

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

***SECTION 1115 DEMONSTRATION PROJECT EXTENSION REQUEST
(SFY 2015 – SFY 2019)***



DRAFT FOR PUBLIC COMMENT

August 20, 2013

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Executive Summary

As we approach 2014, Massachusetts is once again at the forefront of health care reform, as the first state to have passed, in 2012, sweeping health care cost containment legislation. Chapter 224, as the legislation is known, is part of a deliberate, incremental strategy in Massachusetts to ensure access to affordable care, improve how care is delivered and spend health care dollars more efficiently. Many of Massachusetts's coverage successes and quality and cost containment innovations to date have their origins in the MassHealth 1115 Demonstration (the Demonstration), most notably key components of the state's previous landmark reform legislation, Chapter 58 of the Acts of 2006. With this proposal, Massachusetts seeks to continue that tradition and extend the Demonstration for five years (SFY2015-2019).¹ The Demonstration's goals continue to be to:

- Maintain near-universal coverage;
- Redirect spending from uncompensated care to insurance coverage;
- Enact delivery system reforms that promote care coordination and integration of services, disease management, successful care transitions and improved health outcomes, and
- Advance alternative payment methods to plans and providers that financially reward accountability for quality and costs.

A Track Record of Success. Massachusetts has been successful in achieving the goals of the Demonstration during its first 17 years. MassHealth enrollment has grown through eligibility expansion and recently because of the recession, and the creation of Commonwealth Care added nearly 200,000 more to the ranks of the insured. Only 3.1 percent of the Massachusetts population was uninsured in 2011, the lowest rate of any state and a fraction of the national rate of 16.0 percent. To help maintain coverage gains, MassHealth has in recent years instituted a number of improvements to reduce administrative barriers to coverage.

An original goal of the Demonstration was to extend managed care enrollment to most MassHealth members. About two-thirds of all members are now enrolled in managed care. A large portion of those who remain outside of managed care arrangements – non-elderly dual eligibles – will soon have access to integrated managed care in the One Care program.

The Demonstration is a centerpiece of the state's health care reform, and public support for reform continues to be high among Massachusetts residents, physicians and employers. An interim evaluation of the current Demonstration renewal period shows that the state continues to make progress towards its goals.

¹ A list of frequently used abbreviations for this Request is provided as Appendix A.

Moving the Demonstration into the Affordable Care Act Framework. With the implementation of the federal Affordable Care Act (ACA), some MassHealth programs will continue, some will end, and others will be introduced. With the recent Waiver amendment, submitted in June 2013, the Demonstration's goals and objectives now fully align with the ACA. Eligibility for subsidized coverage will be simplified and Massachusetts's coverage structure will align more closely with the national vision for insurance affordability programs. Implementation of the ACA will also expand the availability of subsidized coverage to new groups in Massachusetts.

Chapter 224: Improving Quality and Containing Costs. With the passage of Chapter 224, Massachusetts reaffirmed its commitment to transform the health care delivery system by moving the market away from fee-for-service payment and toward a system capable of delivering better health care and better value for all residents of the Commonwealth.

Chapter 224 requires MassHealth to play a significant role in advancing far-reaching system changes intended to contain costs and improve health care quality in the Commonwealth. Attainment of the law's ambitious goals and implementation of the law's provisions will take a number of years to complete. Accordingly, the five-year timeframe MassHealth seeks for this Demonstration renewal will enable MassHealth to support the Commonwealth's long-term vision for health care reform and to carry out the provisions of Chapter 224.

Requested Changes to the Demonstration

Five-Year Renewal Term and the One Care Integrated Care Model

A five-year renewal term, as authorized by the Social Security Act, will support the full implementation of the Commonwealth's Duals Demonstration and its integrated care model known as One Care. The Duals Demonstration and the 1115 Demonstration are closely interrelated and provide complementary authorities that enable the Commonwealth's efforts to institute a fully integrated and fully capitated delivery model for disabled members. Massachusetts aims to learn from the Duals Demonstration and explore expanding the One Care model to non-dual eligible disabled members through the 1115 Demonstration in future years.

Advancing Alternative Payment Models

1. Transforming health care delivery and payment through the Primary Care Payment Reform Initiative

The Commonwealth requests authority to set shared savings / risk targets for providers and to make shared savings payments or, as applicable, recoup payments to providers under alternative payment arrangements involving shared risk.

2. Pursuing a future Accountable Care Organization initiative

The authority to engage in shared savings and shared risk payment arrangements with providers will establish the foundation for the Commonwealth to fully implement both the PCPRI and a future Accountable Care Organization (ACO) model currently in development. With PCPRI as its foundation, MassHealth would consider making three key changes to the future model: shifting the contracting entity from a Primary Care Clinician (PCC) to an ACO; adjusting the payment model to encourage providers to take on higher levels of risk; and modifying quality metrics and delivery model requirements to extend beyond a medical home to a “medical neighborhood.”

Pediatric Asthma Pilot Program

The Commonwealth requests continued authority to implement a Pediatric Asthma Pilot Program for MassHealth members aged two through 18 with high risk or poorly controlled asthma who are enrolled in selected PCC Plan practices.

Safety Net Care Pool

The Commonwealth requests the following authorities for the SNCP:

1. Elimination of the Provider Sub-Cap
2. a. Continued expenditure authority for existing Designated State Health Programs
b. New authority for additional programs, including
 - State-supported subsidies for individuals with incomes up to 300 percent of the Federal Poverty Level (FPL) who enroll in certain Qualified Health Plans (QHPs) that are qualified by the Health Connector as ConnectorCare plans
 - New state health programs associated with Chapter 224 and related efforts to advance Massachusetts’ ambitious health care reform and cost containment agenda
3. Continued authority for the Delivery System Transformation Initiatives
4. Continued authority for supplemental payments for Cambridge Health Alliance
5. Continued authority for the Infrastructure and Capacity Building Grants program

Express Lane Renewal

The Commonwealth is proposing to continue its current Express Lane renewal process for families and to expand the Express Lane renewal process to childless adults receiving MassHealth and Supplemental Nutrition Assistance Program benefits.

Medicare Cost Sharing Assistance

For MassHealth Standard disabled or caretaker/ parent elderly members at or under 133 percent FPL who are eligible for Medicare, the Commonwealth requests authority to pay the cost of monthly premiums, deductibles and coinsurance under Medicare Part A and Part B.

Early Intervention / Applied Behavioral Analysis for Autism

MassHealth requests continued authority for enhanced early intervention program services for children with autism spectrum disorders.

Budget Neutrality

Massachusetts has continued to demonstrate savings under the Demonstration and comply with the budget neutrality requirement.

Public Notice and Comment Period

The public process used prior to submitting this Request conforms with the transparency and public notice requirements outlined in 42 CFR § 431.400 et seq., and the requirements of Standard Terms and Conditions 14, 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 State's approved State plan. The Commonwealth remains committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Section 1 MassHealth's Role in Massachusetts' Evolving Health Care System

As 2014 approaches, Massachusetts is once again at the forefront of comprehensive health care reform and system improvement. As it led the nation in providing access to health coverage for nearly all state residents in 2006 (through Chapter 58 of the Acts of 2006), Massachusetts recently became the first state to pass sweeping health care cost containment legislation. In 2012, Massachusetts enacted Chapter 224 of the Acts of 2012 to slow the growth in state health care costs, improve quality of care and patient outcomes, and increase transparency and oversight of provider and payer price and cost data. These bold initiatives, in which MassHealth plays a key role, are part of a deliberate, incremental strategy to ensure access to affordable care, improve how care is delivered and spend health care dollars more efficiently. Many of the coverage successes and quality and cost containment innovations to date have their origins in the MassHealth 1115 Demonstration (the Demonstration).

