



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, Massachusetts 02108



CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

DANIEL TSAI
Assistant Secretary for
MassHealth

Tel: (617) 573-1600
Fax: (617) 573-1891
www.mass.gov/eohhs

Testimony of Daniel Tsai, Assistant Secretary for MassHealth and Medicaid Director
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Good morning, Chairs and other distinguished members of the Joint Committee on Ways and Means. Thank you for the opportunity to come before you to discuss the MassHealth program and Governor Baker's Fiscal Year 2020 budget proposal.

The Baker administration is committed to a strong and sustainable MassHealth program that robustly meets the needs of the 1.86 million people (or 27% of residents) covered by the program.

We have made significant progress towards making MassHealth sustainable while maintaining coverage, access and benefits for the population we serve. We have reduced annual spending growth from historical double-digits (12.5% in FY15) to single digits by more efficiently managing the program, fixing our eligibility systems, implementing new measures to strengthen program integrity and recoup payments in instances of fraud or abuse, and embarking on the most significant restructuring of the program in twenty years. The FY 20 budget reflects a continuation of these sustainability initiatives, with a low growth rate of 0.1% gross and 4.3% net over FY 19.

In this testimony I will discuss five specific elements of the FY 20 budget: (1) the expansion of MSP eligibility to make health care more affordable for seniors (2) a proposal to manage high-cost drug spending in the MassHealth program (3) an update on MassHealth investments to promote nursing facility sustainability (4) an update and overview of the MassHealth restructuring with the ACO and Community Partners programs, and (5) reforms to behavioral health care.



MassHealth Overview

MassHealth offers essential health care coverage to approximately 1.86 million people or 27% of the Commonwealth's residents, including some of our most vulnerable citizens. Thirty-six percent of MassHealth members are non-disabled children, 39% are low-income non-disabled adults, and 26% are people with disabilities and/or seniors. MassHealth also covers a range of long-term services and supports not covered by commercial insurance or Medicare. These include nursing home care, community long-term services and supports, transportation to medical appointments, specialized behavioral health and other services for unique populations that private insurers often do not reach. In addition, we are also the "coverage of last resort" for about 440,000 individuals who have other insurance. MassHealth generates over \$10 billion of federal revenue per year and accounts for over 75% of the total federal revenue that comes into the state. Nearly all MassHealth spending qualifies for a federal match.

H.1 FY 20 Highlights

The Governor's proposed FY 20 budget funds MassHealth programmatic accounts at \$16.539 billion gross, \$6.586 billion net, an increase of 0.1% gross, 4.3% net over FY 19 estimated spending. The FY 20 budget assumes the pre-payment of \$222 million in expenses in FY 19 to manage some revenue cliffs facing MassHealth in FY 20, including the expiration of the Supplemental Employer Medical Assistance Contribution (\$226 million in FY 20), otherwise known as EMAC, and a reduction to the federal match rate for CHIP (\$54 million in FY 20, growing to \$110 million in FY 21). This pre-payment allows MassHealth to mitigate the impacts of the fiscal cliff, which would otherwise have resulted in an H.1 budget with a 2.8% gross, 7.6% net increase. In addition, the budget includes \$646 million in supplemental payments for hospitals funded by the Medical Assistance and Safety Net Provider Trust Funds, excluding intergovernmental transfers.

The FY 20 budget reflects significant continued efforts to ensure a sustainable MassHealth program without impacting eligibility or benefits. The budget forecasts 0.6% caseload growth from June 2019 to June 2020, a growth rate below historical trends due to major eligibility system improvements and program integrity initiatives. MassHealth will continue our commitment to program integrity in FY 20 by pursuing \$50 million in new solutions; these do not impact eligibility, benefits, or rates.

H.1 further maintains MassHealth program sustainability by including limited rate increases in addition to targeted investments and required spending increases. ACO and Managed Care Organization capitation rates will increase by approximately 2%, under the HPC benchmark, to account for growing utilization and population health needs. The FY 20 budget maintains and builds upon the Baker-Polito Administration's commitment to improving access for behavioral health, including the continuation of a

\$200 million investment over 5 years through MassHealth's Substance Use Disorder waiver, a \$60 million investment in Applied Behavioral Analysis (ABA) services for children on the Autism Spectrum Disorder (ASD), and a \$50 million net increase in Community Health Center (CHC) rates over 5 years (\$10 million per year) – a significant portion of which enhances rates for psychiatry services. Other areas of significant targeted investment include \$12 million per year for the restoration of certain dental services and \$25 million in rate increases for nursing facilities, one of the largest rate increases for nursing facilities in recent years.

