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

MassHealth Section 1115 Demonstration Amendment Request

July 20, 2017

Contents

Introduction

Massachusetts has a longstanding commitment to universal health care coverage. Working with the federal government, we have reached and maintained an insurance rate of 96-97%, the highest rate in the country.[1] Our state-based Marketplace, known as the Health Connector, established in 2006 under Massachusetts' comprehensive state health care reform law, administers a robust individual and small group insurance exchange with nine carriers participating. Today, more than 250,000 individuals have health care coverage through the Health Connector, including 193,000 low to moderate income residents who receive federal and state subsidies. MassHealth, our Medicaid and Children's Health Insurance Program, covers 1.9 million individuals, or nearly 30% of the Commonwealth's residents.

Massachusetts attributes much of its success in expanding health coverage to strong state bipartisan collaboration, commitment to innovation, and to the federal-state partnerships that have supported the Commonwealth's reform efforts.

However, at 40% of the Commonwealth's budget, MassHealth's continued growth will constrain the state budget unless significant reforms are implemented and key aspects of the program are restructured. In recent years, Massachusetts has seen a steady increase in the number of residents enrolled in MassHealth, despite near universal health care coverage, steady population numbers, and low unemployment. This is explained, to a considerable degree, by reductions in the percentage of residents covered through commercial insurance. Changes in the makeup of the economy, increased cost of health care, expansion of high deductible commercial health insurance and the high cost of insurance for small employers are all contributing factors to the shift from the commercial market to public coverage.

The Baker-Polito administration has implemented reforms to make the MassHealth program sustainable. We have reduced annual growth in program spending from double digits to single digits without reducing benefits or eligibility, in large part due to focused efforts to improve program integrity and strengthen eligibility systems and processes. In addition, we have initiated the restructuring of the existing MassHealth program into an innovative accountable care program under the recently approved five-year 1115 demonstration agreement with the Centers for Medicare and Medicaid Services (CMS), which will shift the majority of our managed care eligible members into Accountable Care Organizations (ACOs).

In June, MassHealth selected 18 ACOs across the state to enter into contract negotiations with the state. These ACOs have the potential to cover more than 900,000

[1] http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf

MassHealth members and include approximately 4,500 primary care providers. The ACO program will promote integration and coordination of care for members, while holding providers accountable for their quality and cost. MassHealth's ACOs will integrate their efforts with community-based health and social service organizations to improve behavioral health, long-term supports and health-related social needs for MassHealth members as appropriate.

To build on this restructuring, additional federal flexibility is needed for further reforms in MassHealth and the commercial insurance market that support long-term fiscal sustainability. Massachusetts is committed to reforming MassHealth in a manner that protects coverage gains and aims to improve the quality and integration of health care delivery, particularly for our members with the most complex needs.

MassHealth's requests for flexibility through this amendment request include:

- ***Aligning coverage for non-disabled adults with commercial plans***
    1. Enroll non-disabled adults with incomes over 100% FPL in subsidized commercial plans through the state's exchange (the Health Connector)
    2. Align MassHealth benefits for all non-disabled adults in a single plan that mirrors commercial coverage, by enrolling non-disabled parents and caregivers with incomes up to 100% FPL in MassHealth's CarePlus Alternative Benefit Plan
    3. Modify the premium assistance program for non-disabled adults with access to commercial insurance to reduce Medicaid "wraps" on top of the commercial plan while ensuring continued affordability for members
    4. Implement an eligibility "gate" that would not allow non-disabled adults with access to affordable employer-sponsored or student health insurance to enroll in MassHealth
    5. Eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector
- ***Adopting widely-used commercial tools to obtain lower drug prices and enhanced rebates***
    6. Select preferred and covered drugs through a closed formulary that assures robust access to medically necessary drugs
    7. Procure a selective and more cost effective specialty pharmacy network
- ***Improving care, reducing costs and achieving administrative efficiencies***
    8. Implement narrower networks in MassHealth's Primary Care Clinician (PCC) Plan to encourage enrollment in ACOs and Managed Care Organizations (MCOs)

9. Remove barriers to effective behavioral health care by waiving federal payments restrictions on care provided in Institutions for Mental Disease (IMDs)
10. Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers are participating in a single MassHealth ACO
11. Implement the cost sharing limit of five percent of income on an annual basis rather than a quarterly or monthly basis
12. Implement cost sharing greater than five percent of income for members over 300% FPL eligible exclusively through the demonstration

In parallel with this request, Massachusetts will submit an additional set of flexibility requests to enable the Commonwealth to take a state-specific approach to employers' shared responsibility for maintaining near universal coverage and to stabilize our commercial health insurance market. Massachusetts will also continue discussions with CMS to pursue flexibility to enable MassHealth to better manage care and costs for dually eligible members using 1115A waiver authority.

