MassHealth and Health Connector Requests for Federal Flexibility

Executive Office of Health & Human Services and Massachusetts Health Connector Authority

August 2017

Public Comment Process

- The purpose of this hearing is to receive comments from the public on the
  - Request to Amend the MassHealth Section 1115 Demonstration
  - Requests for Federal Flexibility to Support Commercial Market Stability & Reforms

- We will receive comment from those in the room first in the order on the sign-in sheet, and then open the line to those who would like to provide comment

- Please leave any written comments with MassHealth or Health Connector staff today, or at the second listening session in Chicopee on August 16, 2017 or provide any written comments to:
  - MassHealth by 5:00 pm on August 21st
  - Health Connector by 5:00 pm on August 25th

- In order to make sure that everyone may be able to provide oral testimony on the regulations, we will limit everyone to 3 minutes of testimony. If you have additional comments, you may submit them in writing.

- Before you begin speaking, please state your name and if you are representing an organization or business, the name of the business or organization.

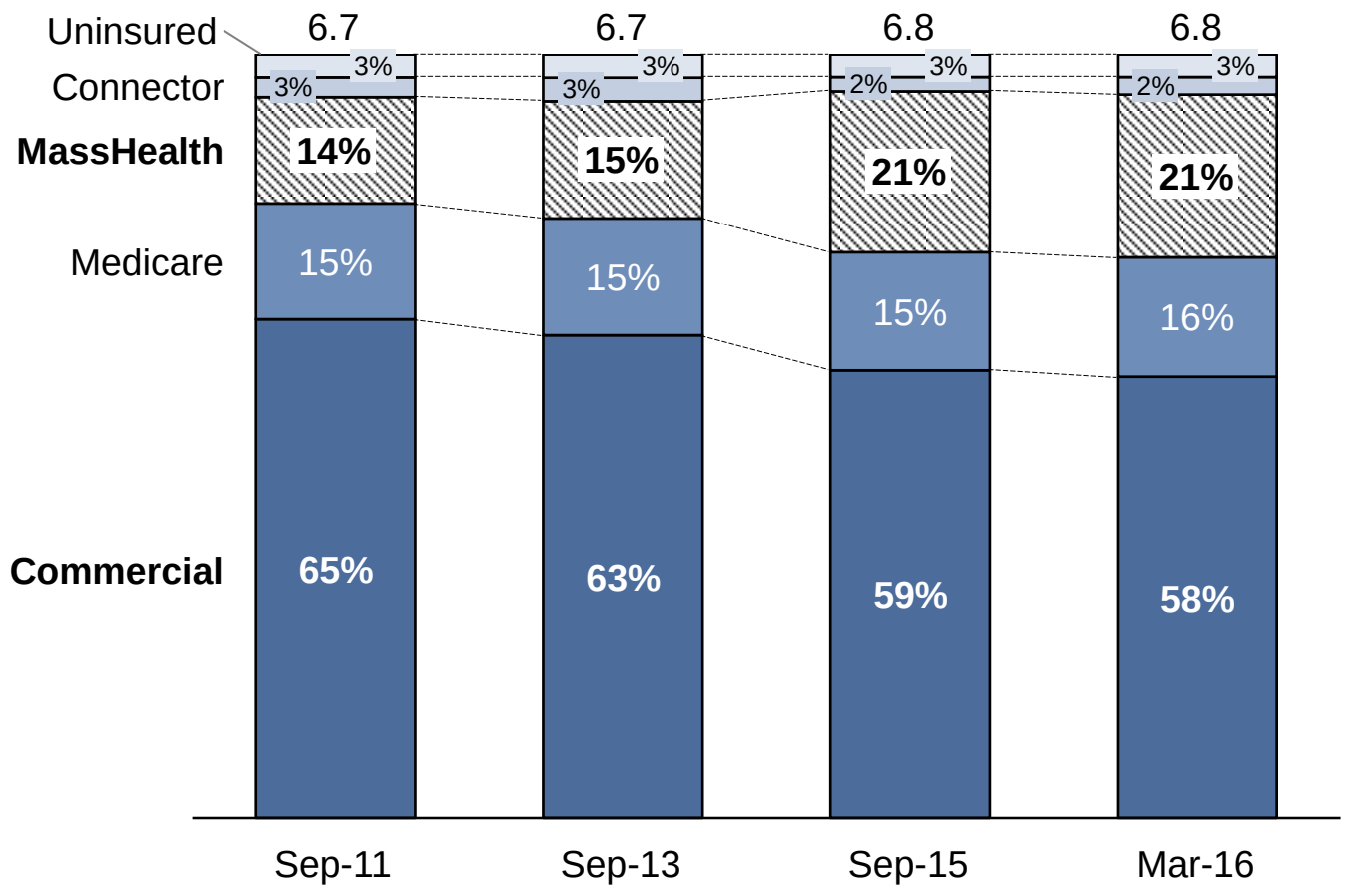
- If you have not yet signed in, please see a staff member to fill out a testimony slip so that you may be heard.