Since 1997, the Demonstration has served as a vehicle of progress for Massachusetts' health care system, with MassHealth leading or joining others' efforts to move the entire system toward person-centered, integrated, outcomes-based and cost-efficient care. The state has been extraordinarily successful in achieving the Demonstration's original objectives of expanding access to health insurance coverage, simplifying MassHealth's application and eligibility determination processes, and moving people into managed care arrangements. While these core objectives remain, the program's goals have evolved with successive extensions of the Demonstration. Since 2006, the Demonstration has supported the state's efforts to:

- maintain near-universal coverage,
- redirect spending from uncompensated care to insurance coverage,
- enact delivery system reforms that promote care coordination and integration of services, disease management, successful care transitions and improved health outcomes, and
- advance alternative payment methods to plans and providers that financially reward accountability for quality and costs.

Massachusetts' 2006 health care reform law, known as Chapter 58, made major structural changes to how care is delivered and paid for in Massachusetts and served as the model for the federal Affordable Care Act. Its component pieces – expansions of MassHealth coverage for low-income adults and children, creation of a subsidized insurance program for low-to-moderate income people, establishment of a marketplace for affordable, quality health insurance, and mechanisms to ensure participation in and funding for the new system – provide a cohesive system of coverage with protections to ensure affordability and shared responsibility. The Demonstration was the foundation of this reform as it authorized and funded the public and subsidized coverage expansions. Amendments to the Demonstration in 2006 incorporated Chapter 58's reforms, rationalized and reinforced the state's health safety net system and embedded new commitments to containing costs in Medicaid. These system

enhancements helped solidify the federal government’s continuing investment in Massachusetts’ Medicaid program.²

Chapter 58 also set the stage for comprehensive statewide cost containment activities with the creation of the Health Care Quality and Cost Council, which was responsible for setting quality, cost and health equity goals for the state, including in Medicaid. Massachusetts’ cost containment commitment evolved further with Chapter 305 of the Acts of 2008, which created the Special Commission on the Health Care Payment System. The Special Commission developed principles and recommendations for provider payment reforms that would reduce the dramatic cost and quality variations in Massachusetts’ health care system. Broad stakeholder input and collaboration led to both the Council’s Roadmap to Cost Containment and the Special Commission’s Final Report in 2009.^{3,4} Together, these reports establish the framework for the state’s vision for an all-payer statewide transition to global payments for Accountable Care Organizations (ACOs) and other integrated models, with Patient-Centered Medical Homes (PCMHs) at their core. During this time, MassHealth was piloting value-based pay-for-performance purchasing models with several different providers and had committed to reducing the rate of spending growth in Medicaid.

All of these activities focused stakeholder attention on cost containment and built momentum for the consensus around Chapter 224 in 2012. Chapter 224, described in more detail in Section 4, requires statewide health care cost growth benchmarks and significant reporting of quality and cost data by providers and payers, both public and private. The law creates two new entities to monitor and oversee cost growth trends and market changes, including provider structural changes and the development of ACOs, PCMHs and alternative payment methods. Chapter 224 has major implications for the Demonstration within the context of these broader system changes, as the state will lead these system reforms by adopting alternative payment methods for most of the Medicaid population by 2015. Additionally, the continued success of the state’s landmark health coverage initiative depends on the state’s success in containing health care cost growth.

The Commonwealth’s most recent Section 1115 Demonstration Amendment, submitted to CMS on June 4, 2013, contemplates significant changes to the Demonstration by incorporating the key coverage provisions of the Affordable Care Act that go into effect in January 2014 (these are summarized briefly in Section 3).⁵ These changes will restructure MassHealth’s programs and how care is delivered within them, and together they will reinforce and enhance the Demonstration’s primary goal of providing

² Blue Cross Blue Shield of Massachusetts Foundation. “Massachusetts Health Care Reform Bill Summary.” July 1, 2006. <http://bluecrossfoundation.org/sites/default/files/060700MHRLawSummary.pdf>

³ Massachusetts Health Care Quality and Cost Council. “Roadmap to Cost Containment: Massachusetts Health Care Quality and Cost Council Final Report.” October 2009. <http://archives.lib.state.ma.us/handle/2452/46756>, accessed August 9, 2013.

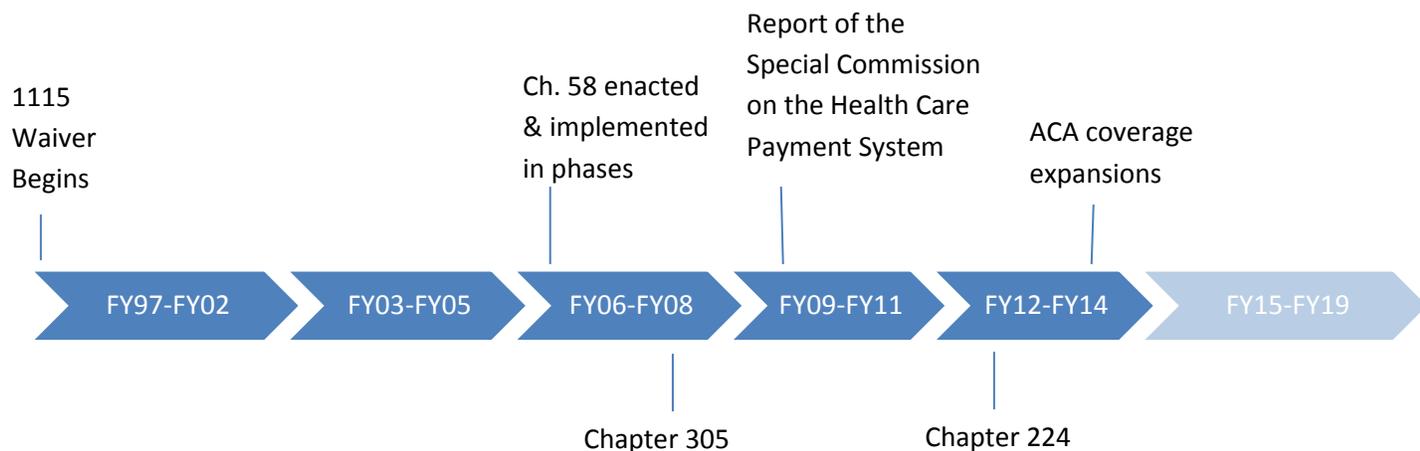
⁴ Massachusetts Special Commission on the Health Care Payment System. “Recommendations of the Special Commission on the Health Care Payment System.” July 2009. <http://www.mass.gov/chia/docs/pc/final-report/final-report.pdf>, accessed August 9, 2013.

⁵ Available at: <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html>.

seamless access to affordable health care coverage to the state’s low-income and vulnerable populations.

Figure 1 presents a timeline of the Demonstration’s operating periods and key milestones.