Proposed MassHealth Reforms

Aligning coverage for non-disabled adults with commercial plans

Non-disabled adults are the most economically mobile group among Medicaid members and do not have disabilities that require the unique services offered in Medicaid on a long-term basis. They are more likely than other groups to be employed, to experience income growth over time, and to enter the commercial health insurance market. As a result, we believe that benefits and coverage for non-disabled adults should better align with commercial health insurance. Achieving this alignment will also help to address the significant shift we have seen over the last several years from private to public coverage. To that end, Massachusetts proposes five reforms, described in detail below.

1. *Enroll non-disabled adults with incomes over 100% of the FPL into subsidized health plans through the Health Connector*

We propose to shift coverage for non-disabled adults ages 21 to 64 with incomes over 100 percent of the FPL, including ACA expansion enrollees and parents and caretakers, to subsidized commercial plans through the Health Connector. We estimate that this population is comprised of approximately 40,000 ACA expansion enrollees and approximately 100,000 non-disabled parents and caretakers with incomes over 100% of the FPL. This change would be effective in January 2019.

Non-disabled adults with incomes over 100% of the FPL are similar in many respects to individuals currently enrolled in commercial health insurance plans. Their needs can be

met in commercial health insurance products with appropriate affordability protections. In addition, this group of individuals is most likely to move between MassHealth and Health Connector coverage today as their income fluctuates. Shifting this population to the Health Connector will improve continuity and reduce churn by allowing adults to stay in the Health Connector as long their income remains above 100% of the FPL. This approach is consistent with the pre-ACA coverage structure in Massachusetts under state health reform, when lower income adults were covered through the Connector in a program called Commonwealth Care, which was nearly identical to the current subsidized coverage offerings through the Connector.

The coverage available to this population through the Health Connector is comprehensive and affordable. Qualified Health Plans through the Health Connector are required to cover the Essential Health Benefits as well as state-mandated benefits. Massachusetts has a particularly robust affordability structure for lower income Marketplace enrollees, including a state premium and cost sharing wrap program known as ConnectorCare, which supplements federal subsidies. Individuals transitioning to the Connector will have access to a range of commercial health insurance options, including a $0 premium plan option. Their total annual out of pocket expenses will be capped at $1,250 annually for an individual ($2,500 for a family), and Massachusetts' experience is that average co-pays for the population at this income level are much lower (~$200-300 per year). Many of the health insurance carriers available through ConnectorCare are also MassHealth Managed Care options.

In addition, while Qualified Health Plans do not include dental coverage, these individuals will have access to dental services through the Health Safety Net program, which reimburses hospitals and community health centers for uncompensated care for eligible low-income patients. Alternatively, enrollees can purchase separate dental insurance for approximately $30 a month through the Health Connector.

Pregnant women and populations that would have been eligible for MassHealth prior to the ACA based on HIV status or in the breast or cervical cancer treatment program would remain in MassHealth. In addition, members will have an opportunity to identify themselves for a formal disability determination if they have not already done so. Anyone determined disabled based on federal or MassHealth processes, as well as those determined by MassHealth to be medically frail, would remain in MassHealth coverage and would continue to have access to medically necessary long-term services and supports (LTSS).

2. Consolidate coverage for non-disabled adults <100% FPL in coverage that aligns more closely with commercial coverage

For non-disabled adults with incomes up to 100 percent of the FPL who would remain in MassHealth, we propose better aligning coverage with commercial plans. Given the high potential for income fluctuation and shifts between MassHealth and commercial coverage for non-disabled adults, aligning coverage for this population with commercial plans will promote continuity for members. In addition, these policies will help to stem the enrollment shift from the commercial market to public coverage in Massachusetts.