Agenda

- **MassHealth 1115 Demonstration Amendment Request**
- Health Connector Flexibility Requests

Affordability, rising health care costs, and other factors have resulted in more residents covered by MassHealth and fewer by Commercial insurance since 2011

MA population by primary health coverage type
Million residents



Change 2011-2015

+523k

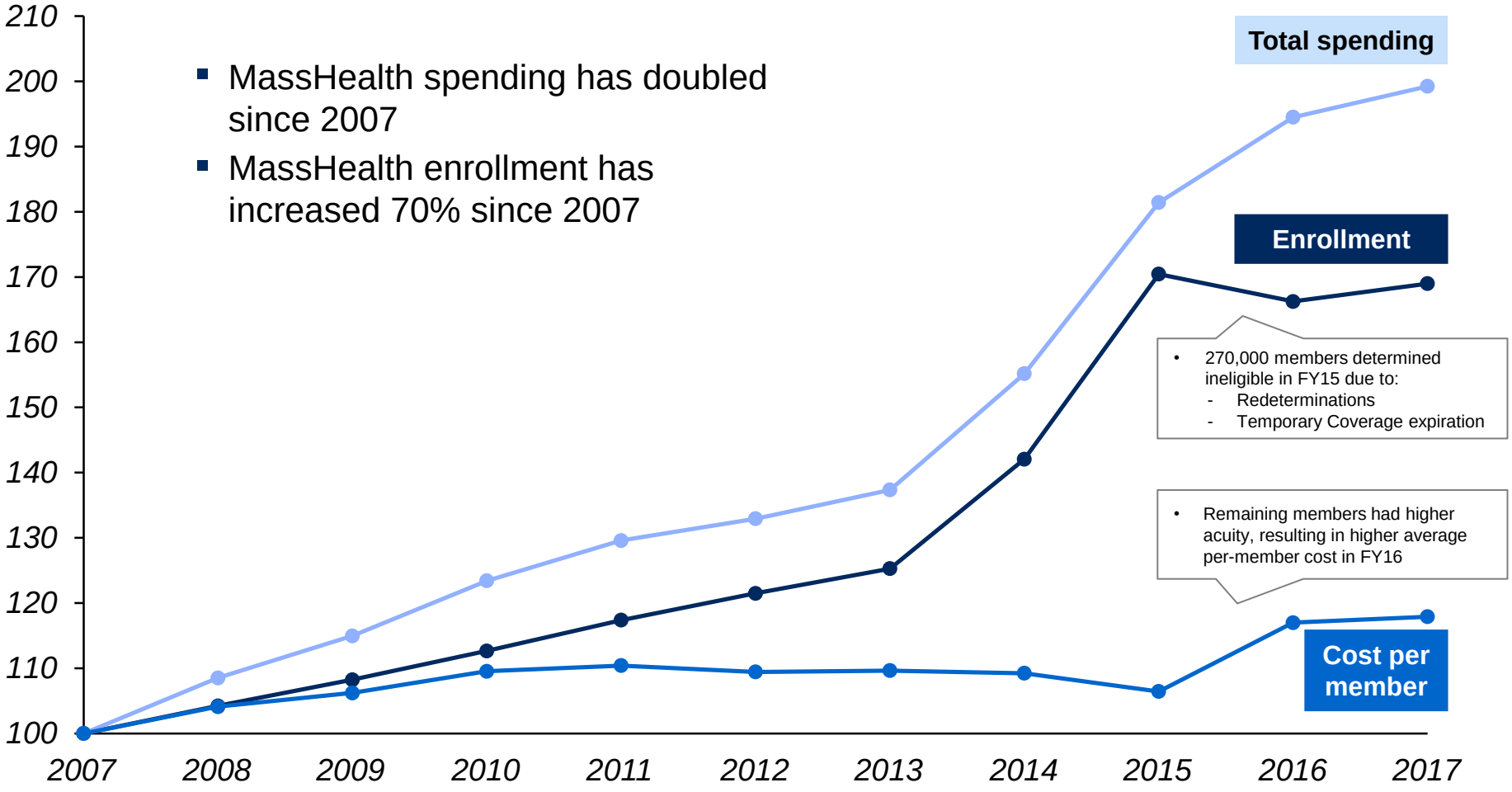
-454k

Total MassHealth enrollment at 28% of population (including Medicaid as secondary payer for Medicare and Commercial)

Source: CHIA

Enrollment has been the primary driver of MassHealth spending growth

MassHealth Program Spending Breakdown
Percent change since 2007



Major initiatives underway to rebalance caseload and achieve historically low enrollment growth, but reforms are needed for sustainable growth

- Significant drivers of MassHealth enrollment growth include both:
  - **Shift to public coverage** over multiple years as the share of lives covered in commercial plans has decreased, and the share of lives covered by MassHealth has increased
  - **Gaps in operational systems and processes due to ACA implementation**