Figure 1



With this proposal, Massachusetts seeks to extend the MassHealth 1115 Demonstration for five years (SFY2015 – SFY 2019), as authorized by Section 1915(h)(2) of the Social Security Act. The Demonstration currently provides eligibility for MassHealth medical assistance coverage for over 130,000 dual eligible individuals under age 65. Many of these individuals are eligible to participate in the state’s new integrated care program for non-elderly dual eligible persons, called One Care: MassHealth plus Medicare, described in more depth in Section 5. The Demonstration provides Medicaid eligibility authority for many of these individuals, as well as the authority for them to participate in managed care arrangements, as documented in the state’s August 2012 Memorandum of Understanding with CMS about this new program. A five-year extension timeframe will enable the state to fully implement One Care, refine the model based on lessons learned, and begin to expand One Care’s integrated care model to similar populations receiving services through the Demonstration who are not dual-eligibles.

Furthermore, many key initiatives outlined in this proposal, such as the Primary Care Payment Reform Initiative, the Pediatric Asthma Pilot Program, and the Delivery System Transformation Initiatives, are integral to the success of the Commonwealth’s health care system transformation efforts. These programs, as well as other Chapter 224 initiatives, are part of a longer-term strategy to improve quality and reduce the cost of care. The Commonwealth and health care providers have made significant progress in preparing for and implementing new models of care, and are committed to refining and expanding these models. With a five-year Demonstration renewal, the Commonwealth will be able to focus on this long-term strategy, demonstrate the effectiveness of these programs, and ensure the sustainability of the health care system’s transformation.

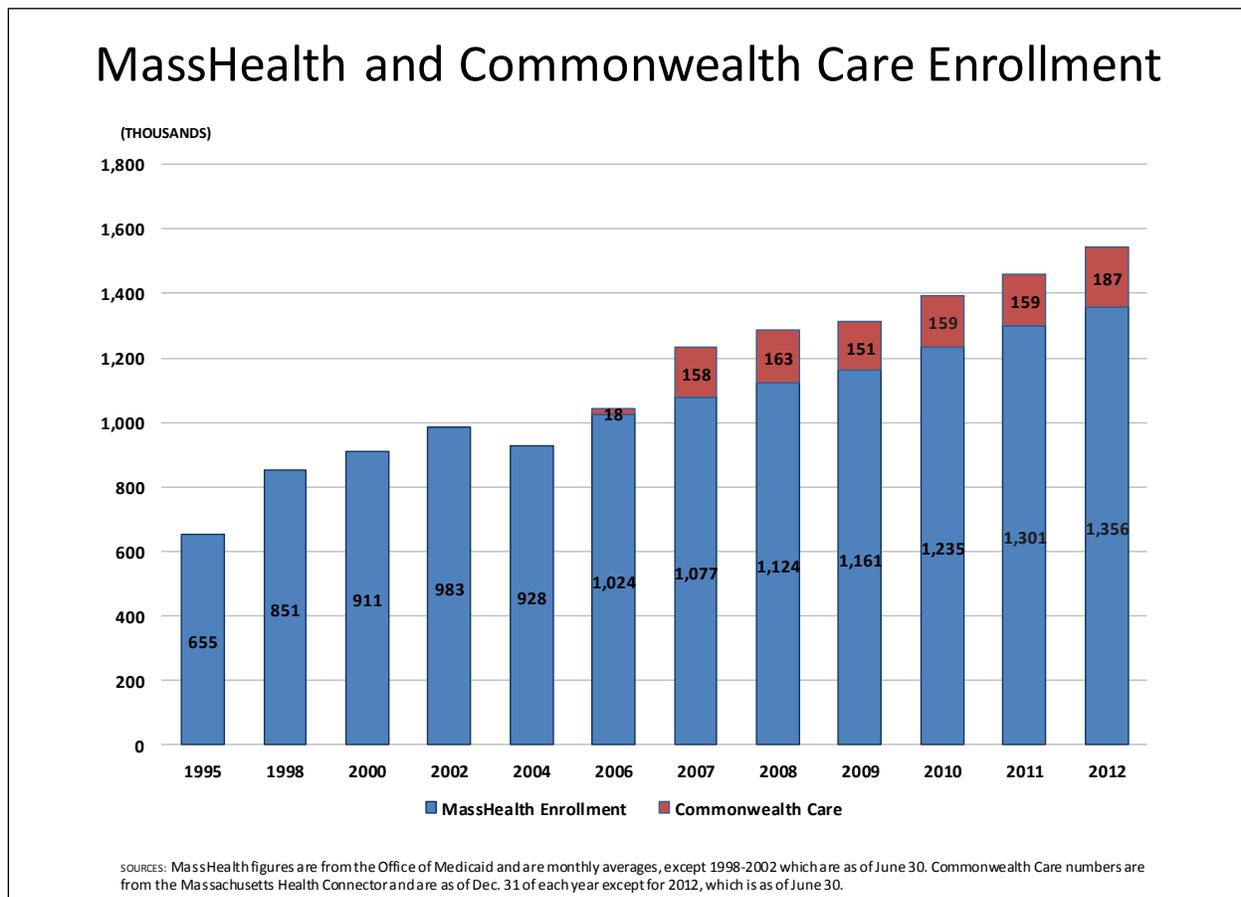
Section 2 Massachusetts' Successes

Coverage

Massachusetts has been successful in achieving the goals of the Demonstration. A main goal since the start of the Demonstration has been to improve access to health care by expanding health insurance coverage. The Demonstration has been an unequivocal success in this regard. In the original waiver period and the first extension, the mechanism for coverage expansion was the MassHealth program itself, by making the program available to previously ineligible groups and by expanding income eligibility for people in categories already eligible. Through these expansions MassHealth enrollment grew to over one million members in 2006, from under 700,000 prior to the start of the Demonstration.

Beginning in 2006, with the passage of the Massachusetts health care reform law and the associated Waiver amendment, the goal explicitly became achieving near-universal coverage for the state, and the Commonwealth Care program was introduced. Today, MassHealth enrollment is about double what it was before the Demonstration began and covers about one of every five Massachusetts residents. Commonwealth Care adds nearly 200,000 more to the ranks of the insured.

