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

SECTION 1115 WAIVER AMENDMENT

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Section 1 Context for Health Care Reform in Massachusetts

On April 12, 2006, Governor Mitt Romney signed landmark legislation designed to provide access to affordable health insurance coverage to all Massachusetts residents. The legislation, Chapter 58 of the Acts of 2006, titled *An Act Providing Access to Affordable, Quality, Accountable Health Care* (Act), builds upon the MassHealth Section 1115 Demonstration Project extension negotiated between Governor Romney and federal officials and approved by the Centers for Medicare and Medicaid Services (CMS) on January 26, 2005. The Act accomplishes several key goals of the demonstration extension, including improving the fiscal integrity of the MassHealth program, directing more federal and state health care dollars to individuals and less to institutions, and subsidizing the purchase of private insurance for low-income individuals to reduce substantially the number of uninsured in the Commonwealth. The Act is included in this document as Attachment A.

The timing was ripe for comprehensive health care reform in Massachusetts. Despite Massachusetts' significant investment in its health care system and relatively low rate of uninsurance—roughly 8% compared to 15% nationally—policy makers were becoming increasingly frustrated with the steadily rising number of uninsured, the untamed health care inflation, and the inefficiencies, lack of accountability and perverse financial incentives inherent in the structure of the state's Uncompensated Care Pool.

With approximately 500,000 uninsured state residents (up from 420,000 in 2002), Massachusetts has one of the lowest rates of uninsurance in the country due to generous employer-based coverage and a significant expansion of its Medicaid program (called MassHealth) in the late 1990s. In 2005, 70% of employers in the state subsidize health insurance for their workers while MassHealth has over 1,030,000 members as of March 2006. However, double-digit annual increases in health insurance premiums have made it increasingly difficult for employers, particularly small employers, to continue to offer health insurance benefits to their employees. These factors created an environment that made comprehensive health care reform a necessary, but attainable, goal.

The structure of the state's uncompensated care pool exacerbated the need for reform. Dollars in the $700 million uncompensated care pool primarily flow to hospitals for the costs of caring for the uninsured. The charge-based pool payments result in some hospitals receiving higher reimbursements from the uncompensated care pool than MassHealth, creating a financial disincentive to aggressively screen patients for MassHealth eligibility. This incentive structure resulted in a system that encouraged uninsurance and escalated costs of uncompensated care. Additionally, costs of the uninsured were shifted to the insured as the costs of providing uncompensated care passed from providers to insurers to employers to insured individuals. State leaders recognized a need to shift the public financial investment in health care from supporting uncompensated care to supporting an insurance-based model of care. Experience has shown that an insurance-based model of care rationalizes costs across the system and

provides access to health care in lower-cost settings that focus on preventive care, quality care, and chronic disease management.

In Massachusetts, bipartisan desire, strong and unwavering leadership, and unique funding opportunities combined to make comprehensive health care reform possible. The effort is a remarkable achievement of collaboration, negotiation and compromise among and between state and federal officials. The result entails using federal and state health care dollars in an innovative way through a public-private partnership to expand affordable health insurance to all state residents, and recognition that everyone must contribute to be successful. The Act reforms health care by modernizing health insurance laws, removing barriers to purchasing private insurance, redirecting government assistance from hospitals to individuals, increasing transparency in cost and quality, and demanding greater responsibility from all participants in the system.

The opportunity to extend the Commonwealth's MassHealth Section 1115 Demonstration Project provided the mechanism through which the state could transform its health care system. As described below, while only a portion of the Act is tied to the 1115 waiver authority, each aspect of the legislation is interrelated and integral to achieving comprehensive reform and expanded coverage.

Section 2 The Role of the MassHealth Section 1115 Demonstration Project

Massachusetts' 1115 Demonstration Project was implemented in July 1997. The initial waiver period ran from State Fiscal Year (SFY) 1998 to SFY 2002 and mandated enrollment in managed care for most of Medicaid's non-institutionalized members under the age of 65. In addition, the waiver streamlined Medicaid eligibility by eliminating face-to-face interviews, shortening the Medicaid application and eliminating asset test requirements, and expanded Medicaid eligibility for certain populations, including pregnant women and infants, disabled individuals, and unemployed adults. The waiver also created the Insurance Partnership program, which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance. MassHealth also incorporated uninsured children at or below 200% of the federal poverty level (FPL) who were made eligible for federally funded health insurance coverage through the State Children's Health Insurance program (SCHIP), which was created by the Balanced Budget Act of 1997.

As part of mandating managed care, the MassHealth waiver included a unique feature designed to ensure access to care for Medicaid enrollees and the financial viability of two important safety net providers in the state during the transition from a fee-for-service to managed care delivery system. Through the waiver, the state was authorized to make supplemental rate payments to two new hospital-based Medicaid managed care organizations (MMCOs) operated through the Boston Public Health Commission (BPHC) and the Cambridge Public Health Commission (CPHC). Boston Medical Center[1]

[1] Formerly Boston City Hospital.

and Cambridge Hospital, the affiliated hospitals, historically served a disproportionate share of Medicaid and uninsured residents.