Reducing Health Care Costs for Low Income Seniors: Medicare Savings Program Expansion

Currently, 1 in 3 low-income seniors in Massachusetts spend more than 20% of their income on health care. The Medicare Savings Program (MSP), jointly run by the federal and state governments, helps low-income elders pay for their health care costs. Under the MSP, MassHealth and the federal government share the cost of assisting elders with premiums and out-of-pocket costs in Medicare Parts A and B, which cover hospital and medical services. The FY 20 budget proposes to expand MSP income eligibility from 135% FPL to 165% FPL and to double the asset limit. With a new state investment of \$7 million net annually, \$4 million net in FY 20, this expansion will allow MassHealth to bring in more than \$100 million in federal subsidies that will go directly to approximately 40,000 low income seniors to significantly reduce their health care costs.

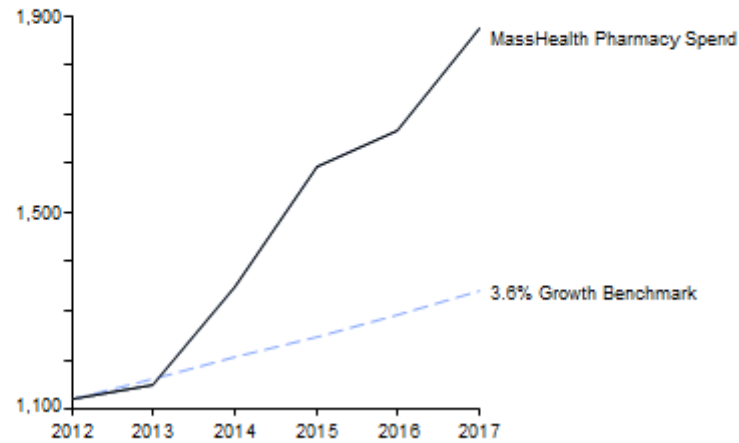
Of the approximately 40,000 elders that will benefit from the expansion, 25,000 elders will be newly eligible for Medicare Part D federal subsidies, drastically reducing their annual out-of-pocket prescription drug costs, in addition to receiving MassHealth support for the Medicare premiums and/or cost sharing. Another 15,000 elders currently with MSP will receive additional support for their Medicare premiums and/or cost sharing. For example, a 79 year old with \$17,000 in social security income per year could see a drop in annual out-of-pocket health care costs from approximately \$6,000 to \$600, or from 36% to 3% of their income. In this manner, the proposed MSP eligibility expansion will significantly reduce health care costs for low-income seniors, and aligns Massachusetts policy with recommendations from the Governor's Council to Address Aging in Massachusetts.

Managing High-Cost Drug Spending in Medicaid: Prescription Drug Pricing Proposal

Drug spending is growing faster than all other categories of MassHealth spending and is one of the largest contributors to overall program growth. MassHealth prescription drug spending has nearly doubled from \$1.1 billion to \$1.9 billion over five years. Some have said MassHealth costs are growing only because enrollment is rising. In truth, enrollment has declined since 2015, while drug spending has risen by \$260 million over that time. The primary driver of drug cost growth on an aggregate and per member basis is high-cost drugs, at times costing \$1 million per course of treatment.

MassHealth Rx spending has nearly doubled over 5 years

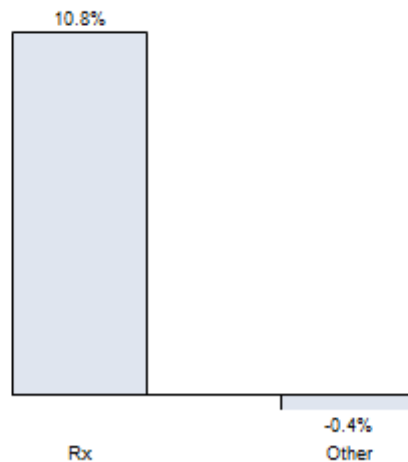
MassHealth pharmacy spend
\$ Millions



In fact, between 2016 and 2017 drug spending on a per member basis grew by 10.8% while all other MassHealth spending combined shrank by 0.4%. In other words, high-cost prescription drug spending consumed the majority of all new spending and investments in the MassHealth program, leaving little to no room for investments in all the other critical services and benefits for the 1.86 million members we serve.