Figure 2



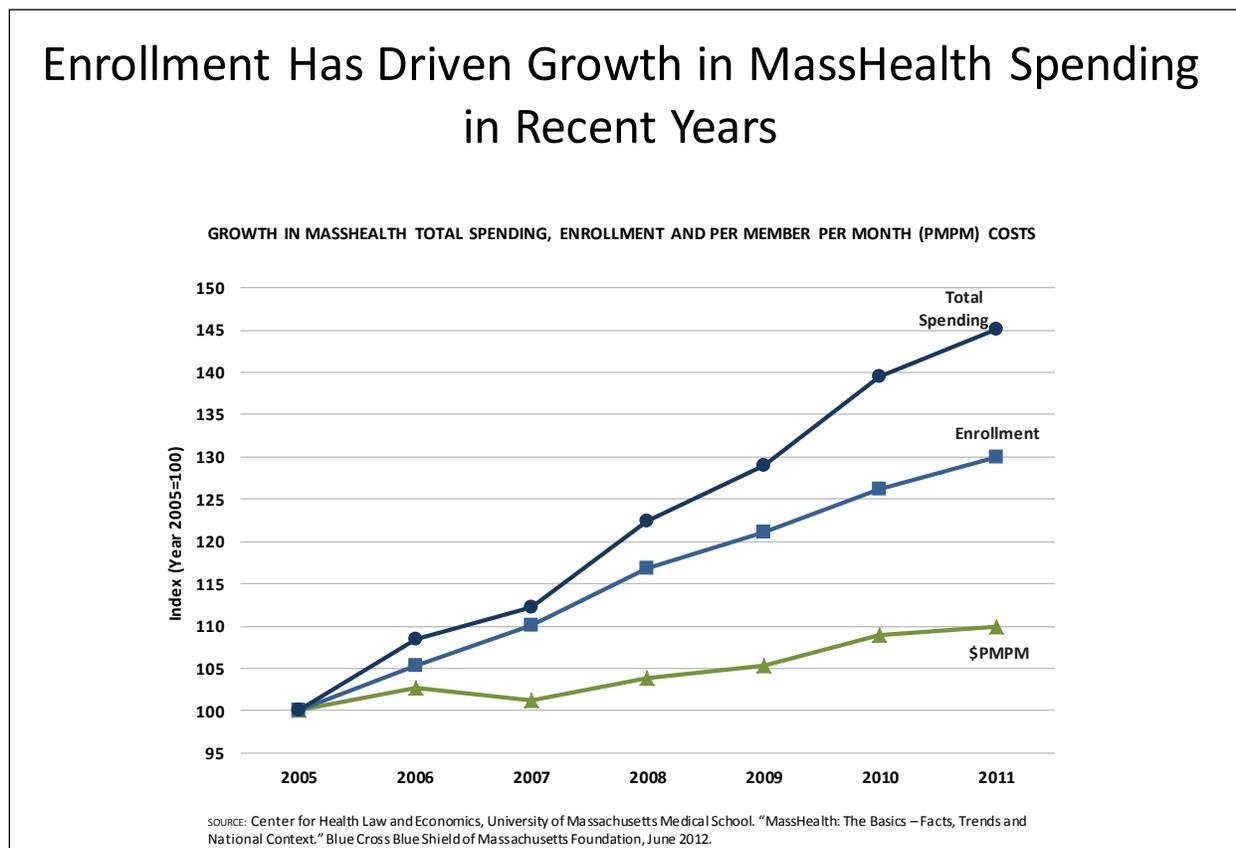
Some of the MassHealth enrollment increase in the last several years is a reflection of Medicaid's traditional safety net role, as recession-driven unemployment led to a reduction in coverage through employer-sponsored insurance across the state (though the number of employers offering coverage did not decline, remaining higher than the national average). The annual Massachusetts Health Insurance Survey shows the overall uninsured rate declining to 1.9 percent of the population in 2010, rising slightly to 3.1 percent in 2011, though this uptick is not statistically significant. In 2011, the most recent year for which data are available, 1.2 percent of children and 3.7 percent of non-elderly adults were without insurance.⁶ To compare with national statistics, the Current Population Survey measured the Massachusetts uninsured rate at 4.5 percent in 2010-11, the lowest rate by far of any state and a fraction of the national rate of 16.0 percent.⁷ Whatever the source, Massachusetts has clearly made significant gains in its goal of greatly expanding insurance coverage.

The coverage expansions in MassHealth have naturally led to increased total spending in the program, but most of the increase has been driven by enrollment rather than by spending per enrollee. From fiscal year 2005 through 2011, spending per member increased an average of just 1.6 percent per year, while enrollment grew an average of 4.5 percent per year over the same time period.

⁶ Center for Health Information and Analysis. "Massachusetts Health Insurance and Employer Survey Chartbook: Updates for 2011." January 2013.

⁷ U.S. Census Bureau, Current Population Survey, 2009 to 2012 Annual Social and Economic Supplements.

Figure 3



Reducing Barriers to Coverage

Maintaining gains in coverage requires that people eligible for MassHealth and Commonwealth Care are able to enroll and remain enrolled with minimal difficulty. During the current Demonstration extension period MassHealth has placed a great emphasis on reducing the administrative barriers to coverage that cause enrollment volatility, or “churn.” Recent improvements include⁸:

- *Administrative review* – automatic eligibility renewal, based on a match with current program data, for members whose circumstances are unlikely to change from year to year (such as elders living in nursing facilities). Members meet the criteria if they have Social Security as their sole source of income and also have Medicare coverage.
- *Express lane renewal* – renewal process completed through a data match with the Supplemental Nutrition Assistance Program (SNAP) for families enrolled in that program. Children in SNAP are eligible for this process by authority of the Children’s Health Insurance Program Reauthorization

⁸ Robert Seifert and Amanda Littell-Clark, “Enrollment Volatility in MassHealth: A Progress Report.” Massachusetts Medicaid Policy Institute, April 2013. <http://bluecrossmafoundation.org/publication/enrollment-volatility-masshealth-progress-report>, accessed August 9, 2013.

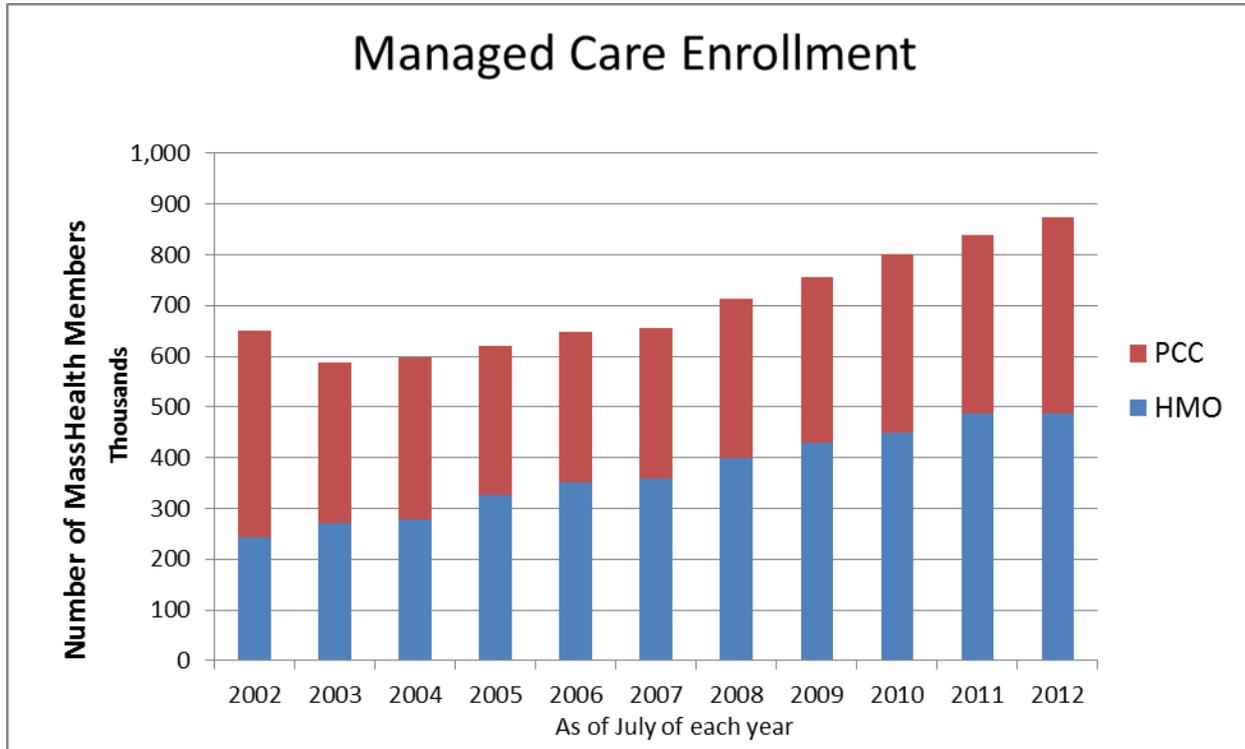
Act of 2009 (CHIPRA); Massachusetts included the parents and caretaker relatives of those children as part of the latest Demonstration extension.