To encourage development of these MMCOs, CMS waived for Massachusetts the federal upper payment limit (UPL) for managed care organizations (MCO) for BPHC's HealthNet Plan and CPHC's Network Health. This allowed for enrollment-based MCO supplemental payments. Secondly, CMS authorized the use of intergovernmental transfers (IGTs) from BPHC and CPHC in lieu of state general fund appropriations in order for the state to finance the non-federal share of the MCO supplemental payments. The MCO supplemental payments enabled these two entities to develop and sustain viable managed care plans to serve MassHealth enrollees. The MassHealth waiver was renewed in 2001 under its original special terms and conditions (STCs), including continuation of the waiver of the UPL for HealthNet and Network Health, for the three-year period of SFYs 2002-2005.

In June 2004, the state submitted a waiver extension proposal to CMS to continue to operate the MassHealth Demonstration Project through SFY 2008. Negotiations between state officials and CMS focused on a few key areas of concern to CMS, including the MCO supplemental payments and, pursuant to CMS's nationwide review of IGTs, the source of the non-federal share of those payments. By the end of SFY 2005, supplemental payments to the two MCOs reached a total of $770 million—$385 million in federal funds and $385 million in IGTs. CMS predicated waiver renewal on two key points: 1) payments to MMCOs must conform to the Balanced Budget Act of 1997's Medicaid managed care regulations, which replaced the UPL as a payment limit with actuarially sound rates; and 2) the Commonwealth must terminate all then-existing IGT funding mechanisms.

To address CMS's concerns and preserve the federal support previously committed to the system, Governor Romney proposed the idea of redirecting federal and state funds from providers of uncompensated care to individuals in an insurance-based health care system. In this way, the state would be able to preserve the $385 million in federal funds at risk because of the change in federal MCO reimbursement requirements, and state and federal dollars would be invested in a health care system with more efficiency, accountability, and transparency. To limit federal financial exposure, CMS agreed to create a capped Safety Net Care Pool, included under the 1115 waiver's total budget neutrality ceiling, dedicated to reducing the number of uninsured state residents. Matchable expenditures under the Safety Net Care Pool are capped at $1.34 billion annually. This figure is derived from SFY 2005 MCO supplemental payment amount ($770 million) and the state's annual aggregate disproportionate share hospital (DSH) limit ($574.5 million in FFY 2005). Working with CMS, the Commonwealth has identified $385 million in existing state general fund health expenditures that are not otherwise matched with federal funds (i.e., costs not otherwise matchable or CNOM) to replace the disallowed IGTs. The MassHealth waiver extension was approved by CMS on January 26, 2005. The framework for Massachusetts' Safety Net Care Pool is outlined in the STCs in Attachment B, Section 6.

The Act provides details to the waiver's framework by prescribing key program features and implementation steps for the Safety Net Care Program, but also makes broader reforms to the overall health care system. Neither the waiver STCs nor the Act totally ends the free care system in Massachusetts, but both contemplate a success-based model with a glide path toward insurance. As the number of people with insurance grows, the amount of money flowing directly to providers for uncompensated care is projected to decline.

Section 3 Key Elements of Health Care Reform

3.1 Individual Responsibility [Sections 12 and 13 of Chapter 58 of the Acts of 2006]

As of July 1, 2007, residents of the Commonwealth age 18 and over are required to have creditable health insurance coverage (with no lapse in coverage for more than 63 days). Individuals will be required to indicate on their individual tax return whether they have creditable coverage either individually or as a named beneficiary, whether they are claiming an exemption from the requirement for religious reasons, or whether they have a certificate issued by the Commonwealth Health Insurance Connector (see Section 3.3) indicating that no health insurance offered through the Connector was deemed to be affordable for that individual. Individuals who fail to indicate whether they have creditable coverage or are exempt, or who indicate that they do not have creditable coverage will lose their personal tax exemption if they file individually or one-half of the personal tax exemption if they file jointly. Individuals will be able to dispute the application of the mandate or the affordability of coverage through an appeals process established by the Connector. Beginning January 1, 2008, individuals must indicate on their tax returns whether they had creditable coverage in force for each of the 12 months of the taxable year for which the return is filed. Tax penalties will be imposed on individuals who fail to indicate that they have creditable coverage or are exempt, or who indicate that they do not. Fines received will be deposited into the Commonwealth Care Trust Fund (see Section 3.4).