Pharmacy spend is growing much faster than other categories of MassHealth spending

Average PMPM (per member per month) Spend growth FY16-FY17



Competition in the market works to drive down drug costs. For example, MassHealth leveraged competition in the Hepatitis C drug market to negotiate significant supplemental rebates with manufacturers, reducing per member spend by 75% over four years. However, new high-cost drugs are increasingly the only drugs in their classes. Without competition to motivate manufactures to come to the table, MassHealth is in effect left as a price taker. We do not have the tools to manage drug costs. The Baker-Polito FY 20 budget contains a Prescription Drug Pricing Proposal that would strengthen the tools available for MassHealth to manage drug spending growth without any limitation on member access or exclusion of drugs.

This proposal would allow MassHealth to directly negotiate payment arrangements with drug manufacturers and establish target drug values through a public process, similar to the rate-setting process that exists for most other MassHealth services. If negotiations are unsuccessful, MassHealth may refer a manufacturer to the Health Policy Commission (HPC) to publically justify their prices, and if the HPC determines the price is unreasonable, it may refer the case to the Attorney General's Office for investigation under state consumer protection laws. This proposal builds upon the process established in the well-vetted 2012 cost containment legislation by extending HPC oversight to drug manufacturers.

Some will say that MassHealth should be looking at Pharmacy Benefit Manager (PBM) margins. Indeed, through a second component of the proposal that does not require legislative authority, MassHealth will increase PBM transparency and limit PBM margins and "spread pricing" using contractual tools with our managed care entities. In addition, it is important to keep in mind that unlike other states, MassHealth does not use PBMs for more than half of our pharmacy program, so a substantial portion of the program is already protected from any potential impacts of PBM margins.

Stabilizing the Nursing Facility Industry

The nursing home industry is facing challenges driven by consumer preferences in the long term care industry. Many older adults and individuals with disabilities want to receive care in their home and community instead of in nursing homes. Indeed, the number of MassHealth members being served in non-institutional settings is growing while the number being served in nursing homes is shrinking. As a result, almost one in four nursing homes has an occupancy rate under 80%, while the average occupancy rate is 86%.

Low occupancy poses a financial challenge to nursing facilities, as occupancy correlates to payment both from Medicare and MassHealth. The nursing home industry is facing further financial challenges due to changes in federal Medicare policy. Medicare policy has decreased the utilization of nursing homes by 25% and decreased funding by \$300 million since 2011. Additional Medicare reimbursement changes will become effective in October 2019.

Despite the declining number of members residing in nursing homes, MassHealth has invested in short-term stabilization strategies. For example, MassHealth increased our total nursing home expenditure from 2015-17 by 1.4% even as the number of MassHealth members in nursing homes decreased by 3.2%. Despite what some have claimed, MassHealth payments to nursing homes are equivalent to rebasing rates to 2015 cost report data, not 2007 cost report data.

Nursing homes remain a component of long-term care services offered to MassHealth members, and the Baker-Polito Administration has put forth a plan to provide a path towards sustainability. Working with the industry, in October 2018, MassHealth added \$25 million more in annualized funding to support short-term stabilization and maintained 38.3 million in funding for direct care workers. Meanwhile, EOHHS has engaged stakeholders to initiate a year-long effort to develop long-term reforms to the nursing home industry. The current structure of the nursing home industry is not sustainable. Long term reforms are required to solve these challenges; increased MassHealth funding alone is not enough.

MassHealth restructuring overview: ACO and Community Partners implementation

MassHealth's ACO program is the most significant restructuring of MassHealth since the 1990s. This multi-year effort is focused on reshaping and improving how health care is delivered for MassHealth members, allowing MassHealth to pay for health care based on value, not on the volume of services delivered. The ACO restructuring seeks to address four key goals identified through over two years of stakeholder engagement: 1) Materially improve member experience 2) Strengthen the relationship between members and primary care providers 3) Transition to accountable care that measures and pays providers based on quality, cost and member experience and 4) Integrate behavioral health, long term supports and services, and social services with physical health.