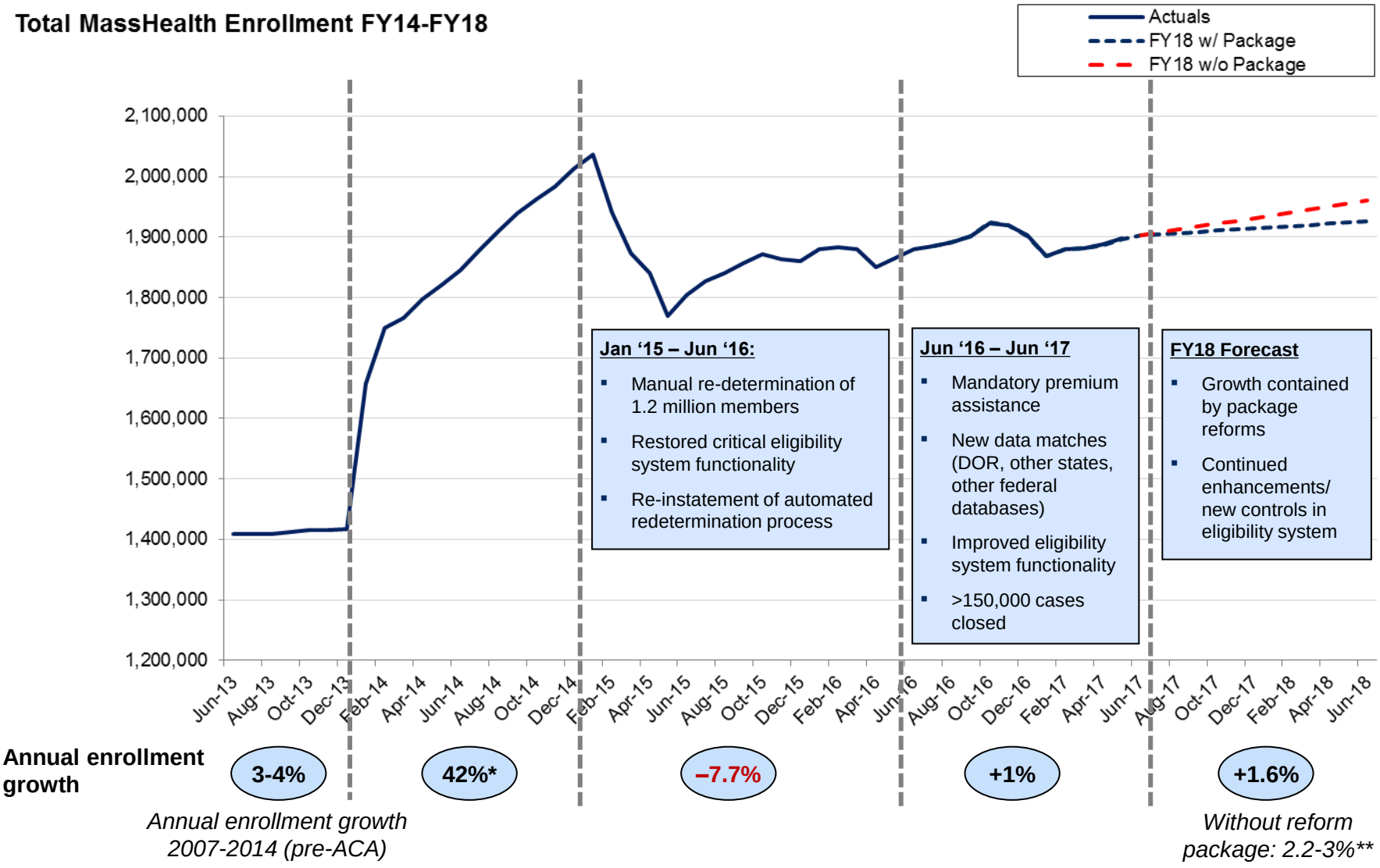
- **Since 2015, MassHealth has been addressing eligibility systems and improving program integrity to ensure only those eligible are on MassHealth**, including:
  - Completing ~1.2M redeterminations in 2015 (members' eligibility had not been checked since 2013, or >2 years)
  - Implementing new data matches to confirm income, residency, and assets (DOR, other states, other federal databases, bank accounts)
  - Enforcing mandatory premium assistance policies for individuals with access to insurance

- **As a result, MassHealth has achieved the lowest levels of enrollment growth in 10 years**
  - ~1% enrollment growth in FY17 vs. 3-4% from 2007-14 and 42% in CY 2014
  - >420K ineligible members closed over the past 2.5 years

- **These efforts have rebalanced the caseload. The largest opportunities for caseload cleanup have been captured**

- **The reform package allows for 1.6% caseload growth**

We have achieved historically low enrollment growth due to fixing eligibility system defects and enhancing eligibility controls



Annual enrollment growth

3-4%	42%*	–7.7%	+1%	+1.6%

Annual enrollment growth 2007-2014 (pre-ACA)

