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May 15, 2018

Chairwoman Karen E. Spilka
Senate Committee on Ways and Means
State House, Room 212
Boston, MA 02133

Chairman Jeffrey Sánchez
House Committee on Ways and Means
State House, Room 243
Boston, MA 02133

Dear Chairs Spilka and Sánchez:

Line Item 4000-0328 of the FY2017 budget appropriated $50,000 for the Executive Office of Health and Human Services (EOHHS) to pursue, enhance and submit applications for existing or new state plan amendments, state plan options, state waiver or demonstration requests, and federal grants for federal approval under the Patient Protection and Affordable Care Act, 42 U.S.C. 18001 et seq. In this report, EOHHS provides an update to the House and Senate Committees on Ways and Means on the status of submitted and pending applications.

I am grateful for your continued support of the MassHealth program. Please feel free to contact Monica Sawhney at monica.sawhney@state.ma.us if you have any questions about this report.

Sincerely,

Daniel Tsai
Assistant Secretary for MassHealth and Medicaid Director

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services

Report to Legislature on the Status of Applications for Enhanced Federal Funding

Update on Implementation of 1115 Waiver Extension Approval (2016)

Under MassHealth's 1115 Demonstration Waiver Extension, finalized on November 4, 2016, CMS approved a number of initiatives that significantly increase federal revenue for the Commonwealth, including implementation of a statewide accountable care organization (ACO) program in conjunction with a Delivery System Reform Incentive Payment (DSRIP) program, as well as expanded services for MassHealth members with substance use disorders (SUD) to addresses the state's opioid addiction epidemic. MassHealth has been working with providers, stakeholders, and our federal partners to launch all of these programs. Further details on these initiatives are provided below.

a) **Update on Accountable Care Organization and DSRIP implementation**

Beginning March 1, 2018, MassHeath implemented a major program restructuring through the launch of 17 Accountable Care Organizations (ACOs) that are currently serving approximately 825,000 members. Under this model, MassHealth is paying for health care based on value, not volume of service delivered. MassHealth's basic structure has been a predominantly fee-for-service payment model that leads to care that is too often fragmented and uncoordinated. ACOs, which are provider-led organizations, have accountability for the cost and quality of care. They are responsible for improving health outcomes and member experience through strong care coordination and integration of behavioral and physical health care. ACOs will also screen members for issues like housing and food insecurity, which greatly impact health outcomes, and connect them to social services.

ACOs will be financially accountable for metrics based on quality outcomes and member experience. These include direct member surveys to measure member experience and satisfaction in ACO models, as well as metrics in areas such as prevention and wellness; chronic disease management; behavioral health-related screening and treatment; helping members with disabilities remain living in the community; and ensuring appropriate follow-up care after a hospitalization.

MassHealth and its ACO and managed care organization (MCO) partners are committed to supporting members in choosing a health plan and providers that best meet their needs. Prior to the March 1st implementation date, MassHealth worked to ensure that all health plans exchanged important information, such as authorizations for services and prescriptions, for members who were changing plans, as well as identified members with complex conditions for special outreach. During a Continuity of Care period through May 31st, ACOs and MCOs are covering members' existing providers even if they are not in the plan's network and honoring authorizations for health care services from a member's prior plan, as need to ensure a smooth transition. MassHealth members also have until July 1, 2018, to change their health plan for any reason.

In addition, starting in July 2018, MassHealth will implement its new Community Partner (CP) program for Behavioral Health (BH) and Long Term Services and Supports (LTSS). The state has procured 27 CPs across the state, which are community-based providers with deep expertise in BH and LTSS. CPs will provide high touch wrap-around supports and care coordination for the most complex members. They will engage with complex members to keep them connected and supported in their care. For BH CPs, these include individuals with serious mental illness, addictions, or both (co-occurring conditions). For LTSS CPs, these include individuals with disabilities requiring a complex set of long term services and supports that span both medical and/ or hands-on care for activities of daily living. ACOs are required to partner with CPs.