3.2 Insurance market reforms [Sections 48-100 of Chapter 58 of the Acts of 2006]

The health insurance market in Massachusetts has several barriers that make it difficult for small employers and individuals, particularly part-time workers, contractors, workers with multiple jobs, and sole proprietors, to purchase affordable health insurance. Individuals face a choice of two expensive products, while small employers face prohibitive minimum participation and contribution requirements before insurers will do business with them. To level the playing field, the Act merges the non-group and small-group insurance markets, thereby pooling risk and creating more affordable choices for individuals and small employers seeking to buy health insurance. The Act also creates insurance products for young adults ages 19-26 with more flexible benefit packages, and extends dependent coverage through age 25 (or two years following the loss of dependent status under the Internal Revenue Code, whichever occurs first). The reforms create more flexibility in the market by permitting deductible levels consistent with federal Health Savings Accounts (HSA) laws, permitting co-insurance, and updating preferred provider

network and health maintenance organization laws to permit value-driven, tiered provider networks. The Act also imposes a moratorium on new mandated benefit legislation until at least January 1, 2008. Finally, the Act requires employers with more than 10 full-time employees to create "cafeteria plans", as authorized by Section 125 of the Internal Revenue Code (26 U.S.C. §125), enabling employees to use pre-tax dollars to pay health insurance premiums.

3.3 Commonwealth Health Insurance Connector Authority [Section 101 of Chapter 58 of the Acts of 2006]

The Act creates an independent public authority called the Connector to administer the Commonwealth Care Health Insurance Program (see Section 3.4) and facilitate the purchase of health insurance plans that meet quality and other standards set by the Connector's board. The Connector will have a board consisting of 11 members, including the Medicaid Director. Non-working individuals, employees of large employers who do not have access to employer-sponsored insurance, and employees of small employers (defined as those with 50 employees or less) can purchase plans through the Connector. Through the Connector, non-traditional workers, such as part-time and seasonal workers, contractors, sole-proprietors, and those with multiple jobs, will be able to purchase portable health insurance coverage that goes with them from job to job. Additionally, for workers with multiple jobs, the Connector can aggregate contributions from multiple employers. Through the Connector, small businesses will be able to offer a choice of affordable products to their employees, with the ability for employees to use pre-tax dollars for their share of the premium.

The Connector will determine the premium assistance subsidy levels for Commonwealth Care Health Insurance Program enrollees and will remit the premium assistance payments, along with the insured individual's portion of the premium payment, to the health plans offering the coverage beginning October 1, 2006. The legislative language creating the Connector reflects the expectation that there be significant involvement and agreement with MassHealth in developing and implementing the eligibility process for the Commonwealth Care Health Insurance Program.

3.4 Commonwealth Care Health Insurance Program [Section 45 of Chapter 58 of the Acts of 2006]

One of the most innovative features of the Act is a private insurance-based premium assistance program for currently uninsured individuals at or below 300% FPL who are not eligible for MassHealth (Medicaid or SCHIP) or Medicare. The Connector in consultation with the Office of Medicaid will administer the Commonwealth Care program. Commonwealth Care premium assistance payments will be expended from the Commonwealth Care Trust Fund [Section 8 of Chapter 58 of the Acts of 2006] and will be eligible for federal financial participation (FFP) from the Safety Net Care Pool created by the 1115 waiver (see Section 5).

Any individual with household income at or below 300% FPL who is a resident of the Commonwealth for at least six months prior to application is eligible for the premium

assistance program. In addition, the individual's employer must not have provided health insurance coverage for which the individual is eligible in the previous six months *and* for which the employer contributed at least 20% of the annual premium for family coverage or 33% of the annual premium for individual coverage. Finally, the individual must not have accepted any financial incentive from the employer to decline the employer's subsidized coverage. Eligibility determinations for Commonwealth Care will be determined in coordination with and using MassHealth eligibility determination procedures, including use of the Commonwealth's on-line application system called the Virtual Gateway. Applicants for and enrollees in the program are entitled to various consumer protections, including notice and appeals rights. Anti-discrimination provisions in the Act require an employer who offers subsidized insurance to make an equal contribution to all employees regardless of income. This key protection is designed to prevent crowd-out by preventing employers from dumping low-income employees into the Commonwealth Care Health Insurance Program. Initial enrollment in the program is expected to begin on October 1, 2006, with a three-month open enrollment period beginning on March 1, 2007 in anticipation of the July 1, 2007 start date of the individual insurance requirement.

Private health insurance plans will sponsor the Commonwealth Care products. To ease the transition to a competitive, insurance-based system for the state's safety net providers, the products will be offered for the first three years of the program exclusively by the Medicaid managed care organizations participating in the MassHealth program as of July 1, 2006 [see Section 123 of Chapter 58 of the Acts of 2006]. These include two commercial plans (Fallon and Neighborhood Health Plan) and two Medicaid-only plans (HealthNet and Network Health). Market exclusivity, however, is tied to meeting enrollment benchmarks, which if not met could open the market to other private plans. Market exclusivity for the first three years is maintained if total enrollment among all Medicaid managed care organizations is at least 40,000 as of June 30, 2007 (or 12 months after the program is implemented, whichever is later) and 80,000 as of June 30, 2008 (or 24 months after the program is implemented, whichever is later).