Therefore, MassHealth proposes to enroll all non-disabled adults up to 100% FPL, including parents and caretakers, in a common Alternative Benefit Plan (ABP) known as MassHealth CarePlus. MassHealth CarePlus is currently available to ACA expansion enrollees ages 21-64 and would be extended to include non-disabled parents and caretakers ages 21-64 as well. CarePlus benefits are similar to those in MassHealth Standard except that they do not include LTSS (for individuals with disabilities, who will not be affected by this population shift). Massachusetts has also submitted an 1115 demonstration amendment to eliminate coverage for non-emergency medical transportation for non-disabled adults, with the exception of transportation to substance use disorder (SUD) treatment services. We estimate that approximately 230,000 non-disabled parents and caretaker relatives would shift from MassHealth Standard to MassHealth CarePlus. This change would be effective in January 2019.

Pregnant women and members with HIV or breast or cervical cancer would remain in MassHealth Standard. In addition, members will have an opportunity to identify themselves for a formal disability determination if they have not already done so, and anyone determined disabled would remain in MassHealth Standard. MassHealth will also continue to allow medically frail individuals to opt into MassHealth Standard coverage.

3. *Modify the premium assistance program for non-disabled adults with access to commercial insurance to reduce Medicaid benefit "wraps" on top of the commercial plan while ensuring continued affordability for members*

Consistent with the goal of aligning coverage for non-disabled adults with commercial plans, MassHealth is working to maximize participation in its premium assistance program for employer sponsored commercial insurance or student health insurance when it is available and cost effective. This includes enforcing mandatory enrollment in an employer or student health insurance plan when adults have access to insurance through their employer or a spouse's employer. In addition, we believe that such commercial coverage should be sufficient to meet their needs without additional MassHealth wraps for services. To ensure this is the case, MassHealth has a process to verify that an employer or student health plan is comprehensive before enrolling any member in it through the premium assistance program. Therefore we request flexibility not to provide any additional benefit wrap, except for a limited number of services not

typically covered by commercial. In addition, in order to ensure the cost effectiveness of the premium assistance program, we request a waiver to not provide a Medicaid cost sharing wrap when a member in premium assistance receives services from a provider that is not enrolled as a MassHealth provider, consistent with MassHealth's current practice.

4. *Implement a "gate" that would not allow individuals with access to affordable employer-sponsored or student health insurance to enroll in Medicaid, similar to the policy for Marketplace coverage*

As noted in the introduction above, Massachusetts has seen a significant shift as the percentage of lives covered in commercial coverage has decreased, and the percentage of lives in public coverage has increased dramatically over the last several years. There are many factors that contribute to this shift, and we do not expect that this trend will be reversed. However, we do believe that individuals with access to affordable insurance through their employer or student health insurance plan should not enroll in MassHealth. We propose to implement an eligibility rule that would not allow non-disabled adults with access to insurance through their employer for which the premium costs less than five percent of income to enroll in MassHealth. The same rules would apply to student health insurance available to non-disabled adults ages 21-64.

Applicants would have the opportunity to submit a hardship waiver for special circumstances, such as if their employer offered coverage with an affordable premium but unaffordable cost sharing (e.g., a low-premium, high-deductible plan).

5. *Eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector*

Federal rules require MassHealth to cover emergency services for individuals who would otherwise be eligible for Medicaid State Plan coverage, but for their immigration status. However, many of these individuals are also eligible for comprehensive, affordable coverage through the Health Connector with the benefit of both federal and state subsidies. MassHealth is currently providing redundant coverage for these individuals, given that all Qualified Health Plans cover emergency services. Therefore MassHealth proposes to eliminate its redundant MassHealth Limited coverage for adults who are also eligible for subsidized ConnectorCare coverage with a $0 premium and only nominal cost sharing.

For this population of adults up to 133% of the FPL, ConnectorCare coverage is comprehensive and affordable. Qualified Health Plans must provide the Essential Health Benefits. Under Massachusetts' unique program combining state and federal subsidies, all eligible enrollees up to 133% of the FPL have access to a $0 premium plan option; those under 100% FPL have co-pays equivalent to MassHealth co-pay

levels, and those between 100 and 133% FPL have co-pays that meet the state's affordability standards and are capped at $1,250 annually (though, as noted above, most people's co-pays at this income level are $200-$300 a year). In this context, MassHealth Limited coverage is redundant and unnecessary. In addition, eliminating MassHealth Limited coverage when Connector coverage is available will further incent eligible individuals to enroll in and utilize the comprehensive coverage option available to them, furthering the Commonwealth's goal of universal coverage.

MassHealth will continue to provide MassHealth Limited coverage during a 90-day enrollment period after an individual is determined eligible for ConnectorCare. In addition, the Health Safety Net is available to reimburse for any other MassHealth-covered service provided at a hospital or community health center during this 90-day ConnectorCare enrollment period.