- *Citizenship verification* – data match with the Social Security Administration to verify citizenship.
- *Electronic document management* – improved system for MassHealth to receive, scan, track and process application and redetermination documents. The system allows members to monitor progress on redetermination or verification documents through the online Virtual Gateway and does not penalize members if their forms are received on time but there is a delay in processing.
- *Job update form* – refined use of a form generated by a data match with the Department of Revenue that was the source of a great deal of churn because terminations from uncompleted forms were often quickly reversed.

Managed Care

Another original goal of the Demonstration was to extend managed care enrollment to most MassHealth members, for both quality and cost purposes. Massachusetts has been successful here as well, as Figure 4 illustrates. As of July 2012, 486,000 members were enrolled in managed care organizations (MCO) and 389,000 in the Primary Care Clinician (PCC) Plan, accounting for about two-thirds of all members. Members who remain outside of managed care arrangements are largely those who have other coverage in addition to MassHealth, including Medicare (dual eligibles). Many non-elderly dual eligibles will now have access to integrated managed care in the One Care program.

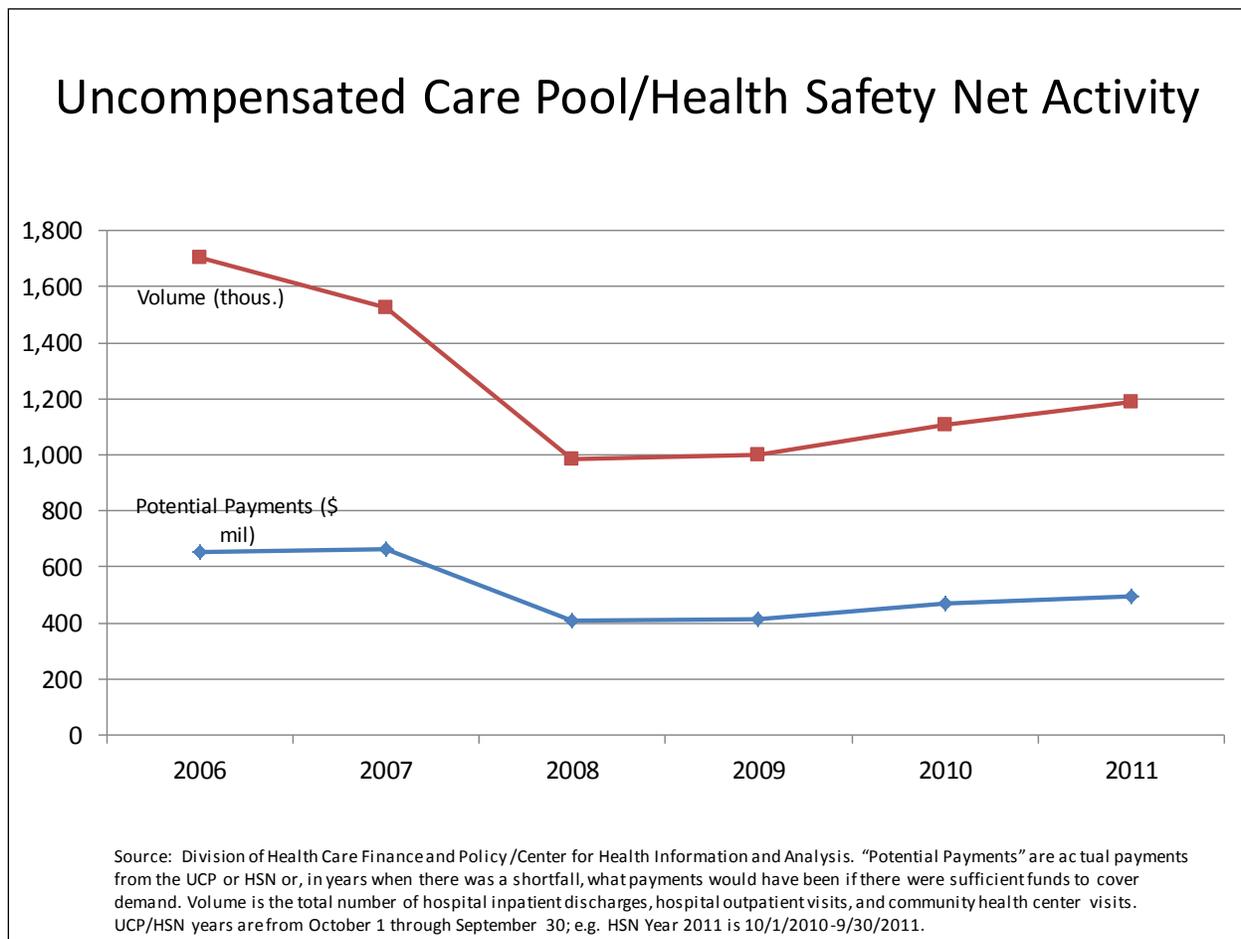
Figure 4



Redirecting Uncompensated Care Spending

A goal of the Demonstration since 2006 has been to redirect spending for care delivered to uninsured people to spending for coverage for those people. To a great extent that goal was achieved by the creation of the Safety Net Care Pool and the Commonwealth Care program, which shifted dollars away from supplemental payments for hospitals and health plans and toward health insurance premium subsidies. It would seem logical that the increase in coverage brought about by the Demonstration and the Massachusetts health care reform law would reduce the need for as much spending on uncompensated care as before, and that reduced need would be reflected, for example, in the use of the Health Safety Net (HSN), a component of the Safety Net Care Pool. In general, that has been the case. After 2007, demand on the HSN declined precipitously, in terms of both payment and volume, likely due to a combination of a shrinking uninsured population and changes in eligibility rules for the HSN as it transformed from its previous incarnation as the uncompensated care pool. Since 2008 use of the HSN has gradually risen, but is still well below pre-reform levels. The slight increase in the HSN utilization is explained by the rise in the number of uninsured during the recession.

Figure 5



Continued Support for Reform

The Demonstration is a centerpiece of the state's health care reform, and public support for reform continues to be high. About two-thirds of non-elderly adults in Massachusetts supported reform when it began in 2006, and that statistic has not significantly changed since then. Members of minority groups tend to be slightly more supportive, but there is no significant difference in support between those with incomes above and below 300 percent of the Federal Poverty Level (FPL). Most employers believe health care reform has been good for Massachusetts. Among physicians, three-quarters believe the Massachusetts reform law should continue, eight in ten believe it has helped the previously uninsured, and nearly nine in ten believe that it improved or did not affect the quality of care.⁹

Monitoring Quality and Access to Care

Massachusetts monitors the quality and access to care provided under the Demonstration in multiple ways. First, all contracts with providers require the monitoring and reporting to the state of key aspects of quality, member experience and access. These contract provisions are the foundation for all quality management activities. In addition, the Commonwealth has, and routinely updates, a Quality Strategy that addresses quality standards and processes. The Quality Strategy covers not only managed care entities, but also addresses quality and access under alternative payment mechanisms.

The third way Massachusetts monitors quality and access is through its own measurement activities. The state produces reports on a portion of the CHIPRA Core Measure set and the Adult Core Measure set. It produces an annual report of Health Care Effectiveness Data and Information Set (HEDIS) results for the contracted managed care entities and makes the report available to the plans and also to consumers through the MassHealth website, (<http://www.mass.gov/eohhs/researcher/insurance/masshealth-annual-reports.html>). Every two years, MassHealth conducts a survey of member experience to assess how members perceive access to and quality of care.