Restructuring with ACOs and Community Partners is a major component of the state's five-year innovative 1115 Medicaid waiver, bringing in $1.8 billion in new federal funds, in the form of DSRIP, over five years. Community Partners will receive $550 million in DSRIP funding over five years ($401 million of which are for BH CPs). Much of the remainder of DSRIP is allocated for ACOs for developing infrastructure and supporting care coordination and care management. A portion of the funding is also set aside for strengthening the primary care and behavioral health workforces through statewide investments (for example, loan forgiveness and additional family medicine residency slots in community health centers, and increased statewide training capacity for frontline healthcare workers such as community health workers and behavioral health peer specialists).

b) Update on Substance Use Disorder Waiver Implementation

This key component of the MassHealth 1115 Waiver addresses the state's opioid addiction epidemic with expanded services for MassHealth members with substance use disorders (SUD). In conjunction with the Department of Public Health, MassHealth is implementing a more comprehensive array of outpatient, residential inpatient, and community SUD services to promote treatment and recovery, including for individuals with co-occurring mental health and addictions disorders. All full-benefit MassHealth members will be eligible to receive expanded SUD services, regardless of the delivery system through which they receive care.

In total, the SUD Waiver will enable investments of $219 million over five years, including $30 million in FY19, to expand treatment for SUD. The majority of this funding will be used to expand the number of residential recovery beds by 500 over the course of five years, with a specific emphasis on new beds that will have the sufficient clinical supports for individuals with both substance abuse and mental health needs. In addition, we are expanding access to recovery coaches, recovery support navigators, and Medication Assisted Treatment for SUD.

1115 Demonstration Amendment Request (2017)

In September 2017, MassHealth submitted to CMS a request to amend its 1115 demonstration. This proposal builds on MassHealth's current restructuring efforts, requesting additional federal flexibility for further reforms in MassHealth and the commercial insurance market that will support long-term fiscal

sustainability. Major components of this request that would increase federal revenue and/or result in significant cost savings include:

- The ability to adopt widely-used commercial tools to obtain lower prescription drug prices and enhanced rebates;
- The transition of coverage for non-disabled adults with incomes over 100 percent of the federal poverty level (FPL) to comparable coverage through the Health Connector; and
- A waiver of all federal payments restrictions on care provided in Institutions for Mental Disease (IMDs).

In response to feedback received from stakeholders, MassHealth made several updates to the final proposal that was submitted to CMS. MassHealth remains committed to reforming the program 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, while also putting the program on a more sustainable fiscal trajectory.

a) **Adoption of 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. As a result, in addition to using all currently available tools to manage the rapid growth of drug costs, MassHealth's updated waiver proposal includes a request to exclude drugs from its formulary in certain specific circumstances, as well the ability to procure a selective and more cost effective specialty pharmacy network.

If approved, MassHealth would exclude drugs from its formulary only if MassHealth is unable to reach agreement after direct negotiations with the manufacturer on a cost-effective price after federal rebates, and after the state has undergone a transparency process with disclosures from the manufacturer of cost information. MassHealth would not be able to exclude a drug unless it is also excluded by either the Commonwealth's state employee plan (GIC) or at least one national pharmacy benefits manager with more than 10 million lives. There would also be strict guardrails, strong member protections, and a public notice period as part of this process. This proposal focuses on increasing MassHealth's negotiating leverage specifically for new-to-market therapies that have limited competition and for which the existing tools are not sufficient to achieve cost effective prices.

The Governor has proposed parallel state legislation that would a) allow MassHealth to negotiate directly with manufacturers and require transparency disclosures if a cost effective price is not reached, and b) allow MassHealth to exclude a drug from its formulary if the process described in (a) is unsuccessful, subject to all the limitations noted above.