During the initial transition period leading up to implementation of this change, Massachusetts will open a Special Enrollment Period for MassHealth Limited members who are eligible for ConnectorCare but unenrolled, augmented with an outreach and enrollment campaign to ensure members enroll in ConnectorCare coverage. In addition to our own direct outreach efforts, MassHealth and the Health Connector plan to provide small grants to community organizations and providers for outreach and enrollment activities for this transition, particularly focusing on members for whom English is not their first language.

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

Rapidly growing pharmaceutical spending poses an important risk for the financial sustainability of MassHealth. Since 2010 MassHealth drug spending has risen at a compound annual growth rate of 13%. If growth in drug costs continues at the current trajectory it may crowd out important spending on health care and other critical programs.

MassHealth is committed to ensuring patients have access to the highest standard of care available, and we believe we can continue to provide this access while driving down unreasonably high drug costs. MassHealth seeks to use all available tools to manage the rapid growth of drug costs–including a current initiative to negotiate advantageous supplemental rebates with manufacturers. However, the state currently lacks basic formulary management tools available to commercial payers. Whereas commercial payers can elect whether or not to cover drugs based on clinical efficacy and affordability, MassHealth is required to cover any drug for which the manufacturer participates in the federal Medicaid rebate program. The requirement to cover any such drug hinders our ability to secure additional supplemental rebates. In addition, maintaining an open formulary with coverage for nearly all drugs makes MassHealth's

coverage appear attractive when compared to commercial plans, incentivizing consumers to seek MassHealth coverage even when other employer-sponsored insurance options are available to them. This is an important concern to MassHealth, given the significant shift we have seen over the last several years from commercial insurance to Medicaid coverage in Massachusetts.

We seek to guarantee our members' access to high quality, medically necessary care, while minimizing unnecessary spending on drugs whose incremental clinical value is unproven. To that end, we request a waiver of the permissible coverage restriction requirements for outpatient drugs in two additional instances, as described below.

6. *Select preferred and covered drugs through a closed formulary that assures robust access to medically necessary drugs*

   6a. Adopt a commercial-style closed formulary with at least one drug available per therapeutic class

Adopting a closed formulary with at least a single drug per therapeutic class would enable MassHealth to negotiate more favorable rebate agreements with manufacturers. For each therapeutic class, the state could offer manufacturers an essentially guaranteed volume in exchange for a larger rebate. At present MassHealth has limited ability to offer such volume deals to manufacturers, given the requirement to cover all drugs in the Medicaid rebate program. In recent years the majority of commercial pharmacy benefit managers (PBMs) have adopted such closed formularies, which allow them to customize their drug offerings based on clinical efficacy and cost considerations. As an example, for 2017 CVS Health excluded from its formulary 35 additional products–some because a less expensive, medically equivalent drug had become available and some because the drugs were hyperinflationary, having dramatically increased in price without clear justification. Medicare Part D commercial plans are also permitted to employ such closed formularies (as authorized under 42 CFR 423.120) with at least two drugs per therapeutic class. Medicare Part D plans may also include just a single drug per class if only one drug is available, or if only two drugs are available but one drug is clinically superior. Given that Medicare and other commercial plans are permitted to adopt closed formularies, we believe Massachusetts should have the same flexibility for Medicaid.

Maintaining the highest standard of patient care will remain a paramount concern even with introduction of a closed formulary. In selecting drugs available in each therapeutic class, MassHealth will ensure that the selected drugs meet the clinical needs of the vast majority of members and that they are cost effective. In addition, MassHealth will maintain an exceptions process to cover drugs that are not on the formulary when medically necessary, similar to the existing clinical review process used for situations

such as determining coverage of off-label indications. MassHealth's review process for all drugs includes a careful assessment of clinical trial results, published literature, comparisons with other related drugs, modeling of the expected patient populations who would benefit from the drug, and coverage by other payers.

6b. Exclude from the formulary drugs with limited or inadequate evidence of clinical efficacy

Many drugs coming to market through the FDA's accelerated approval pathway have not yet proven their efficacy on primary endpoints in clinical trials. Massachusetts seeks the ability to use its own rigorous review process, in partnership with the University of Massachusetts Medical School, to determine coverage of new drugs and to guarantee that patients access clinically proven, efficacious drugs. Through this process, the state could avoid exorbitant spending on high-cost drugs that are not medically necessary. The 21st Century Cures Act was intended to expedite the drug approval process by reducing the level of evidence required for drugs to reach the market and allowing doctors, patients, and payers to decide whether to purchase them. Unfortunately, current rules do not allow Medicaid programs to exercise discretion about whether these drugs should be covered without being fully clinically proven.