Fourth, the state retains an External Quality Review Organization (EQRO) to annually evaluate the measurement and quality improvement activities undertaken by managed care entities. The EQRO also assesses compliance with federal quality regulations every three years. Overall, Massachusetts maintains a robust quality management program for members enrolled in the Demonstration program.

⁹ "Health Reform in Massachusetts. Expanding Access to Health Insurance Coverage: Assessing the Results." Blue Cross Blue Shield of Massachusetts Foundation, March 2013. <http://bluecrossmafoundation.org/publication/updated-health-reform-massachusetts-assessing-results>, accessed August 9, 2013.

Section 3 Moving Massachusetts' Health Care Reform into the ACA Framework

Over the 17 years of the Demonstration thus far, eligibility has been expanded to encompass populations that have grown in numbers and diversity. MassHealth members qualify for coverage by virtue of a combination of age, income, family status, pregnancy, disability status, specific disease, and employment status. Over time, MassHealth has developed a number of programs within the Demonstration to serve these diverse groups, using targeted eligibility criteria and benefit packages for different populations. With the implementation of the ACA, some of these programs will continue, some will end, and others will be introduced. (Changes to Demonstration programs as of January 1, 2014 were described in detail as part of the Waiver amendment submitted in June, 2013.) With the recent amendment, the Demonstration's goals and objectives now align with the ACA. All MassHealth members who were eligible prior to ACA implementation will remain eligible, though some will be in different programs offering similar or richer benefits and affordability levels.

The shift to the ACA environment will simplify eligibility for subsidized coverage in the Commonwealth and align Massachusetts' coverage structure more closely to the nationwide vision for insurance affordability programs outlined in the ACA. At the same time, implementation of the ACA will expand the availability of subsidized coverage to new groups, such as people earning between 300 percent and 400 percent FPL.

The following table shows how subgroups are covered prior to ACA implementation, and how that configuration will change.

Table 1. Demonstration Program Populations

Pre-2014	As of January 1, 2014
<p>MassHealth Standard</p> <p>Children up to age 19 ≤150% FPL Children receiving Title IV-E adoption assistance Parents ≤133% FPL Pregnant women ≤200% FPL Adults w disabilities (age 19-64) ≤133% FPL Individuals in need of treatment for breast or cervical cancer ≤250% HCBS Waiver group ≤300% SSI and <\$2,000 assets Former foster care youth up to age 21</p>	<p>MassHealth Standard/Alternative Benefit Plan (ABP 1)</p> <p>Children up to age 19 ≤150% FPL Children receiving Title IV-E adoption assistance Parents ≤133% FPL Pregnant women ≤200% FPL Adults w disabilities (age 19-64) ≤133% FPL Individuals in need of treatment for breast or cervical cancer ≤250% HCBS Waiver group ≤300% SSI and <\$2,000 assets Former foster care youth up to age 21 PLUS 19-20 year olds ≤150% FPL Individuals with HIV ≤133% FPL Individuals receiving services through the Department of Mental Health ≤133% FPL Former foster care youth up to age 26</p>
<p>MassHealth CommonHealth</p> <p>Adults and children with disabilities who are not eligible for MassHealth Standard based on income</p>	<p>MassHealth CommonHealth</p> <p>UNCHANGED</p>
<p>MassHealth Family Assistance</p> <p>Individuals with HIV ≤200% FPL Children 150.1-200% FPL</p>	<p>MassHealth Family Assistance</p> <p>Individuals with HIV 134-200% FPL (≤133% in Standard) Children 150.1-200% FPL</p>
	<p>MassHealth CarePlus</p> <p>Individuals ≤133% FPL previously eligible for MassHealth Essential, MassHealth Basic Medical Security Plan, Insurance Partnership, Commonwealth Care, or receiving services paid for by the Health Safety Net Newly eligible individuals ≤133% FPL</p>
<p>MassHealth Insurance Partnership</p> <p>Employees of small employers receiving premium assistance, ≤300% FPL</p>	<p>DISCONTINUED</p> <p>Members move to MassHealth CarePlus or QHP + State Wrap (ConnectorCare)</p>
<p>MassHealth Basic</p> <p>Childless adults ≤100% FPL who are long-term unemployed and receiving mental health services or Emergency Aid to Elders, Disabled and Children</p>	<p>DISCONTINUED</p> <p>Members move to MassHealth Standard or MassHealth CarePlus</p>

Pre-2014	As of January 1, 2014
MassHealth Essential Childless adults ≤100% FPL who are long-term unemployed	DISCONTINUED Members move to MassHealth Care Plus
Medical Security Plan Individuals eligible for Unemployment Compensation, ≤400% FPL	DISCONTINUED Members move to CarePlus or QHP (with state wrap up to 300% FPL, without from 301-400%)
Commonwealth Care Adults ≤300% FPL not previously eligible for other MassHealth programs	DISCONTINUED Members move to MassHealth Standard, MassHealth CarePlus, or QHP + State Wrap (ConnectorCare)
MassHealth Limited Emergency services only for federally non-qualified non-citizens ineligible for other MassHealth programs	MassHealth Limited UNCHANGED
Health Safety Net (HSN) Individuals who are uninsured or underinsured, ≤ 400% FPL	Health Safety Net (HSN) UNCHANGED, though many previously uninsured will move to MassHealth CarePlus or QHP + State Wrap
	Qualified Health Plan (QHP) + State Wrap (ConnectorCare) Individuals not otherwise eligible for MassHealth, 133.1% to 300% FPL Lawfully present immigrants, 0-300% FPL

Section 4 Chapter 224: Improving Quality & Containing Costs in the Massachusetts Health Care System

With the passage in 2012 of Chapter 224, “An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation,” Massachusetts reaffirmed its commitment to transform the health care delivery system by moving the market away from fee-for-service payments and toward a system capable of delivering better health care and better value for all residents of the Commonwealth. The legislation sets out a broad vision for health care in Massachusetts and creates specific mechanisms to enable the state to better assess health care costs with the intention of slowing the growth of such costs in the future. Among other things, Chapter 224:

- Establishes a statewide health care cost growth target;
- Requires state programs, including MassHealth, to lead by example in moving toward alternative payment models;

- Allows for anticipated changes in the health care delivery system, including the adoption of ACO and PCMH models;
- Commits significant resources to investing in community-based public health initiatives and the health care delivery system; and
- Increases transparency through enhanced reporting and the use of health information technology (HIT).

Chapter 224 requires MassHealth, along with other payers and providers, to play a significant role in meeting the Commonwealth's goals of cost containment and improved health care quality. Below is a summary of the major provisions of Chapter 224, describing MassHealth's role in advancing the sweeping health care system changes envisioned in the law.¹⁰

Cost Growth Targets

Through the Health Policy Commission (HPC), a newly created independent agency, Massachusetts will become the first state in the nation to establish and enforce an annual health care cost growth benchmark. Under the benchmark, health care entities – including most clinics, hospitals, ambulatory surgery centers, large physician groups, ACOs and private and public payers such as MassHealth – will be required to hold the annual increase in total health care spending to the state economy's growth rate for five years, through 2017. The annual increase must be even lower for the next five years: 0.5 percentage points below the state economy's growth rate, although this rate can be modified under certain conditions. These targeted benchmarks are ambitious, with savings projected to be as high as \$220 billion in a 15-year period.