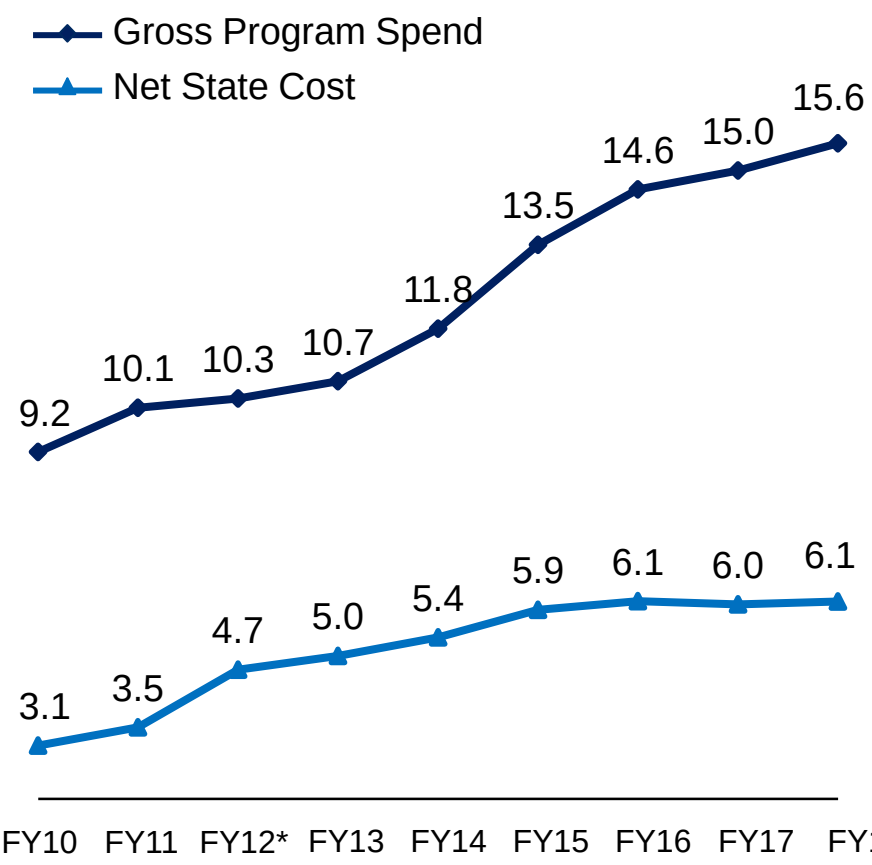
*Without reform package: 2.2-3%***

* ACA Medicaid expansion + Temporary Medicaid due to failed HIX

** Approximate range of caseload growth in conference budget; high end of range reflects exposures built into budget

MassHealth spending has been reduced from historical double-digit annual growth to single-digits, but reforms are required for sustainable growth

MassHealth Program Spending
$ billions



	CAGR				
	FY10-13	FY13-15	FY16	FY17	FY18 GAA
Gross Program Spend	5.1%	12.5%	8.5%	2.7%	**5.0%** w/o package; **3.7%** w/ package
Net State Cost	16.9%	9.2%	3.1%	-1.1%	**5.6%** w/o package; **1.0%** w/ package

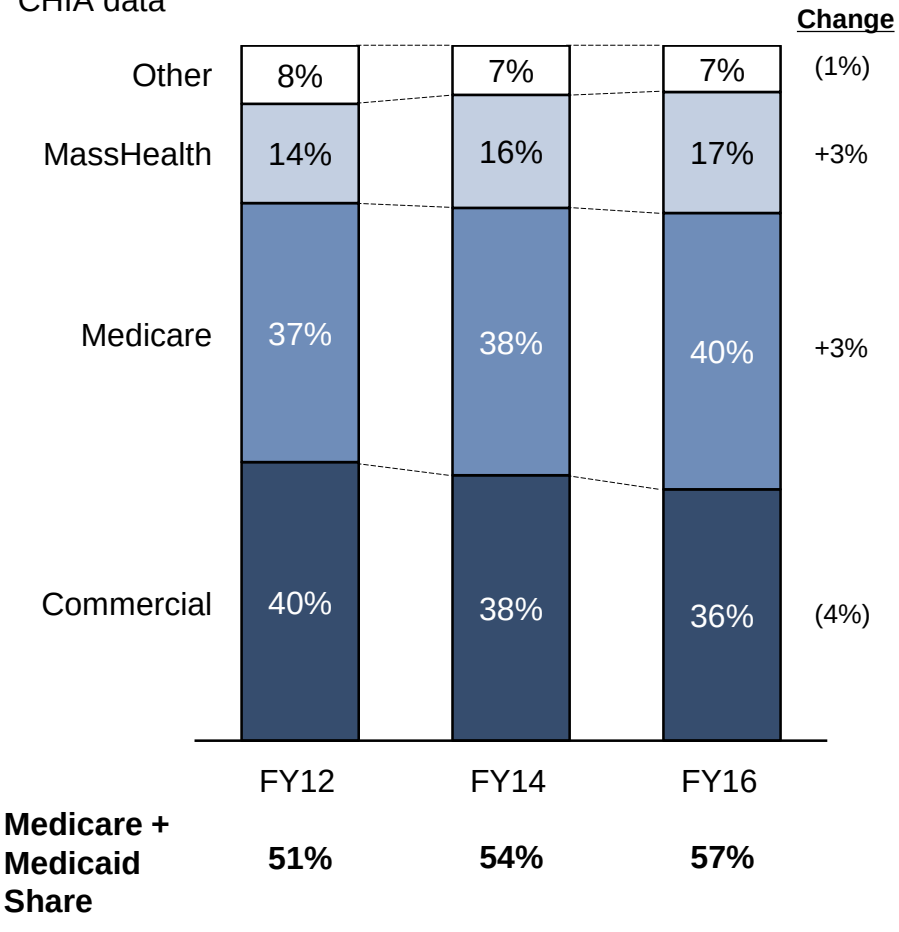
Numbers assume MassHealth absorbs $47M exposure in conference budget**

Negative net growth due to management initiatives, including:
- $30M in increased Rx rebates
- $73.5M one-time DSRIP revenue
- $25M in higher CHIP revenue