Health plans will offer the Commonwealth Care products through the Connector and the Connector will make the sliding scale premium contribution payments, along with the insured individual's portion of the premium payment, directly to the health plans. The Board of the Connector will annually develop a sliding scale premium schedule in consultation with the Office of Medicaid and the Connector will collect premiums from individuals. Total premiums for Commonwealth Care products are yet to be determined, but are expected to be roughly $300 per month with no deductibles. As noted earlier, funding for the premium assistance will come from the Commonwealth Care Trust Fund, and if funds are insufficient, enrollment in the program can be capped. There will be a comprehensive and extensive outreach and education plan developed and implemented by the Connector in conjunction with the Office of Medicaid, health plan representatives, safety net hospitals and consumer advocates.

The state legislation creates a special program under Commonwealth Care for individuals at or below 100% FPL. For these individuals, the Connector can procure basic benefit plans that must include inpatient services, outpatient and preventive services, prescription

drugs, behavioral health services, and dental services. The only cost-sharing that is authorized is co-payments and they must be similar to the co-payments in MassHealth.

3.5 Health Safety Net Office and Health Safety Net Trust Fund [Section 30 of Chapter 58 of the Acts of 2006]

Beginning October 1, 2007, the Act contemplates a new office called the Health Safety Net Office (HSN Office). The HSN Office will administer a Health Safety Net Trust Fund, which is the successor to the Uncompensated Care Pool starting in hospital rate year (HRY) 2008. The HSN Office is tasked with establishing reimbursement rates for acute hospitals and community health centers for covered health services provided to uninsured and underinsured patients. Payment from the fund will be claims-based, fee-for-service, and calculated according to Medicare reimbursement principles adjusted for a variety of factors stated in the Act, and as deemed necessary based on the circumstances of individual hospitals. Any shortfall must be allocated to reflect each hospital's proportional financial requirement for reimbursements from the fund. Eligibility criteria, payment methodologies, reimbursement rates, and shortfall allocation methods will need to be developed. The state is required to submit to the legislature the new methodology for "equitably allocating free care reimbursements" in HRY 2008. The state also will submit the new methodology to CMS for approval. The Act contemplates that the existing hospital assessment and insurance surcharge, in addition to state general funds, will be used to fund the Health Safety Net Trust Fund. As noted earlier, over time there is the expectation of an inverse relationship between dollars in this Health Safety Net Fund, which will pay for uncompensated care, and dollars in the Commonwealth Care Trust Fund, which will subsidize health insurance premium assistance for low-income residents.

3.6 Transparency in Quality and Cost [Section 3 of Chapter 58 of the Acts of 2006]

The Act creates a Health Care Quality and Cost Council to set quality improvement and cost containment goals for the Commonwealth. The Council has the authority to collect cost, price and quality data from health care providers, pharmacies, payers and insurers. The Council is responsible for developing and maintaining a web site for consumers and purchasers containing cost and quality information on providers. This feature will provide greater transparency and accountability on the part of providers and insurers and will better inform consumer and purchaser choices. Having such data available publicly also gives providers greater incentives to improve care. The Act requires disclosure of average charges and payments accepted for certain commonly performed services at hospitals, physician's offices and other providers, such as community health centers, and allows for additional data collection and work with other interested parties to develop quality measures for various procedures and disclose this information in a similar manner. The Council resides in the Executive Office of Health and Human Services (EOHHS) but is governed by a board consisting of public and private members.

3.7 Medicaid Provider Pay-for-Performance [Section 25 of Chapter 58 of the Acts of 2006]

The Act commits the Commonwealth to a three-year process for increasing Medicaid reimbursement rates to acute hospitals and physicians. Beginning in the second year, October 2007, such rate increases are dependent upon hospitals meeting quality improvement goals as determined by EOHHS, in conjunction with a newly created MassHealth Payment Policy Advisory Board [see Section 3 of Chapter 58 of the Acts of 2006]. As specific pay-for-performance methodologies are developed, the Commonwealth will confer with CMS, in addition to commercial payers operating in Massachusetts. EOHHS will submit to CMS for approval new payment methodologies by December 31, 2007.

Section 4 Requested Changes to the MassHealth Demonstration

The Commonwealth seeks certain changes to the MassHealth program for which we request applicable amendments to our section 1115 Demonstration Project and Title XXI State Plan. These changes are described below. Safety Net Care Pool funding sources and payment methodologies and the budget neutrality impact are described in Sections 5 and 6, respectively.

4.1 Eligibility Expansion to Children in Family Groups with Income from 200% of the Federal Poverty Level (FPL) to 300% FPL

Massachusetts seeks to increase the upper income limit for children (from birth to 18 years old inclusive) applying for or receiving MassHealth from 200% FPL to 300% FPL, in conformity with the provisions of Title XXI (SCHIP).