We made meaningful progress towards these goals in FY 19, launching 17 ACOs in March 2018 and 27 Community Partners in July 2018. As a reminder, ACOs are provider-led organizations that are accountable for the cost and quality of care. Community Partners are community-based providers with behavioral health and long term services and supports expertise that provide wrap-around supports and care coordination for the most complex members.

Transitioning members into ACOs went as planned due to the dedicated focus on continuity of care, including an extended continuity of care period. Over 850,000 MassHealth members are now enrolled in an ACO and enrollments across plans have been stable. ACOs have so far invested \$350 million in team-based, integrated care (e.g. staffing models that co-locate psychiatrists and social workers in primary care). Community Partners are working to engage and support high-touch care management for 45,000 members with complex behavioral and long term care needs, and community workers have successfully reached over 10,000 of these members to-date. We are just eight months into the full ACO

and Community Partners programs (March –June 2018 were focused on continuity of care for members) and expect to release data on Year 1 member experience, quality and cost at the end of 2019.

Looking toward FY 20, we will focus on four priority areas:

- First, integrate and strengthen team-based care, including for those with addiction and mental illness. This includes ACOs investing \$250 million in staffing and infrastructure to support member-centered, team-based, data-drive, outcomes-oriented care; launching a member experience survey to hold ACOs accountable for member experience; continuing to roll out investments for student loan repayments for primary care and behavioral health clinicians and for new residency programs offered at safety net providers.
- Second, engage and improve care for 45,000 members with complex clinical and social needs through the Community Partners program and through standing up a Flexible Services program that allows ACOs to help with housing and nutrition supports.
- Third, improve data and operational supports for ACOs and providers (e.g. continuing to build MassHealth data feed capabilities to help ACOs more quickly understand their performance and population).
- Finally, we will focus on executing day-to-day oversight of ACOs, including overseeing ACO compliance, enrollments and customer service.

Improving Behavioral Health

The Baker-Polito Administration has focused on improving behavioral health, which refers to mental health, addictions, and co-occurring mental health and addiction disorders. To this end, the Administration will have invested a total of \$1.9 billion across agencies through FY 22 to improve the access and availability of behavioral health services. This includes investing \$400 million over five years in Behavioral Health Community Partners to help link members to the behavioral health services they need, and expanding treatment for substance use disorder (SUD) by \$219 million over five years (\$50 million in FY 20) through MassHealth's federal 1115 waiver. With this SUD funding to-date, MassHealth has contracted with nine providers to launch roughly 130 new residential rehabilitation services beds in early 2019; 51 MassHealth providers have contracted to provide Recovery Coach and/or Recovery Support Navigator services; and MassHealth has launched a remote consultation system to support primary care providers with questions about administering Medication-Assisted Treatment or managing chronic pain.

Additionally, effective January 1, 2019, MassHealth introduced telehealth coverage for outpatient and emergency behavioral health services for all 1.86 million MassHealth members. Tele-behavioral health coverage provides new flexibility for MassHealth providers and allows members to remotely access the

expertise of providers across the Commonwealth in real time, enhancing access to timely and appropriate behavioral health services. MassHealth anticipates spending approximately \$3-4M on tele-behavioral health services in FY 20.

While this Administration has made some important investments to address the immediate issues with behavioral health care, these are not sufficient to address longstanding systemic barriers to accessing care. Ambulatory and outpatient behavioral health care is still fragmented and often insufficient to meet the needs of patients and their families. We can and must do better for the individuals and family members with addictions, mental illness, and co-occurring disorders. To this end, EOHHS is embarking on a significant effort to design the way that ambulatory behavioral health care is delivered in the Commonwealth- to create a system of care that presents a no-wrong-door point of entry with same-day access for patients, integrates addiction and mental health services, provides truly community-based crisis response, meets the unique needs of children and youth, and upholds consistent evidence-based standards. This EOHHS effort will be undertaken as a collaboration between MassHealth, the Department of Mental Health, the Department of Public Health, the Department of Children & Families, and the Department of Youth Services, who will work to align payments and policies to streamline licensure, credentialing and regulations. Over the next year, we will engage closely with stakeholders – including consumers and advocates, providers, plans and other experts – on the design and implementation plan for this redesign.

Thank you for holding this hearing, and thank you for your continued support for the MassHealth program. I have appreciated the opportunity to talk with many of you individually about our efforts to strengthen the MassHealth program, and I look forward to a continuing dialogue with you about this budget proposal as the process moves forward.