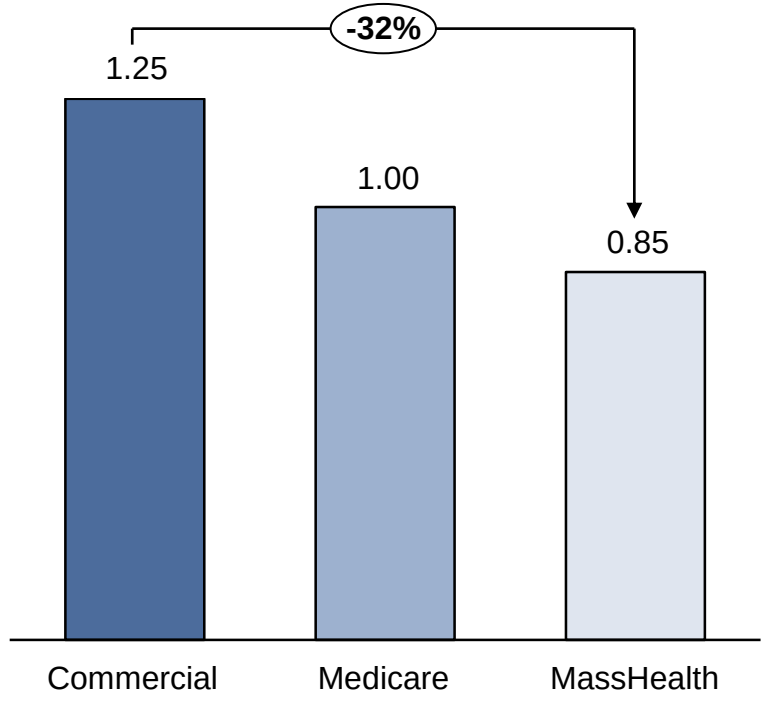
**Commonwealth lost >$1B in federal revenue with sunset of enhanced revenues under the American Recovery and Reinvestment Act (ARRA)*
Note: Excludes ELD Choices spending for all years.
*** If MassHealth cannot absorb this exposure, projected net growth is 6.4% without the reform package or 1.7% with the reform package*

The proposed reforms are also critical for health care providers' sustainability – the shift in volume toward public coverage puts significant pressure on provider fiscal health

MA hospital payor mix
% of Gross Patient Service Revenue (GPSR)
CHIA data



Relative unit price by payor (approximate)
% of Medicare fee schedule*



* Approximate. Commercial % of Medicare estimated by comparing 2015 payment-to-cost ratios as reported on 2015 hospital cost reports; MassHealth % of Medicare does not include supplemental payments to hospitals.

The Governor's reform package creates structural sustainability for MassHealth while maintaining affordable coverage for all our residents

- **Preserves quality, comprehensive coverage for 140,000 non-disabled adults >100% FPL at a savings to the Commonwealth**
  - Maximizes federal revenue for subsidized coverage
  - ~15% of the CarePlus expansion population will be impacted by this shift*
  - All individuals have access to $0 premium plan

- **Builds on the Connector's recent success of affordable coverage**
  - Prior to 2014, the expansion population was covered in Massachusetts on the Connector

- **Improves continuity of coverage for non-disabled adults ages 21-64** who move back and forth between the Connector and MassHealth due to income changes

* 40,000 of 300,000 CarePlus expansion lives

Aligning coverage for non-disabled adults ages 21 – 64 with commercial plans

Details

1. Renew employer reporting on ESI through revised HIRD

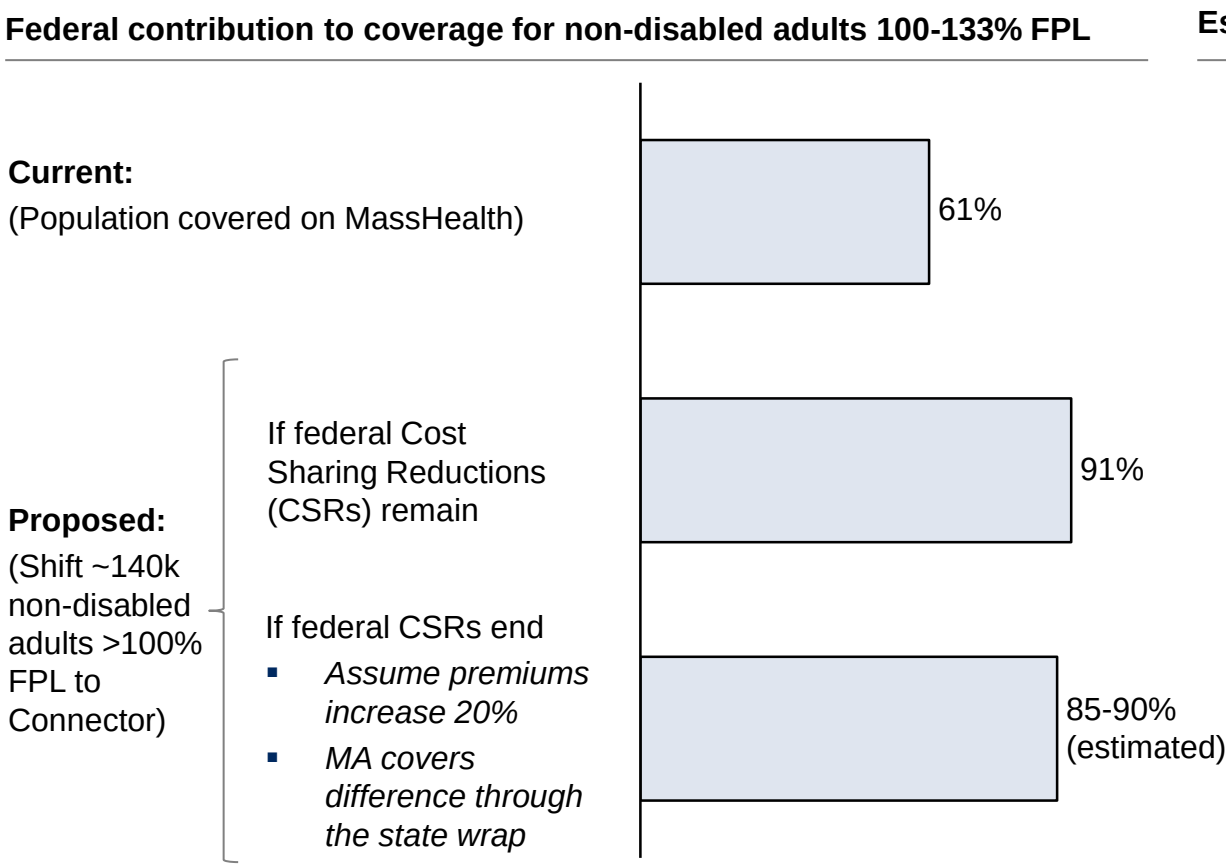
- Reinstates revised Health Insurance Responsibility Disclosure (HIRD) form
- Must be in effect as of January 1, 2018
- Employers report on employer sponsored insurance (ESI) offerings, including employee eligibility, benefits, premiums, cost sharing
- Necessary to enable MassHealth to maximize uptake of ESI with premium assistance; current insurance investigation process is largely manual and relies on employers' voluntary responses
- Requires state approval; does not require federal approval