To monitor and enforce the benchmark, the HPC, with support from the Center for Health Information and Analysis (CHIA), will subject health care entities including MassHealth to hearings, reporting requirements, reviews of costs and, if appropriate, performance improvement obligations for failing to keep costs below the benchmark. The two state agencies, HPC and CHIA, will identify entities with total medical expense increases that are "excessive" by analyzing collected data and holding annual cost trend hearings. Beginning in 2015, the HPC will have the authority to enforce compliance with the benchmark by requiring health care entities to implement performance improvement plans and, as a last resort, by assessing civil penalties of up to \$500,000.

¹⁰ For a full description of Chapter 224's requirements and its implications for MassHealth, see A. Gosline and E. Rodman, "Summary of Chapter 224 of the Acts of 2012," available at: <http://bluecrossmafoundation.org/publication/summary-chapter-224-acts-2012>, and R. Seifert and R. Gershon, "Chapter 224 of the Acts of 2012: Implications for MassHealth." Blue Cross Blue Shield of Massachusetts Foundation, September 2012, available at: <http://bluecrossmafoundation.org/publication/chapter-224-acts-2012-implications-masshealth>.

Alternative Payment Methodologies

To promote the adoption of payment methods other than fee-for-service in both the public and private sectors, Chapter 224 encourages payers to develop and implement alternative payment methodologies (APMs) which may include shared savings arrangements, bundled payments and global payments.

Chapter 224 calls on MassHealth to swiftly transition its members to APMs, by requiring that 25 percent of members participate in APMs by July 1, 2013, 50 percent by July 1, 2014 and 80 percent by July 1, 2015. In addition, the law requires other public payers such as the Group Insurance Commission – as well as private payers – to implement APMs and reduce the use of fee-for-service payments.

In part to meet the requirements of Chapter 224, MassHealth has developed the Primary Care Payment Reform Initiative (PCPRI), an alternative payment model that allows primary care providers to assume accountability for the cost and quality of care through a risk-adjusted, per member, per month payment, a quality incentive payment and a shared savings / risk payment. PCPRI will be implemented across MassHealth's managed care programs including the PCC Plan and the MCOs. MassHealth plans to build on PCPRI to initiate an alternative payment program for contracting with ACOs and health systems to assume accountability for total medical expenses, as outlined in Section 5 below. MassHealth also continues to develop an alternative payment program focused on high-risk pediatric patients with asthma, with the goals of achieving better care coordination and higher quality care at total lower costs by preventing unnecessary hospital admissions and emergency room utilization.

Delivery System Transformation

Chapter 224 contemplates certain changes to Massachusetts' health care delivery system that go part and parcel with the adoption of APMs, such as the use of accountable care and medical home models, the adoption of downside risk payment arrangements and the potential consolidation of providers. The law creates a significant monitoring and regulatory role for the state in this anticipated delivery system transformation. When combined with Chapter 224's provisions on APMs, the new state authorities and the programs created under the law represent significant steps to encourage providers and payers to shift the delivery system framework in a systematic, monitored way while protecting consumers from certain potential risks associated with the changes.

In alignment with the goals and requirements of Chapter 224, MassHealth is promoting similar delivery system transformations and enhanced care integration through its new program designs, including PCPRI (described above), the One Care program and the development of health homes in the Medicaid State Plan. For PCPRI, primary care providers will transition over time to operate as medical homes and will be required to integrate primary care services with behavioral health care services. In the One Care program, a member's primary care, behavioral health care and long-term services and supports will be integrated and provided in coordination with a medical home as the foundation of the member's care. MassHealth is also developing a health home service to be delivered by certain behavioral health providers, to serve members with chronic behavioral health conditions, integrating behavioral health and primary care.

Resources for Community-based Public Health and Health Care Delivery System

As Chapter 224 puts forth a vision for the next phase of state health care reform, it also provides for significant investments of state resources in community-based public health and the health care delivery system. For example, the law creates a new Healthcare Payment Reform Fund to provide competitive awards to foster innovation in health care payment and service delivery, a new Prevention and Wellness Trust Fund designed to promote evidence-based community preventive health activities, a Distressed Hospital Fund primarily focused on community hospitals and a tax credit for small businesses that implement wellness programs.

To align with the Commonwealth's investment in ongoing programs and new initiatives created by Chapter 224, MassHealth continues to operate the Commonwealth's Safety Net Care Pool (SNCP), which has been a critical vehicle for state health care reforms in Massachusetts since 2006. In addition to authorizing funding for Commonwealth Care, the SNCP has supported providers to continue providing care for large numbers of newly insured and residually uninsured individuals in the Commonwealth. The SNCP also has provided funding to hospitals, community health centers, and other providers to invest in infrastructure and delivery system reforms that support Massachusetts' move toward more integrated systems of care and alternative payment arrangements that reward quality and outcomes. Key SNCP components include:

- Provider payments, including the Health Safety Net, made to certain providers for uncompensated costs of care for uninsured and underinsured patients;
- Delivery System Transformation Initiatives (DSTI), an innovative program that incentivizes and rewards safety net providers for investing in integrated delivery systems and capabilities necessary for payment reform; and
- Infrastructure and capacity building funds, which support grants for hospitals and community health centers for the maintenance, expansion and improvement of care provided to low-income and uninsured patients.

Transparency and Health Information Technology

Chapter 224 seeks to improve the transparency of health care data and costs for consumers, providers, payers and the state on a number of fronts. To assist with the monitoring of the cost growth benchmarks and supporting policy analysis, one state agency, CHIA, is charged with collecting and analyzing health care data to make information on the quality, price and cost of health care services readily available to the public. Health insurance carriers are required to establish a toll-free telephone number and website that enables an insured individual to find out the charge for a proposed service and any relevant cost-sharing amounts.

Underlying Chapter 224's promotion of more transparent health care information in the Commonwealth, the law encourages advancements in HIT. Among other things, the law sets the ambitious goal that by January 2017, most health care providers in the Commonwealth must implement fully interoperable electronic health record (EHR) systems that connect to the statewide health information exchange, and every patient must have electronic access to their health records. Also by 2017, ACOs, medical homes and risk-bearing provider organizations will be required to have interoperable EHR systems available to coordinate care, share information and prescribe electronically. The law shores up financial resources to promote HIT such as adding \$30M to the e-Health Institute Fund to defray costs to providers of adopting EHR systems and creating the HIT Revolving Loan Fund to make zero interest loans to providers developing interoperable HIT. MassHealth's partnership with the federal government in monitoring providers' implementation of meaningful use requirements for HIT and operating the Medicaid EHR Incentive Program complement the HIT goals outlined in Chapter 224.

Moving Health Reform Forward

Overall, Chapter 224 requires MassHealth to play a significant role in advancing far-reaching system changes intended to contain costs and improve health care quality in the Commonwealth. As the law sets ambitious goals, attainment of these goals and implementation of the law's provisions will take a number of years to complete. Accordingly, the five-year timeframe MassHealth seeks for this Demonstration renewal is key to enable MassHealth to support the Commonwealth's long-term vision for health care reform and to carry out the necessary provisions of Chapter 224. As reflected in the requests outlined in Section 5 below, MassHealth will continue to be fully engaged with CMS to ensure the success of these vital health care system transformation efforts in the Commonwealth.