MassHealth proposes to utilize the flexibility granted under the waiver to exclude drugs with limited or inadequate clinical efficacy from its primary formulary. Limited or inadequate clinical efficacy will be defined as when one or more of the following conditions exist:

- Primary endpoints in clinical trials have not been achieved;
- Only surrogate endpoints have been reported;
- Clinical benefits have not been assessed;
- FDA-approval is contingent upon verification of clinical benefit in confirmatory trials;
- The drug provides no incremental clinical benefit within its therapeutic class, compared to existing alternatives.

Members would continue to have access to the latest drugs that provide proven additional clinical benefits. Whenever a new drug is proven to have incremental clinical value relative to peer drugs in its therapeutic class, it would be covered. In addition, breakthrough drugs with proven clinical benefit in new therapeutic classes would be covered. Only in cases where the incremental clinical benefit is undemonstrated would the state consider excluding a drug from its standard formulary. Members could still request coverage of non-formulary drugs, using the exceptions process as described above.

New drugs approved under the FDA's accelerated approval pathway can be particularly costly and would be ideal for more rigorous evaluation of coverage and potential labeling as non-formulary where appropriate. In addition, re-formulations of older, existing drugs–for example Tirosint (levothyroxine) and Doryx (doxycycline)–that provide no incremental clinical benefit might be labeled non-formulary as well. While commercial payers can exercise discretion to exclude drugs from their formularies in such situations, MassHealth currently does not have this latitude.

7. Procure a selective and more cost effective specialty pharmacy network

The use of selective specialty pharmacy networks has become standard practice for commercial health plans, including MassHealth managed care organizations, which cover over 800,000 MassHealth members. However, without a waiver MassHealth is currently unable to procure a selective network for specialty pharmacy for members in its PCC Plan and fee-for-service coverage. MassHealth is seeking a waiver so that it can procure a high-quality, cost effective pharmacy network for specialty pharmacy that will provide continued access to specialty prescriptions drugs at a lower cost to MassHealth. Members will be able to access specialty prescription drugs through the selected pharmacies' locations and, as needed, through mail order or home delivery. This approach will both yield cost savings and better align MassHealth coverage with commercial health plans, including its own contracted MCOs.

Improving care, reducing costs and achieving administrative efficiencies

8. Implement narrower networks in MassHealth's Primary Care Clinician (PCC) Plan to encourage enrollment in ACOs and MCOs

Historically, MassHealth has had both MCOs and a PCC Plan as options for managed care eligible members, and MassHealth is in the process of implementing its full ACO program beginning in January 2018. While we anticipate that over 900,000 of MassHealth's 1.3 million managed care eligible members will be enrolled in MCOs, members whose primary care providers are not participating in an ACO will have the option of enrolling in the PCC Plan or in a traditional MCO. ACO-enrolled members will also have the opportunity to opt out if they prefer to change primary care providers.

In order to promote coordinated, integrated care, MassHealth seeks to encourage members to enroll in ACOs and MCOs rather than the PCC Plan. Currently, the PCC Plan has open provider networks (any willing and qualified provider), minimal utilization management, and limited care coordination outside of behavioral health. As we move toward a majority ACO structure for managed care eligible members, ACOs will rely on more integrated networks of providers to coordinate care for their attributed members. It is important to strengthen controls on both the networks and the management of the PCC Plan, thereby incenting members to enroll in more managed, integrated plan

ACOs and MCOs. For example, we would procure a narrower, high value network of hospitals and possibly primary care providers. This approach also supports the alignment of MassHealth coverage with commercial coverage, in which more limited networks are the norm.

9. Remove barriers to effective behavioral health care by waiving federal payments restrictions on care provided in Institutions for Mental Disease (IMDs)

Massachusetts is seeking a waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64. These waivers are necessary to bolster Massachusetts' ability to confront the opioid crisis and to strengthen the Commonwealth's mental health and substance use treatment systems.