2. Shift non-disabled adults >100% FPL to ConnectorCare

- 40K childless adults; 100K parents/ caretakers
- ConnectorCare offers $0 premium, $0 deductible, <$200 avg copays/year*
- Dental available for purchase or at community health centers for no cost
- Disabled/medically frail needing LTSS remain on MassHealth Standard
- Savings ($85M net in FY19/$169M net in FY20+) due to higher federal contribution, <u>not</u> to lesser benefits
- Connector coverage requires tax filing due to federal advance premium tax credits; potential benefit of tax filing = Earned Income Tax Credits
- *<u>No change</u> in coverage for children, pregnant women, disabled, elders, members with HIV or breast/cervical cancer, or medically frail*

**ConnectorCare out-of-pocket max for individuals 100-150% FPL is $1,250 per year but average copays are far lower; copays for ConnectorCare members <u>≤</u>100% FPL are the same as MassHealth's*

The proposed shift of non-disabled adults ages 21-64 from MassHealth to Connector generates significant net savings



Estimated savings vs. Status quo	FY19	FY20+
If federal Cost Sharing Reductions (CSRs) remain	$85M	$169M
If federal CSRs end	$80-85M	$160M

- Unique to MA – state "wraps" premiums and cost-sharing through additional subsidies to maintain member affordability
- Even if federal CSRs are eliminated, federal funds would cover a significant portion of the resulting premium increases through Advanced Premium Tax Credits (APTCs), and the effective federal share of subsidies for ConnectorCare would remain relatively stable**

* Includes federal APTCs, CSRs and 1115 matching funds for state wrap

** There may be a short-term disruption from CSR's ending if sufficient notice is not provided

MassHealth and Connector copays (as of January 2019)

		MassHealth* (as of 1/1/19) Members >50% FPL	Connector** (2A&B) Members 100-150% FPL
Medical Maximum Out-of-Pocket (Individual/Family)		2% of income maximum	$750/$1,000
Prescription Drug Maximum Out-of-Pocket (Individual/Family)			$500/$1,000
Preventive Care/Screening		$0	$0
Primary Care to treat injury/illness		$0	$10
Specialist Visits		$4	$18
Behavioral Health and Substance Use Disorder Outpatient Services		$0	$10
Outpatient Therapy Services *Physical, Speech, and Occupational*		$4	$10
Emergency Room Services		$5 (if non-emergency use)	$50
Inpatient Hospital Services		$5	$50
High Cost Imaging (CT/PET Scans, MRI, etc.)		$4	$30
Laboratory Outpatient/Professional		$4 (chiropractor)	$0
X-Rays and Diagnostic Imaging		$0	$0
Durable Medical Equipment and Orthotics		$4	$0
Skilled Nursing Facility		$0	$0
Retail prescription drugs	Generics	$1	$10
	Preferred Brand	$4	$20
	Non-Preferred Brand	$4	$40
	Specialty High Cost	$4	$40

Actual average cost sharing for individuals on this Connector plan <150% FPL: **2-3% of income**

*Table shows PCC Plan copays. ACO/MCO members will have lower copays as an incentive for enrollment in coordinated care options. FFS members will use the ACO/MCO copay schedule.
**Commonwealth Care under Ch. 58 had the same copay schedule as ConnectorCare.

Aligning coverage for non-disabled adults ages 21 – 64 with commercial plans (cont.)

