept, as well as the value of relying on the approved descriptions of the SNCP programs to provide normal spending flexibility based on caseload.

Similarly, 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 renewal, and to normalize the treatment of spending within the SNCP. This subcap was created in the last waiver renewal 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.

The Commonwealth believes that any subcap within the budget neutrality limit creates an unnecessary restriction on spending from what would otherwise be savings relative to projected spending in the absence of the Demonstration. The Commonwealth

understands CMS's need to ensure responsible use of federal funding, and to actively monitor the Demonstration expenditures. The Commonwealth believes that CMS has sufficient control over Safety Net Care Pool expenditures through the budget neutrality agreement, the definitions and methodologies for each included program, and the specific limits for Infrastructure, Designated State Health Programs, and Public Service Hospital Safety Net Care Payments, which the Commonwealth continues to support in the renewal. The Commonwealth will continue to work collaboratively with CMS to provide all necessary information regarding SNCP and overall Demonstration spending on an ongoing basis.

6.6 Budget Neutrality Summary

As noted above, the changes proposed in this renewal request continue to meet budget neutrality requirements during the extension period. The attached budget neutrality demonstration shows that projected expenditures under the waiver will be approximately \$10.1 billion less than projected expenditures in the absence of the Demonstration.

The 1902(k)(2) hypothetical population discussed above results in an increase in the "without waiver" expenditure limit by \$5.66 billion.

Moreover, as detailed in the Commonwealth's quarterly budget neutrality reports, the cushion has been growing over the current Demonstration term as MassHealth has implemented program efficiencies that have kept cost growth below the anticipated trend. In light of the ongoing economic downturn and budgetary challenges, the Commonwealth has continued to reduce costs without affecting access to MassHealth programs. Realized and anticipated savings that continue to be reflected in the current projection include creating consistency among providers in hospital rates, limiting current-year inflation in provider and MCO rates, enhancing compliance activities and utilization management, and other significant savings projects in the Governor's SFY 2011 budget, such as modifications to the hospital payment systems to promote efficiency. The current budget neutrality statement reflects these successful ongoing efforts to implement cost containment initiatives across the MassHealth program in the current economic context.

These two elements have combined to ensure that the expenditures under the waiver are significantly below the expenditure limit imposed by the budget neutrality requirement. The Commonwealth is proud of the extent to which this budget neutrality room represents ongoing and anticipated efforts to control health care costs in Massachusetts. The Commonwealth also recognizes that the renewal period may include a time when the Commonwealth's economic environment will support investment in the Demonstration programs beyond current projections, and is happy that the budget neutrality calculation provides the potential to make such changes.

Section 7 Conclusion

Massachusetts's success in expanding access to health care has led the nation to embrace profound changes in health insurance and health care access. Massachusetts is now engaged in the next phase of reform: rationalizing and controlling health care costs and promoting quality by transforming the way health care services are reimbursed in the

Commonwealth. All of the Commonwealth's payers are grappling with the rate of health care inflation, and new solutions are clearly needed. The PPACA sets the stage for the federal government, state governments, insurers, providers, and health care users alike to embrace innovation and experiment with new strategies. The Commonwealth's proposals for the Demonstration renewal are in this same spirit. Massachusetts is eager to partner with CMS to move into the next phase of reform.

The Commonwealth must tackle this significant cost problem to ensure that affordable, quality health care can continue to be available to all residents, as will all states once they have fully implemented access reform. The Commonwealth will need the support and partnership of the federal government to effectively leverage other payers and health system providers to begin the challenging transition from the fee-for-service system to a system more responsive to the whole person. Massachusetts is fortunate to have one of its key safety net care providers already poised to transform, and hopes to be able to use that example and experience to propel other providers and payers into action. The Commonwealth also hopes to gain the support of Medicare to advance its important work on the Primary Care Medical Homes Initiative, Integrating Care for Dual Eligibles, and ultimately on adopting state-wide Global Payment Reform.

Massachusetts looks forward to the support of CMS in the new Demonstration term to ensure that the Commonwealth has sufficient tools and flexibility to advance these important initiatives. Together, the Commonwealth's payers can transform the delivery system to refocus on high quality care and working toward better care outcomes, and the commitment of CMS to be the Commonwealth's partner is critical to the success of this next stage of reform. The partnership is poised to lead the nation into the next phase of reform and serve as a model once again.