# ATTACHMENT P ADDITIONAL HISTORICAL INFORMATION

The MassHealth demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types and benefit levels. The demonstration was initially implemented in July 1997, and expanded Medicaid income eligibility categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility was also expanded to certain non- categorically eligible populations, including unemployed adults and non-disabled persons living with Human Immunodeficiency Virus (HIV). Finally, the demonstration also authorized 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. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings. However, the Commonwealth’s preferred mechanism for achieving coverage has consistently been employer-sponsored insurance, whenever available and cost-effective.

The implementation of mandatory managed care enrollment under MassHealth changed the way health care was delivered resulting in a new focus on primary care, rather than institutional care. In order to aid this transition to managed care, the demonstration authorized financial support in the form of supplemental payments for two managed care organizations (MCOs) operated by safety net hospital providers in the Commonwealth to ensure continued access to care for Medicaid enrollees. These payments ended in 2006.

In the 2005 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars to further expand coverage directly to the uninsured, funded in part by redirecting certain public funds that were dedicated to institutional reimbursement for uncompensated care to coverage programs under an insurance-based model. This agreement led to the creation of the Safety Net Care Pool (SNCP). This restructuring laid the groundwork for health care reform in Massachusetts, because the SNCP allowed the Commonwealth to develop innovative Medicaid reform efforts by supporting a new insurance program.

Massachusetts’ health care reform legislation passed in April 2006. On July 26, 2006, CMS approved an amendment to the MassHealth demonstration to incorporate those health reform changes, which expanded coverage to childless adults, and used an insurance connector (Marketplace) and virtual gateway system to facilitate enrollment into the appropriate program. This amendment included:

1. The authority to establish the Commonwealth Care program under the SNCP to provide sliding scale premium subsidies for the purchase of commercial health plan coverage for uninsured persons at or below 300 percent of the FPL;
2. The development of payment methodologies for approved expenditures from the SNCP;
3. An expansion of employee income eligibility to 300 percent of the FPL under the Insurance Partnership; and
4. Increased enrollment caps for MassHealth Essential and the HIV/Family Assistance Program.

At this time, there was also an eligibility expansion in the Commonwealth’s separate title XXI

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program for optional targeted low-income children between 200 percent and 300 percent of the FPL, which enabled parallel coverage for children in households where adults are covered by Commonwealth Care. This expansion ensured that coverage is equally available to all members of low-income families.

In the 2008 extension of the demonstration, CMS and the Commonwealth agreed to reclassify three eligibility groups (those aged 19 and 20 under the Essential and Commonwealth Care programs and custodial parents and caretakers in the Commonwealth Care program) with a categorical link to the title XIX program as “hypotheticals” for budget neutrality purposes as the populations could be covered under the state plan. As part of the renewal, the SNCP was also restructured to allow expenditure flexibility through a 3-year aggregate spending limit rather than annual limits; a gradual phase out of federal support for the Designated State Health Programs; and a prioritization in the SNCP to support the Commonwealth Care Program.

Three amendments were approved in 2010 and 2011 to allow for additional flexibility in the Demonstration. On September 30, 2010, CMS approved an amendment to allow Massachusetts to (1) increase the MassHealth pharmacy co-payment from $2 to $3 for generic prescription drugs; (2) provide relief payments to Cambridge Health Alliance totaling approximately $216 million; and (3) provide relief payments to private acute hospitals in the Commonwealth totaling approximately $270 million.

On January 19, 2011, CMS approved an amendment to: (1) increase authorization for Designated State Health Programs for state fiscal year 2011 to $385 million; (2) reclassify Commonwealth Care adults without dependent children with income up to and including 133 percent of the federal poverty level (FPL) as a “hypothetical” population for purposes of budget neutrality as the population could be covered under the state plan; and (3) allow the following populations to be enrolled into managed care: (a) participants in a Home and Community-Based Services Waiver; (b) Katie Beckett/ Kaileigh Mulligan children; and (c) children receiving title IV-E adoption assistance.

Additionally, on August 17, 2011, CMS approved an amendment to authorize expenditure authority for a maximum of $125.5 million for state fiscal year (SFY) 2012 for Cambridge

Health Alliance through the SNCP for uncompensated care costs. This funding was approved with the condition that it be counted toward a budget neutrality limit eventually approved for SFY 2012 as part of the 2011 extension.