The opioid epidemic is both a Massachusetts and a national crisis. In Massachusetts, the majority of available inpatient detox services and psychiatric inpatient treatment are provided in freestanding psychiatric hospitals, many of which are IMDs. The current IMD restrictions act as a barrier to MassHealth's ability to provide the most appropriate, least restrictive and most cost effective care for members with significant behavioral health needs. While Massachusetts already has waivers to pay for certain services in IMDs under the current 1115 (e.g., diversionary and SUD services), we are requesting a broader waiver for IMD, including of the 15-day limit in CMS' 2016 managed care rule. This flexibility will allow the Commonwealth to deploy all available provider capacity to ensuring MassHealth members have access to medically necessary treatment for mental health conditions and substance use disorder, which are often co-ocurrring.

10. Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers are participating in a single MassHealth ACO

In certain area(s) of the state, a majority of primary care providers (PCPs) will be participating in a single MassHealth ACO. This ACO will be required to provide coordinated, integrated care for its members with access to a robust network of PCPs, specialists and other providers. However, other managed care options in such area(s) will not have a large enough pool of PCPs to meet network adequacy requirements for PCPs within MassHealth's time and distance standards.

Therefore, MassHealth requests a freedom of choice waiver to not provide two or more managed care enrollment options in such area(s). Instead, the single ACO would provide high-quality care with a choice of several PCPs to members in such area(s). MassHealth also requests a freedom of choice waiver to allow the PCC Plan not to have

two PCPs within the time and distance standards in order to enroll someone into it. MassHealth will not auto-assign members to the PCC plan if these adequacy standards are not met, but members who are already in the PCC Plan with a PCP who is not participating in the ACO will be allowed to remain enrolled, and members who proactively choose to enroll in the PCC Plan and select an available PCP with an open panel will be allowed to do so.

11. Implement the cost sharing limit of five percent of income on an annual basis rather than a quarterly or monthly basis

Massachusetts seeks flexibility to allow for administrative simplification in the implementation of the ACA's cost sharing limit of five percent of income. Specifically, we seek flexibility to implement the cost sharing limit on an annual basis rather than a quarterly or monthly basis. This aligns with standard practice in the commercial insurance market and will significantly simplify administration of this requirement.

12. Implement cost sharing greater than five percent of income for members over 300% FPL eligible exclusively through the demonstration

Massachusetts covers certain members through the demonstration with incomes above 300% of the FPL. We seek the flexibility to require premiums and cost sharing that may exceed five percent of these individuals' income. At higher income levels, we believe it is reasonable and fair for members to contribute more toward the cost of their care.

Summary of waiver and expenditure authorities requested

The table below lists the waivers and expenditure authorities the Commonwealth is seeking to support the policies described above.

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
1. Enroll non-disabled adults (including ACA expansion enrollees and non-pregnant parents and caretakers) >100% FPL in subsidized commercial plans through the state's exchange	Eligibility Waiver	§1902(a)(10)(A)(i)(8)

2. Align MassHealth benefits for all non-disabled adults in a single plan that mirrors commercial coverage, by enrolling non-disabled parents and caregivers with incomes up to100% FPL in MassHealth's CarePlus Alternative Benefit Plan	Eligibility Waiver Comparability Waiver Waiver of assurance of transportation for NEMT benefits	§1902(a)(10) insofar as it incorporates Section 1931 §1902(a)(10)(B), 1902(a(10(A), insofar as it incorporates Section 1905(a) §1902(a)(4) insofar as it incorporates 42 CFR 431.53 and 42 CFR 440.390
3. Modify the premium assistance program for non-disabled adults with access to commercial insurance to reduce Medicaid "wraps" on top of the commercial plan while ensuring continued affordability for members	Waiver of comparability/amount, duration and scope Waiver of freedom of choice	§1902(a)(10)(B) §1902(a)(23)(A)
4. Implement an eligibility "gate" that would not allow non-disabled adults with access to affordable employer-sponsored insurance (ESI) to enroll in Medicaid	Eligibility Waiver	§1902(a)(10) and §1902(a)(25)
5. Eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector	Eligibility Waiver	§1902(a) insofar as it incorporates Section 1903(v) of the SSA
6. Select preferred and covered drugs through a closed formulary that assures robust access to medically necessary drugs	Waiver of the permissible coverage restriction requirements for outpatient drugs	§1902(a)(54) insofar as it incorporates Section 1927(d)(1)(B; §1902(a)(14) insofar as it incorporates Section 1916 and 1916A; §1902(a)(23)(A)