The Commonwealth requests amendment of its Title XXI (SCHIP) State Plan to extend Family Assistance benefits to children up to 300% FPL. Consistent with our existing SCHIP State Plan, the Family Assistance benefit will be in the form of premium assistance payments on behalf of uninsured children where there is access to employer-sponsored health insurance that meets the basic benefit level, is cost-effective, and for which the employer contributes at least 50% of the total premium cost. MassHealth will provide direct coverage only if the MassHealth health insurance investigation process indicates that qualifying employer-sponsored health insurance is not accessible to the applying child. Direct coverage will be provided through a contracted Managed Care Organization or the MassHealth Primary Care Clinician Plan. Enhanced anti-crowd-out provisions for this higher income group are included in the SCHIP State Plan amendment to create a meaningful deterrent against parents voluntarily dropping private health insurance in order to enroll their children in MassHealth.

Currently, children above 200% FPL may enroll in a state-funded program called Children's Medical Security Program (CMSP) that provides certain limited primary and preventive medical services on a fee-for-service basis. These children now rely on the Uncompensated Care Pool for most inpatient services. MassHealth eligibility expansion

for children will provide access to comprehensive health care, and will shift an important population segment out of the Pool.

Providing income expansion for children through SCHIP will indirectly impact budget neutrality for the MassHealth Demonstration. SCHIP expenditures of the new expansion group will not be demonstration expenditures. However, to the extent that Massachusetts' SCHIP allotment is insufficient, it may become necessary to shift certain expenditures for children in the 1902(r)(2) Medicaid Eligibility Group (MEG) to the demonstration that are now being charged to SCHIP. The precise impact on budget neutrality will depend on the enrollment rate of the expansion group, as well as SCHIP redistribution and reauthorization scenarios that cannot now be predicted. The budget neutrality analysis in Section 6 reflects projected expenditure growth that would accrue to the demonstration given our current estimates.

The Title XXI State Plan amendment for Family Assistance Expansion for Children is included in this document as Attachment B. The Commonwealth requests approval of this amendment effective July 1, 2006.

4.2 Enrollment Cap Increases for Adults in HIV/Family Assistance, CommonHealth, and Essential

Special Terms and Conditions (STC) numbers 21 and 23 of the MassHealth Demonstration authorize enrollment caps for non-state plan demonstration eligible adults in HIV/ Family Assistance, CommonHealth, and Essential. The Commonwealth requests amendments of STC 21 and STC 23 to increase the upper limit of enrollment cap ranges to: 1,300 individuals in HIV/Family Assistance, effective March 9, 2006; 15,600 individuals in CommonHealth, effective March 9, 2006; and 60,000 individuals in Essential, effective July 1, 2006. The enrollment cap increases to HIV/Family Assistance and CommonHealth are revisions to an earlier request submitted to CMS in April 2005 that were revised on March 9, 2006.

These expansion programs serve very vulnerable special needs populations in the demonstration—those who are disabled, HIV positive, or chronically unemployed. It is important that we continue to be able to enroll persons, as we identify them, into the unique demonstration programs that have been developed to meet their needs. Further, it is critical to the concept of individual responsibility that persons who make the requisite effort to obtain health insurance and are eligible for MassHealth benefits are able to enroll. This will further support our efforts to reduce the number of uninsured in the state. There are currently approximately 12,000 persons on the Essential waiting list who are eligible, but unenrolled who would shift from the Uncompensated Care Pool to MassHealth by raising that enrollment cap.

Raising enrollment caps in the expansion programs will allow the Commonwealth to enroll eligible persons in the most suitable health programs while maintaining important controls on caseload growth and demonstration expenditures.

The budget neutrality analysis in Section 6 reflects expenditure growth for the affected expansion groups that is consistent with the requested enrollment cap adjustments.

4.3 Changes to the Insurance Partnership Program

The Insurance Partnership (IP) is a demonstration program to assist small employers (less than 50 employees) and their employees in purchasing employer-based health insurance. The program has two components: a subsidy (incentive payment) for qualified small employers, and premium assistance for their employees. Currently, the IP is available on behalf of employees who are at or below 200% FPL. Also, currently self- employed persons are eligible to receive both the employer subsidy and premium assistance.

In the context of a broader strategy to address the needs of employers and low-income employees in the insurance marketplace, the Commonwealth seeks to make certain changes to the IP in order to bring the program into alignment with other features of health care reform. We request approval to:

- Raise the income eligibility for employees to 300% FPL. Effective October 1, 2006.
- Exclude employees whose employer or family member's employer has provided insurance coverage in the preceding six months for which the employee was eligible. Effective October 1, 2006.
- Limit employee's premium assistance to the value of premium assistance provided under Commonwealth Care (the new private insurance subsidy program for uninsured persons at or below 300% FPL described earlier in Section 3.4). Effective October 1, 2006.
- Prohibit employer incentive payments to self-employed persons (the self-employed would continue to receive premium assistance). Effective July 1, 2007.