In the 2011 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars for the following purposes:

1. Support a Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children with high-risk asthma;
2. Offer early intervention services for children with autism who are not otherwise eligible through the Commonwealth’s currently approved section 1915(c) home and community- based services waiver because the child has not been determined to meet institutional level of care requirements;
3. Utilize Express Lane eligibility methodologies to conduct renewals for parents and caretakers to coincide with the Commonwealth’s intent to utilize Express Lane

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eligibility for children; and

1. Further, expand the SNCP to provide incentive payments to participating hospitals for Delivery System Transformation Initiatives focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

In the extension granted on December 20, 2011 the Commonwealth’s goals under the demonstration were:

1. Maintain near-universal health care coverage for all eligible residents of the Commonwealth and reduce barriers to coverage;
2. Continue the redirection of spending from uncompensated care to insurance coverage; k) Implement delivery system reforms that promote care coordination, person-centered

care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and

1. Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

Under the September 2013 amendment, the Commonwealth revised the demonstration and waiver authorities to comply with the provisions of the Affordable Care Act. Additionally, the amendment supported the Commonwealth’s ability to sustain and improve its ability to provide coverage, affordability and access to health care under the demonstration. The amendment allowed Massachusetts to continue certain programs and realign other programs to comply with the Affordable Care Act provisions that became effective January 1, 2014. For example, the amendment allowed Massachusetts to sunset certain demonstration programs such as MassHealth Basic, MassHealth Essential and the Medical Security Program December 31, 2013. These changes were made to reflect the fact that effective January 1, 2014, the individuals eligible under certain demonstration programs with income up to 133 percent of the federal poverty level (FPL) became eligible under the Medicaid state plan and those with income above 133 percent of the FPL became eligible to purchase insurance through Massachusetts’ health insurance Marketplace, the Health Connector. With the combination of previous expansions and the recent health reform efforts, the MassHealth Medicaid section 1115 demonstration now covers approximately 1.8 million individuals.

In the 2014 extension of the demonstration, the Commonwealth continued its commitment to the same goals articulated for the 2011-2014 extension period. In accordance with these goals, CMS and the Commonwealth agreed to:

* 1. Extend the demonstration for a five-year period based upon the authority under Section 1915(h)(2) of the Social Security Act which authorizes five-year renewal terms for states that provide medical services for dual eligible individuals through their demonstration. The five-year renewal period supported the Commonwealth’s dual eligibles demonstration as some of the authorities for the duals demonstration are contained in the in the section 1115(a) demonstration.
  2. Continue authority for the Pediatric Asthma Pilot Program focused on

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improving health outcomes and reducing associated Medicaid costs for children ages 2-18 with high-risk asthma;

* 1. Continue authority to offer intensive early intervention services for children with autism who are not otherwise eligible through the Commonwealth’s currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
  2. Continue Health Connector Subsidies to provide premium assistance to individuals receiving Qualified Health Plan (QHP) coverage through the Marketplace with incomes at or below 300 percent of the FPL;
  3. Continue and expand the authority for the Commonwealth to conduct streamlined eligibility redeterminations using Supplemental Nutrition Assistance Program (SNAP) verified income data;
  4. Provide for payment of the cost of the monthly Medicare Part A and Part B premiums and the cost of deductibles and coinsurance under Part A and Part B for Medicare-eligible individuals who have incomes up to 133 percent of the FPL, and pay the costs of the Medicare Part B premium only for CommonHealth members with incomes between 133 and 135 percent FPL; and
  5. Through June 30, 2017, provide incentive payments to participating hospitals for Delivery System Transformation Initiatives and the Public Hospital Transformation and Incentive Initiatives, and provide support for Infrastructure and Capacity Building investments focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

During the extension period granted in 2014, the goals of the demonstration were:

* 1. Maintain near universal coverage for all residents of the Commonwealth and reduce barriers to coverage;
  2. Continue the redirection of spending from uncompensated care to insurance coverage;
  3. Implement delivery system reforms that promote care coordination, person- centered care planning, wellness, chronic disease management, successful care

transitions, integration of services, and measurable health outcome improvements; and

* 1. Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

In the 2016 amendment to the demonstration, the Commonwealth and CMS agreed to implement new demonstration components to support a value-based restructuring of MassHealth’s health care delivery and payment system, including a new Pilot Accountable Care Organization program, building toward a transition to fuller accountable care models in the future. In addition, behavioral health services authorized under the demonstration have been expanded to strengthen

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Massachusetts’ system of recovery-oriented Substance Use Disorder treatments and supports, in large part with the goal of addressing the opioid addiction epidemic.

The amendment also made other changes, including expanding CommonHealth eligibility for working adults over age 65; authorizing MassHealth to require enrollment in Student Health Insurance Plans (SHIP) when deemed cost effective and to provide for continuous eligibility for the duration of the SHIP year; and expanding the availability of Health Connector subsidies to include cost sharing subsidies for Health Connector enrollees with incomes at or below 300 percent of the FPL, in addition to premium subsidies for this population that were previously authorized.