7. Procure a selective and more cost effective specialty pharmacy network	Freedom of choice waiver	§1902(a)(23)(A)
8. Implement narrower networks in MassHealth's Primary Care Clinician (PCC) Plan to encourage enrollment in ACOs and MCOs	Freedom of choice waiver	§1902(a)(23)(A)
9. Remove barriers to behavioral health care by waiving federal payment restrictions on care provided in IMDs	Waivers of all IMD payment restrictions Expenditure authority for IMD payments	§1905(a)(29)(B)
10. Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers are participating in a single MassHealth ACO	Freedom of choice waiver	§1902(a)(23)(A)
11. Implement the cost sharing limit of five percent of income on an annual basis rather than a quarterly or monthly basis	Waiver of cost sharing limits	§1902(a)(14) insofar as it incorporates Section 1916 and 1916A
12. Implement cost sharing greater than five percent of income for members over 300% FPL eligible exclusively through the demonstration	Change to current expenditure authority for CommonHealth	1115 Expenditure authority

Budget Neutrality

Budget neutrality prior to amendment

The Commonwealth's projected budget neutrality cushion as of the quarterly report for the quarter ending March 31, 2017[2] is approximately $36 billion total, of which $8.6 billion is attributable to the SFY 2018-2022 waiver period.[3] This estimate incorporates projected expenditures and member months through SFY 2022 as reported through the quarter ending March 31, 2017, combined with the MassHealth budget forecast for SFY 2018-2019. This budget neutrality calculation reflects significant realized and anticipated savings.

Effect of amendment

As reflected in the accompanying budget neutrality workbook, this amendment result in significant savings to the MassHealth program and would reduce the total populations and expenditures under the demonstration. The combined effect of these two dynamics would decrease the Commonwealth's budget neutrality cushion by approximately $1.3 billion for the SFY2018-2022 waiver period, from $8.6 billion to approximately $7.3 billion. The overall reduction is attributable to the shift in the adult, non-disabled population from MassHealth to the Connector and to affordable employer sponsored and student health insurance beginning in SFY18. This shift will reduce both the members and associated expenditures within the budget neutrality calculation, though the Commonwealth will continue to generate room attributable to the additional amendments. Savings are largely attributable to reduced projected spending from provisional eligibility changes. Overall, after integrating the proposed amendments, the Commonwealth and the federal government would continue to realize savings on the Demonstration.

Evaluation

The currently approved demonstration seeks to advance five goals:

- Goal 1: Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care
- Goal 2: Improve integration of physical, behavioral and long-term services

[2] The budget neutrality cushion as of the quarterly report for the quarter ending March 31, 2017 includes member month and actual expenditure data as reported in the CMS-64 report for the corresponding time period. Safety Net Care Pool spending included in the calculation reflects figures as reported in the budget neutrality agreement approved by CMS on November 4, 2016.

[3] Note, CMS introduced a savings phase-out methodology to the Budget Neutrality calculation so that the Commonwealth may only carry forward 25% of selected population based savings each year between SFY18-22.

- Goal 3: Maintain near-universal coverage
- Goal 4: Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals
- Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services

The amendment's impact on the current demonstration's evaluation is described below:

Amendment requests #1, #2 and #5 seek to advance Goal #3, to maintain near-universal coverage and support Hypothesis 3A, which posits that "the waiver's investments in improved enrollment procedures and insurance subsidies will be associated with the continued maintenance of near-universal coverage in Massachusetts." Enrolling non-disabled adults over 100% FPL into subsidized commercial plans through the state's exchange (the Health Connector), covering non-disabled parents and caretakers under 100% FPL in the CarePlus program and eliminating duplicative Limited coverage for adults who continue to be eligible for affordable coverage through the Health Connector supports the state's goal of maintaining near-universal coverage, while also helping to ensure the long-term financial sustainability of the state's health coverage programs.

Amendment requests #8 and #10 advance existing Goal #1 and support Hypothesis 1c as they encourage enrollment in the delivery system reforms models that promote integrated, coordinated care and specifically are designed to lead to stronger ACO and MCO program networks relative to the PCC plan network.

Amendment request #9 seeks to advance existing Goal #2 and supports Hypothesis 2a as it removes barriers to behavioral health care to address the opioid epidemic and strengthen the Commonwealth's mental health and addiction treatment systems.

Amendment request #11 is an administrative simplification measure and is not tied to a specific waiver goal.

Amendment requests #3, #4, #6, #7 and #12 advance a new proposed Goal #6.