It is important that Commonwealth Care and the Insurance Partnership programs are complementary. These changes will combine to guard against private market crowd-out and bring consistency to how the Commonwealth promotes private insurance to small employers and lower income workers.

The increase in income eligibility for the IP will be offset to a certain extent by new restrictions on employer subsidies and limits on premium assistance. Given the very small amount spent on the IP relative to total demonstration expenditures, the budget neutrality impact of these IP changes will be negligible.

We request amendment to the demonstration STCs in Attachment A, item 7, and Attachment C, Section 11 in order to implement the described changes to the Insurance Partnership program.

4.4 Expanding Optional Services

In order to provide CMS with full information, we are including in this submission a description and financial analysis of provisions that were included in the Act, but vetoed

by Governor Romney. Since vetoed provisions can be overridden by the Legislature at any time during the state's legislative year (in this case, until December 31, 2006), CMS should be aware of the potential for possible amendments to this document.

Governor Romney vetoed a provision mandating coverage of several optional Medicaid benefits that were restricted in 2003 for adult MassHealth members, effective July 1, 2006. If the Governor's veto is overridden, MassHealth will submit a State Plan Amendment to CMS in the calendar quarter in which the provision becomes effective to rescind age limitations that were placed on certain optional services as of January 1, 2003. Specifically, the currently vetoed provision requires MassHealth to restore chiropractor, vision, and dental services that were in effect on January 1, 2002 to members age 21 or older and add dental services to the MassHealth Essential benefit package.

Given the Governor's veto, the budget neutrality analysis in Section 6 does not include expenditures related to these benefit expansions. However, an itemized projection of expenditure growth is provided in the event that the Governor's veto is overridden subsequent to submission of this document.

4.5 Wellness Program

Governor Romney also vetoed a provision requiring MassHealth, in cooperation with the Department of Public Health, to develop a wellness program for MassHealth enrollees to encourage activities that lead to desired health outcomes, including smoking cessation, diabetes screening for early detection, teen pregnancy prevention, cancer screening for early detection, and stroke education. If the Governor's veto is overridden, the Commonwealth will seek approval from CMS to pursue a process to reduce cost sharing requirements (premiums and/or co-payments) based on enrollee participation and compliance with the goals of the wellness program.

4.6 Smoking-Cessation Pilot Program

The Act includes a requirement for MassHealth to conduct a two-year pilot program to cover smoking and tobacco use cessation treatment and information for all MassHealth enrollees. Coverage must include nicotine replacement therapy, other evidence-based pharmacological aids, and counseling. The Commonwealth will make a corresponding State Plan Amendment related to this change in benefits.

4.7 Clarifying Language on Certified Public Expenditures (CPEs)

The Commonwealth continues to work with CMS to develop a methodology for certified public expenditures (CPEs) by certain acute hospitals in Massachusetts. Once a final methodology is accepted, the Commonwealth will request revision to the existing waiver STCs in Attachment A, #4. The proposed CPE methodology and proposed replacement language will be submitted to CMS by June 1, 2006. The Commonwealth will seek to make initial CPEs and receive corresponding federal financial participation for the Fiscal Year 2006 prior to July 1, 2006.

4.8 Withdrawal of the Proposed Demonstration Project to modify the MassHealth Disability Determination process for certain adults.

The health care reform legislation included a provision that prevents the MassHealth agency from implementing any new criteria for determining disability that would be more restrictive than the criteria currently used by the Social Security Administration.

The Commonwealth withdraws its proposal, submitted to CMS on August 29, 2003, to amend the Demonstration Project to modify the disability determination process for certain adults because that proposal is not consistent with new state law.

Section 5 Massachusetts' Safety Net Care Pool Implementation

5.1 Safety Net Care Pool Sources and Uses

Attachment C includes financial detail regarding the total cost of the reforms made by the Act for FY 2007. The exhibits include a comprehensive table of the sources and uses of funds necessary to implement health care reform, a schedule for FY 2007 Medicaid and Safety Net Care Pool projected claiming for Federal Financial Participation (FFP), a detailed table on the federal and non-federal sources of funds and uses for the state's Safety Net Care Pool and a schematic of the state fund structure and flow of funds as prescribed in the state legislation. CMS review and approval of these financial statements is requested pursuant to the waiver STCs in Attachment B, #6(f).

5.2 Safety Net Care Pool Payment Methodologies

All payments made from the Safety Net Care Pool will be made according to one of the following payment methodologies. The payment methodologies are described in detail in Attachment D. CMS review and approval of these payment methodologies is requested pursuant to the waiver STCs in Attachment B, #6(g).