Details

3. Eliminate redundant MassHealth Limited for ConnectorCare eligible members

- ~150K lawfully present adults ≤133% FPL; of these, ~20K currently enrolled in ConnectorCare
- Enroll eligible individuals into comprehensive, affordable coverage rather than Limited coverage for emergency services only, reducing number of residually uninsured
- ConnectorCare offers $0 premium, $0 deductible, and affordable copays:
  - Members ≤100% FPL: same copays as MassHealth
  - Members 100-133% FPL: <$200 avg copays/year*
- MassHealth and Health Connector will conduct outreach & enrollment campaign, including grants to community organizations

4. Align coverage for all non-disabled adults ≤100% FPL in MassHealth CarePlus

- ~230K non-disabled parents/caretakers ages 21-64 will shift from MassHealth Standard to CarePlus
- MassHealth CarePlus is more closely aligned with commercial plans than Standard (e.g., no non-emergency medical transportation except for substance use disorder services)
- Reduces impact of churn, as non-disabled adults commonly cycle between commercial insurance and MassHealth as income fluctuates
- Disabled/medically frail who need LTSS remain on MassHealth Standard
- *No change in coverage for children, pregnant women, disabled, elders, members with HIV or breast/cervical cancer, or medically frail*

**ConnectorCare out-of-pocket max for individuals 100-150% FPL is $1,250 per year but average copays are far lower; copays for ConnectorCare members ≤100% FPL are the same as MassHealth's*

Aligning coverage for non-disabled adults ages 21 – 64 with commercial plans (cont.)

Details

5. Implement ESI Gate for non-disabled adults

- ~5K members/ applicants (non-disabled adults ages 21-64) with access to affordable ESI
- To be considered affordable ESI premium + deductibles must be <5% income
- Ex: Single non-disabled adult makes $12K a year, ESI <$50/month
- Exception/hardship process, including for plans with low premium/ deductibles but high cost sharing
- *No change in coverage for children, pregnant women, disabled, elders, members with HIV or breast/cervical cancer, or medically frail*

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6. Reduce MassHealth benefit "wraps" to commercial insurance

- ~25K non-disabled adults ages 21-64 in premium assistance program
- MassHealth provides premium assistance and wraps cost sharing and benefits
- Today, benefit wrap includes services primary insurance covers (e.g., if primary insurance does not approve prior authorization)
- MassHealth would wrap only benefits not covered by commercial (e.g., dental, certain substance use treatment incl. non-emergency transportation)
- No change to premium or cost sharing assistance (as today, cost sharing assistance available for services provided by MassHealth-enrolled providers)

Adopting widely-used commercial insurance tools to obtain lower drug prices and enhanced rebates

7. Implement closed formulary with preferred and covered drugs

Details

- MassHealth seeks to expand the tools it has available to manage the rapid growth of prescription drug costs
  - MassHealth is currently constrained by federal rules requiring Medicaid to cover all FDA-approved drugs if the manufacturer participates in the federal drug rebate program
  - Similar to Medicare Part D and commercial plans, MassHealth would implement a closed formulary with preferred and covered drugs and ensure continued access to medically necessary drugs
- At least one drug per therapeutic class would be covered on the formulary; excluding other drugs allows MassHealth to negotiate better rebates with manufacturers
- MassHealth will review any drugs without proven clinical efficacy to ensure high standards of care for members and cost effectiveness
  - e.g., re-formulations of older existing drugs that provide no incremental clinical benefit, drugs for which FDA-approval is contingent on verification of clinical benefit in confirmatory trials
- Exception process to cover drugs that are not on the formulary when medically necessary
  - E.g., due to drug interactions, individual member's clinical status, etc.
  - Exceptions process will be similar to current prior authorization process for non-preferred drugs

Adopting widely-used commercial insurance tools to obtain lower drug prices and enhanced rebates (cont.)

8. Procure specialty pharmacy network

Details

- Selective specialty pharmacy networks are standard practice for commercial health plans, including MassHealth managed care organizations (MCOs)
- MassHealth will procure a high-quality, cost effective network for specialty pharmacy for PCC Plan and Fee For Service members that will provide continued access members to specialty prescription drugs at a lower cost
- Members will be able to access specialty prescription drugs through the selected pharmacies' locations, mail order or home delivery

Improving care, reducing costs and achieving administrative efficiencies

Details

9. Narrow provider networks PCC Plan

- Narrower networks in Primary Care Clinician Plan (PCC) Plan will encourage enrollment in coordinated care such as Accountable Care Organizations (ACOs) and MCOs
- PCC Plan will continue to provide adequate access but will not include all "willing and qualified" providers for certain provider types (e.g., hospitals)