Additionally, the use of selective specialty pharmacy networks has become standard practice for commercial health plans, including MassHealth managed care organizations. However, without this waiver MassHealth is currently unable to procure a selective network for specialty pharmacy for members in its PCC Plan and through fee-for-service. 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. The procurement for this network would ensure appropriate safeguards for members to ensure that they can continue to access prescription drugs without delay and that populations who require specialized services are appropriately served.

b) Maximizing federal revenue for coverage of non-disabled adults

The Waiver amendment request includes a proposal to transition coverage for non-disabled adults with incomes 100%-138% of the federal poverty level (FPL) from MassHealth to comprehensive, affordable and comparable coverage through the Health Connector. The proposed shift, effective January 1, 2019, allows the Commonwealth to maximize federal subsidies and generate significant revenue while maintaining access to high quality, comprehensive and affordable coverage for members, comparable to what they currently receive through MassHealth.

The Baker administration is committed to health care access and coverage. The proposal maximizes federal revenues and subsidies while preserving comparable coverage and cost sharing for the transitioning population and enhancing coverage for current ConnectorCare enrollees. The increase in federal subsidies is expected to result in $120M in net value to the Commonwealth annually ($60M in FY19).

Importantly, the proposal was updated last September, based on input from stakeholders, to strengthen the coverage available through the Health Connector for this population. Cost sharing for members with incomes 100-138% FPL would be reduced to mirror MassHealth's current cost sharing schedule. In addition, dental coverage would be added for all ConnectorCare members from 0-138% FPL. This would not only maintain dental coverage for members transitioning from MassHealth; it would also newly add dental coverage for 30,000 existing ConnectorCare enrollees. Other covered benefits on the Connector are already comparable to MassHealth coverage, and ConnectorCare plans offer at least one $0 premium plan option and $0 deductibles for all plans.

The Governor also included this proposal in his FY19 budget for the legislature's consideration.

c) Waiving federal payments restrictions on care provided in Institutions for Mental Disease

MassHealth has requested a waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64. This proposal would bolster Massachusetts' ability to confront the opioid crisis and to strengthen the Commonwealth's mental health and substance use treatment systems. While MassHealth can claim federal financial participation

(FFP) for any services approved as part of the SUD Waiver and provided in an IMD, and for up to 15 days in a month through managed care, this waiver would allow MassHealth to claim FFP for all IMD services, including those provided for psychiatric care on a fee-for-service basis.

In Massachusetts, a large share 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. The flexibility requested in this proposal would 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-occurring. It would also open up federal matching funds to support this care for MassHealth members.

Medicaid State Plan Updates

In calendar year 2017, MassHealth submitted 22 State Plan Amendments (SPAs), 17 of which have already been approved by CMS as of April 30, 2018. In calendar year 2018 (as of April 30, 2018), MassHealth has submitted 11 SPAs, one of which has been approved already. Approved amendments updated the payment methodologies for out of state and in state inpatient and outpatient chronic disease and rehabilitation hospitals, nursing facilities, acute inpatient and outpatient hospitals, psychiatric hospitals, clinics, limited services clinics, home health providers, physician and midlevel providers, personal care attendants, and outpatient prescription drugs. Other approved amendments updated the services available under limited services clinics and under the physician and midlevel providers programs. Amendments were also approved to update the benchmark plan used to set benefits for the Alternative Benefit Plans provided to members eligible under the Affordable Care Act's Medicaid expansion.

An additional 12 SPAs submitted prior to 2017 were also approved during 2017 for a total of 23 SPA approvals during the year. The approved amendments include an update to the payment methodology for hemophilia clotting factor medication that had been pending since 2009. Additionally, amendments were approved that expand the services available under the School Based Medicaid program and that allow MassHealth to cover certain brand name drugs over their generic equivalent drugs when more economical.

Pending SPAs include amendments to the language regarding targeted case management services, an amendment to the Student Health Insurance premium assistance program to remove the sunset date, and updates to the payment methodologies for private psychiatric inpatient hospitals, chronic disease and rehab hospitals, restorative and hearing services, and dental services.