Premium Assistance Payment Methodology

- Commonwealth Care Health Insurance Program premium assistance payments

Acute Hospital Payment Methodologies

- Section 122 of Chapter 58 Safety Net Health System Payments
- High Public Payer Hospitals
- Public Service Hospital Safety Net Care Payment
- Uncompensated Care Safety Net Payment
- Pediatric Specialty Hospital and Hospitals with Pediatric Specialty Units Payments

Non-Acute Hospital Payment Methodologies

- Safety Net Care Payment for Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health
- Safety Net Care Payment for State-Owned Non-Acute Hospitals Operated by the Department of Mental Health
- Safety Net Care Payment for Pediatric Non-Acute Hospitals

Institution for Mental Disease Payment Methodologies

- Safety Net Care Payment for Inpatient Services
- Safety Net Care Payment for Administrative Days
- Safety Net Care Payment for Inpatient Services at Community-Based Detoxification Centers

Section 6 Budget Neutrality Projection

As required in the STCs, a detailed budget neutrality projection is required and is included in Attachment E. Projected waiver expenditures include all aspects of the Act that would have an impact on the budget neutrality of the demonstration project, including expenditures from the Safety Net Care Pool, changes to Medicaid eligibility and increases to provider reimbursement. The projection also includes a detailed projection of waiver enrollment and expenditures through SFY 2008. A number of Medicaid benefit expansions were included in the Act as passed by the legislature but were subsequently vetoed by the Governor. Projected waiver expenditures related to vetoed provisions of the Act were not included in the calculation of budget neutrality. However, cost estimates for the vetoed items have been included for CMS review in the event that the legislature overrides the Governor's vetoes during the waiver amendment review period.

Section 7 Monitoring the Rate of Uninsurance

The Demonstration STCs include requirements relating to the monitoring, tracking and reporting of the rate of uninsurance in the Commonwealth and the effectiveness of the Safety Net Care Pool in reducing the rate.

Specifically, the Commonwealth was required to submit a draft evaluation design that included:

- A description of the indicators that will be used to measure the rate of uninsurance annually and over the three-year extension period;
- A description of the baseline measures that will be used;
- Other indicators as appropriate to demonstrate effectiveness of the Safety Net Care Pool;

- How the effects of the demonstration will be isolated from those other initiatives occurring in the Commonwealth.

On June 2, 2005, the Commonwealth submitted its draft evaluation design for the Demonstration to CMS. The design was developed by MassHealth staff in collaboration with the University of Massachusetts Center for Health Policy and Research, and is organized to present strategic objectives, key metrics, and data collection and evaluation methodologies that will provide clear indicators of how successful the MassHealth Demonstration project is in meeting the objectives of the demonstration project overall, with particular focus on the Safety Net Care Pool's goal of reducing the rate of uninsurance through the provision of subsidies to make private health insurance affordable to lower income uninsured residents.

Further, the STCs require that the Safety Net Care Pool program development status and uninsurance data be provided in each annual report for the MassHealth Demonstration. Going forward, the annual reports will include Safety Net Care Pool reporting data similar to that outlined in the evaluation design to monitor the rate of uninsurance and the effectiveness of the Commonwealth Care program. The major tool the Commonwealth will use to establish baselines and monitor the uninsurance rate in Massachusetts is the Division of Health Care Finance and Policy's (DHCFP) survey on Health Insurance Status of Massachusetts Residents.

The survey is the only state specific survey designed expressly to provide reliable estimates of the number of uninsured residents in Massachusetts. This survey provides statistically reliable estimates of uninsured rates on a statewide basis, as well as for five regions in the state. The survey design also allows for comparison of the data among each of the years surveyed to date, 1998, 2000, 2002 and 2004 (2006 is currently in the field).

The survey is designed to provide information on both the uninsured and insured populations. The questionnaire is divided into four parts. The first part, the screener section, asks for basic information on all household members, including whether or not each household member has health insurance coverage. The insured section asks detailed questions of the insured, the uninsured section asks detailed questions of the uninsured and a special section pertaining primarily to pharmacy coverage asks some specific questions of the population ages 65 or older. All households respond to the screener section and then continue to one or more sections as applicable. The questionnaire is available in both English and Spanish.

Survey question responses are weighted in order to produce accurate population estimates. The weights adjust for design features of the sample. Some of these design features include: the sampling methodology, if the unit of interest is individual level or household level, and non-response.

The 2004 Health Insurance Status of Massachusetts Residents survey identified 460,000 uninsured residents (7.4%). Estimates based on the survey indicate that approximately 200,000 of those uninsured residents might be eligible for Commonwealth Care.

Prior to 2006, the DHCFP survey has been conducted every two years. Data from the 2006 survey will be included in the 2006 MassHealth Demonstration Project annual report.