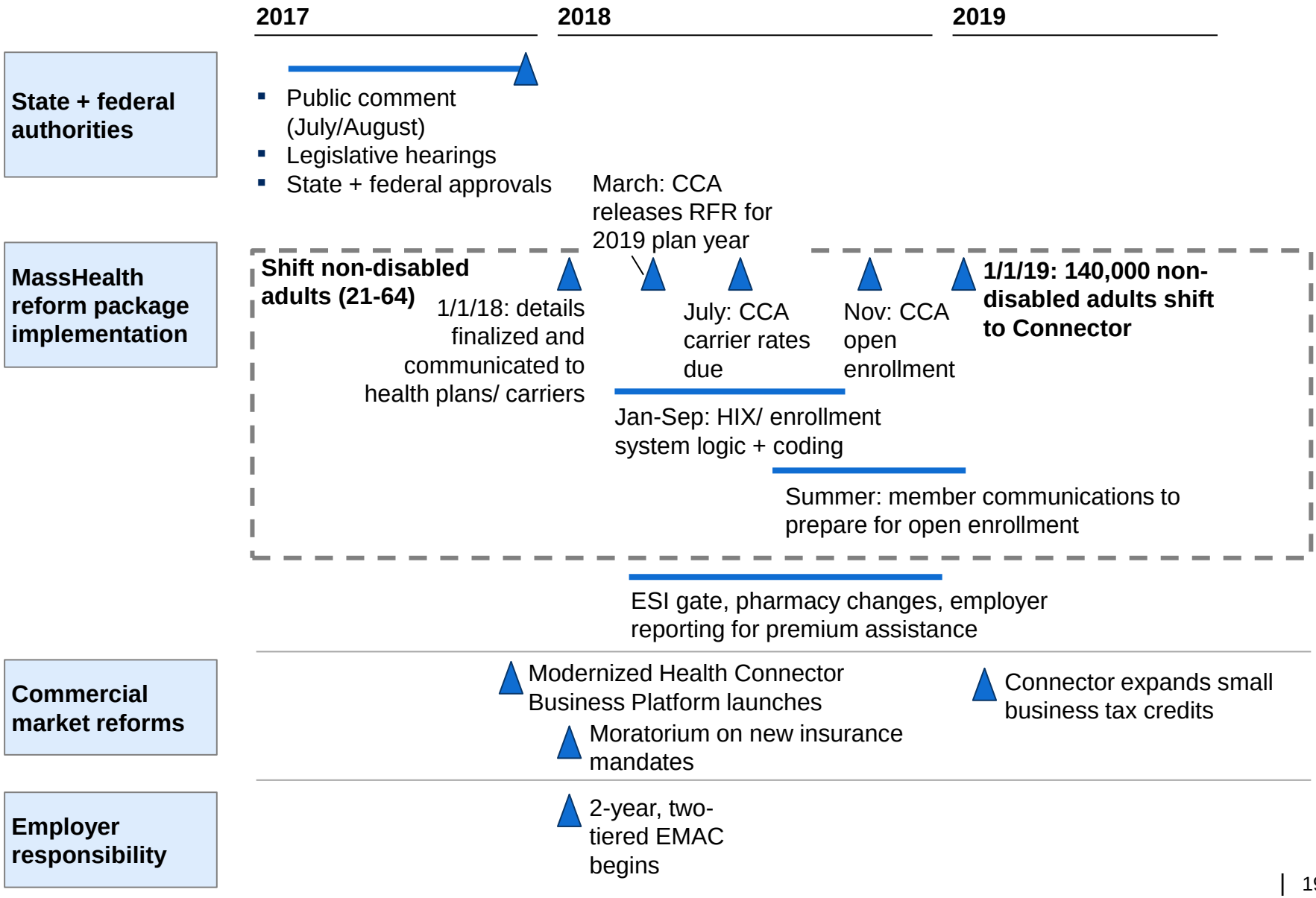
10. Remove restrictions on federal payment for care in IMDs

- Waiving federal payment restrictions on care provided to adults in Institutions for Mental Disease (IMDs) will remove barriers to effective behavioral health care
- IMDs provide a significant portion of inpatient detox services and psychiatric inpatient treatment services in the Commonwealth
- Bolsters MassHealth's ability to confront the opioid crisis and strengthens Commonwealth's mental health and substance use treatment systems

Improving care, reducing costs and achieving administrative efficiencies (cont.)

	Details
11. Allow a single managed care option in certain areas with a large regional ACO	▪ Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers (PCPs) are participating in a single MassHealth ACO ▪ ACO must provide robust network of PCPs, specialists, and other providers ▪ Other managed care options in such area(s) would not have a large enough pool of PCPs to meet MassHealth's network adequacy requirements for PCPs ▪ Members who actively select/already have a PCP that is not part of the ACO can enroll/remain enrolled in PCC Plan
12. Implement MassHealth cost sharing limit on annual basis	▪ Starting 1/1/19, copays will be eliminated for members <50% FPL, adjusted for those over 50% FPL, capped at 2% of income (see slide 12) ▪ MassHealth will implement 5% of income total cost sharing (premiums + copays) limit on an annual basis rather than a quarterly or monthly basis ▪ Allows for administrative simplification ▪ Aligns with standard practice in commercial insurance market
13. Allow cost sharing >5% of income for members >300% FPL	▪ Cost sharing (premiums + copays) could exceed 5% of income for members over 300%FPL eligible exclusively through the demonstration (CommonHealth) ▪ Cost sharing will remain below the state affordability schedule as determined by Health Connector

In order to implement the Reform Package in January 2019, state and federal authority must be final by end of 2017



Agenda

- MassHealth 1115 Demonstration Amendment Request
- **Health Connector Flexibility Requests***

*See https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/07-13-2017/Federal-Flexibility-Request-Update-071317.pdf

Public Comments

EOHHS will accept comments on the proposed Demonstration Amendment through **August 21, 2017.** Visit the MassHealth Innovations website for more information about submitting comments: www.mass.gov/hhs/masshealth-innovations/1115waiver.

Health Connector will accept comments on the proposed Demonstration Amendment through **August 25, 2017.** Visit Health Connector Innovations website for more information about submitting comments: https://www.mahealthconnector.org/about/policy-center/state-innovation-waiver.

Slides from today's presentation are available at the MassHealth Innovations and Health Connector Innovations websites, as well as copies of:

- The Proposed Amendment and related documents
- Details on upcoming public listening sessions
- Information on how to submit comments