- Goal 6: Ensure the long-term financial sustainability of the MassHealth program through the adoption of widely-used commercial tools for prescription drugs, changes to MassHealth eligibility and covered services, and changes to cost sharing requirements for higher income members

Research questions for Goal 6 related to the items included in this waiver amendment request

What is the impact of the waiver's initiatives for prescription drugs, changes to MassHealth eligibility and covered services for individuals with commercial health insurance and changes to MassHealth cost sharing requirements for higher income members?

- Hypothesis 6A: The waiver's initiatives for prescription drugs will result in lowered expenditure growth rates compared to what prescription drug spending would be without the waiver without reducing access to medically necessary drugs.
- Hypothesis 6B: The waiver's changes to MassHealth eligibility and covered services for individuals with commercial health insurance and changes to MassHealth cost sharing requirements for higher income members will result in slowing the shift in enrollment from commercial health insurance (as a percentage of the state's population) to MassHealth primary coverage (as a percentage of the state's population) while maintaining overall coverage.

In order to evaluate Hypothesis 6A, the Commonwealth's evaluator will compare expenditure growth rates for prescription drugs after the new purchasing strategies have been implemented to both historical growth rates and to projected expenditures in the absence of these new strategies, using historical experience and other states' experience as benchmarks to develop projected expenditures in the absence of these strategies. The evaluator will also conduct an assessment of drug classes affected by the closed formulary to confirm that members continue to have access to medically necessary prescription drugs.

In order to evaluate Hypothesis 6B, the change in MassHealth and commercial enrollment as percentages of the state's population during the waiver period (after the proposals are implemented) will be compared to the trends in these percentages prior to the waiver period (e.g., 2011-2017). MassHealth and secondary data sources will be relied upon for this analysis. Such data sources may include data sets and operational statistics from the U.S. Census, Massachusetts Center for Health Information and Analysis, the Massachusetts Health Insurance Survey, and MassHealth claims and encounter data.

The Commonwealth's recently submitted demonstration amendment requests to modify both provisional eligibility for adults and coverage of non-emergency medical transportation for MassHealth CarePlus members also support this goal.

Study Population

With the exception of the measure related to the statewide coverage rates, where the study population is residents of the Commonwealth, all waiver-eligible individuals will be

studied. There is no comparison population for this evaluation component, whose purpose is to determine whether coverage percentages for MassHealth and commercial insurance have changed.

Public Process

The public process for submitting this amendment conforms with the requirements of STC 15, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements as outlined in the Commonwealth's approved State Plan. In addition, the Commonwealth has implemented certain of the transparency and public notice requirements outlined in 42 CFR § 431.408, although the regulations are not specifically applicable to Demonstration Amendments. The Commonwealth is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Notice

The Commonwealth is releasing the Amendment for a thirty day public comment period starting on July 20, 2017 by posting the Amendment, the Budget Neutrality summary, and a Summary of the Amendment (including the instructions for submitting comments) on the MassHealth Innovations website (www.mass.gov/hhs/masshealth-innovations/1115waiver). Notice of the Amendment and the public comment period will also be published in the Boston Globe, the Worcester Gazette and Telegram, and the Springfield Republican on July 21, 2017.

In addition to making the Amendment and supporting documents available online, paper copies are available to pick up in person from the MassHealth Publications Unit, located in Quincy, Massachusetts.

Tribal Consultation

MassHealth will provide a summary of the Amendment through an email to all Tribal leaders or their designees and additional Tribal health contacts on July 20, 2017. The official Summary will include links to the documents and instructions for providing comment.

Public Meetings

The Commonwealth will host two public meetings in various regions of the Commonwealth to seek input regarding the Amendment. Both meetings will include a conference line available, as well as Communication Access Realtime Translation

services and American Sign Language (ASL) interpretation for individuals attending in person.

Listening session #1:
Date: Friday, August 4, 2017
Time: 9 a.m. – 11 a.m.
Location: 1 Ashburton Place, 21st Floor, Boston MA
Conference Line: 1-888-822-7517 Participant Code: 163 4530#

Listening session #2:
Date: August 16, 2017
Time: 10 a.m. – 12 p.m.
Location: Castle of Knights, 1599 Memorial Drive, Chicopee, MA
Conference Line: 1-888-822-7517 Participant Code: 163 4530#

Public Comments

MassHealth will consider comments received by August 21, 2017 for the final amendment that will be submitted to CMS.