Given the critical nature of the health care reform initiative to the citizens of the Commonwealth and the importance to CMS of measuring the impact of the effectiveness of the Safety Net Care Pool concept in the 1115 Demonstration Project, the Commonwealth will increase the frequency of DHCFP surveys to every year for the duration of the demonstration extension period. This will provide solid baseline data for the new Commonwealth Care Health Insurance Program being implemented in SFY 2007, as well as annual measures based on consistent methodologies that will offer comparable data.

Additionally, the Commonwealth will develop program-specific reporting for the Commonwealth Care Health Insurance Program and the Health Safety Net Trust Fund (formerly the Uncompensated Care Pool). Data on the number of covered lives through Commonwealth Care products, number of policies, amount paid in premium subsidies, number of employers purchasing products, and other key indicators will be included in MassHealth annual reports.

In 2005, the Commonwealth implemented joint application for MassHealth and the Uncompensated Care Pool facilitated by the Virtual Gateway (VG). The VG is a web portal that provides a single point of on-line intake, eligibility screening, and referral services for those applying for health programs. Application volume through the VG for MassHealth and Uncompensated Care Pool determinations has increased steadily since implementation. In FY 2006, the VG deployment had reached provider sites constituting 80% of Pool volume. There are currently 120 MassHealth providers using the VG, made up of 72 hospitals and 48 community health centers.

Through these measures we have been able to process eligibility for the Pool through the MassHealth eligibility system, and have been able to identify approximately 200,000 uninsured persons who may become eligible for the Commonwealth Care Health Insurance Program when it is implemented. As Commonwealth Care products start to become available in October 2006, the Commonwealth will track conversion as these Pool users begin to enroll in private managed care insurance through the Connector. The Connector will cast an even wider net as marketing efforts ramp up to reach out to higher income uninsured residents.

The Commonwealth expects that these efforts will reduce the number of uninsured by 100,000 in FY 2007; an additional 125,000 in FY 2008; and an additional 250,000 in FY 2009, for a total of 475,000 individuals. Based on our current estimates, this would reduce the rate of uninsurance to 1% by FY 2009.

Section 8 Timeline for Implementation and Key Milestones

The Commonwealth has established the following key milestones for health care reform implementation. Milestones related directly to MassHealth are contingent upon the

timing of CMS approvals. Section 132 of the Act requires the Commonwealth to develop a detailed health care reform implementation plan and submit it to the legislature within 60 days of the effective date of the Act, which would be June 12, 2006. The Commonwealth will provide CMS with a copy of the implementation plan when it is complete.

April 2006

- Establish the following trust funds for general fund appropriations and transfers: Commonwealth Care Trust Fund; Essential Community Provider Trust Fund; Medical Assistance Trust Fund; Department of Mental Retardation Trust Fund

May 2006

- Creation of Health Care Quality and Cost Council

May-October 2006

- Operationalize the Commonwealth Health Insurance Connector Authority

June 2006

- Reach agreement with CMS on CMS-64 reporting and back-up requirements for Safety Net Care Pool expenditures (Commonwealth Care, Uncompensated Care Pool, and CNOM programs)

July 2006

- Implement SCHIP expansion
- Process applicants from the Essential waiting list
- Propose outreach grants to support Commonwealth Care awareness, public education and enrollment
- Implementation of smoking-cessation pilot program

October 2006

- The Connector will begin offering and enrolling lower-income residents into Commonwealth Care products via Medicaid managed care organizations and begin subsidy payments
- Implement certain Insurance Partnership changes

January 2007

- The Connector will begin to offer private products to unsubsidized persons and employers.

March–May 2007

- Statewide open enrollment period in anticipation of individual insurance requirement beginning on July 1, 2007

July 2007

- Establish the requirement that all individuals over age 18 must obtain and maintain health insurance
- Eliminate Insurance Partnership employer subsidies for self-employed persons

October 2007

- Implement quality-based Medicaid provider pay-for-performance
- Creation of Health Safety Net Office and Health Safety Net Trust Fund

Section 9 List of Attachments

Attachment A: Chapter 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care

Attachment B: SCHIP State Plan Amendment

Exhibit 1: TXXI State Plan Amendment Attachments 4.1 With Proposed Changes

Exhibit 2: TXXI Funding Matrix With Proposed Changes

Attachment C: Safety Net Care Pool Sources and Uses

Exhibit 1: Comprehensive Health Care Reform Sources and Uses (With Notes and Assumptions)

Exhibit 2: Projected Medicaid and Safety Net Care Pool claiming for Federal Financial Participation

Exhibit 3: Safety Net Care Pool Sources and Uses and Schematic of State Fund Structure and Flow of Funds

Attachment D: Safety Net Care Pool Payment Methodologies

Attachment E: Budget Neutrality Projection

Exhibit 1: Federal Budget Neutrality Summary

Exhibit 2: Federal Budget Neutrality Cap

Exhibit 3: Massachusetts Waiver Expenditures