Section 5 Requested Changes to the Demonstration

The Commonwealth is seeking to evolve its partnership with the federal government through the Demonstration to support MassHealth reform initiatives, both short and long-term, that will maintain near universal coverage, continue redirecting spending from uncompensated care to insurance coverage, implement delivery system reforms and advance alternative payment models. This section describes the Commonwealth's requested changes to the Demonstration.

As described in Section 4, Chapter 224 requires MassHealth, along with other payers and providers, to play a significant role in meeting the Commonwealth's goals of cost containment and improved health care quality. To meet these objectives, Massachusetts must continue to reform the organization of the health system to promote collaboration and efficiency, as well as reform the payment system to align high quality outcomes with financial incentives. While the Commonwealth, and MassHealth in particular, is well positioned to continue its leadership role in these areas by focusing on alternative payment methodologies and delivery system transformation including medical homes and integrated care for high risk populations, the Commonwealth's partnership with CMS through the Demonstration remains central to the Demonstration's continued success.

A Five-Year Renewal Period and the One Care Integrated Care Model

As discussed in Section 1, Massachusetts seeks a five-year extension of this 1115 Demonstration, consistent with Section 1915(h)(2) of the Social Security Act, which authorizes five-year renewal terms for states that provide medical services for dual eligible individuals through their Demonstrations. A “dual eligible individual” is defined as an individual who is entitled to, or enrolled for, benefits under Part A of Title XVIII, or enrolled for benefits under Part B of Title XVIII, and is eligible for medical assistance under the State Plan or under a waiver of such plan.

On August 22, 2012, the Commonwealth entered into a Memorandum of Understanding (MOU) with CMS to establish the Massachusetts Capitated Financial Alignment Demonstration (also known as the Duals Demonstration). The Duals Demonstration aligns payments for Medicare and Medicaid services by creating a single integrated care model delivered by contracted health plans that provide the full spectrum of medical, behavioral health, and long-term services and supports to individuals who have the most complex needs and highest service utilization of any population groups in either the Medicaid or Medicare programs. MassHealth calls its Duals Demonstration program One Care. Enrollment in One Care plans begins in October 2013.

In addition to the broader health care system transformation goals that a five-year renewal term would support, the five-year extension is particularly important with regard to the success of the Duals Demonstration. This longer timeframe will enable the Commonwealth to more fully realize the potential of One Care’s fully capitated, integrated care model for dual eligible members under the age of 65. There are critical interdependencies between the 1115 Demonstration and the Duals Demonstration, created by the authorities provided by each and their timelines, which make it essential for the two demonstrations to be able to evolve together and stay in alignment. For example:

- Both demonstration projects include the target population of persons with disabilities who are under the age of 65.
- The 1115 Demonstration provides the eligibility rules that ultimately determine who is a non-elderly “dual eligible individual,” as it contains the rules defining MassHealth Standard and CommonHealth eligibility. Any changes to the income methodology, spend-down, resource, or cost-sharing provisions of the 1115 Demonstration would directly affect the ability of individuals to become enrolled or stay enrolled in One Care. This would de-stabilize services for the Duals Demonstration enrollees and adversely affect our ability to accurately evaluate the Duals Demonstration.
- The Duals Demonstration provides the managed care authority needed to offer the full gamut of Medicare and Medicaid services within the capitation for the One Care plans. The 1115 Demonstration cannot authorize the inclusion of Medicare services, nor does it currently include Medicaid long-term services and supports, as those services are not currently included in the budget neutrality construct of the 1115 Demonstration.

It is therefore imperative that the Commonwealth receive a five-year 1115 Demonstration term in order to ensure a stable eligibility foundation for the Duals Demonstration that would allow for extensions and other adjustments over time.

Further, the Duals Demonstration will provide valuable information about the impact of a fully integrated care model for persons with disabilities even if they are not dual eligibles. One Care was developed to provide the following:

- Intensive care coordination and complex care management
- Long-term services and supports coordination
- Primary care and behavioral health integration
- Diversionary behavioral health services (identical to those authorized through expenditure authority in the 1115 Demonstration)
- State plan long-term services and supports
- Home care services
- Peer supports and community health workers to support recovery and wellness

The Commonwealth will test this model and use experience with One Care to determine how the program can best be expanded to serve Medicaid-only populations as well. Here again, Massachusetts will need to leverage one Demonstration to inform the other. In many respects, Medicaid-only members with disabilities are “pre-duals.” They have been determined to meet Social Security Administration standards for disability but have not yet met the two-year requirement to be eligible for Medicare. There is every reason to believe that the model of care being used in the Duals Demonstration, if proven to be effective in promoting the right care, in the right place, at the right time, will be similarly effective with the Medicaid-only population with disabilities. The 1115 Demonstration would be our primary vehicle for expanding this model of care over the next five years.

Advancing Alternative Payment Models

The Commonwealth requests authority to set shared savings / risk targets for providers and to make shared savings payments or, as applicable, recoup payments to providers under alternative payment arrangements involving shared risk. This authority will serve as the foundation for both MassHealth’s Primary Care Payment Reform Initiative and a broader accountable care model in development. Each is described in more detail below.

1) Transforming Health Care Delivery and Payment through the Primary Care Payment Reform Initiative

Historically, the payment and delivery systems in Massachusetts, as in the rest of the country, have been grounded in a traditional fee-for-service (FFS) structure that does not inherently promote efficiency, quality or coordination of care. MassHealth, particularly in light of the recent passage of comprehensive

health care cost containment legislation, Chapter 224 of the Acts of 2012, is fully committed to transforming its payment and delivery systems. The Primary Care Payment Reform (PCPR) Initiative is MassHealth's flagship alternative payment model. Based largely on the successes and findings of the Massachusetts Patient Centered Medical Home Initiative (MA-PCMHI), MassHealth has developed PCPRI as a broader, scalable model for alternative payment methodologies and medical home transformation in the Commonwealth.

In operation since 2011, MA-PCMHI is a three-year, multi-payer initiative to transform selected primary care practice sites into patient-centered medical homes. As a participating payer, MassHealth implemented this initiative for enrollees in both its Primary Care Clinician (PCC) Plan and its contracted Managed Care Organizations (MCOs). As a condition of participation in the MA-PCMHI, each practice must meet (i) reporting requirements on clinical and operational measures and (ii) benchmarks to indicate continued progress towards medical home transformation.

Forty-six practices, representing a range of sizes, structures, and geographies, have participated in MA-PCMHI. From more than two years of experience with this initiative, MassHealth has reached three key conclusions:

- i) **Fee-for-service reimbursement for primary care inhibits medical home transformation.** Practices receiving fee-for-service payments are inclined to increase the number of patient visits, which runs contrary to the medical home model of ensuring the appropriate amount of care is consolidated into one visit. Additionally, practices do not receive fee-for-service reimbursement for care coordination and care management activities, which are critical components of the patient-centered medical home model. This is a disincentive that may decrease the emphasis placed on those services.
- ii) **Integration of behavioral health services into primary care is a significant challenge.** There are technical, legal, and cultural barriers to full integration of behavioral health services, and overcoming these barriers will require significant investment of training and resources.
- iii) **Medical home transformation requires time and resources.** Practices demonstrated progress toward becoming medical homes during the Demonstration period, but such changes have required both organizational transformation and individual transformation at a staff level.

Like MA-PCMHI, the PCPRI is based on a vision for primary care providers to take accountability for the cost and quality of care through a patient-centered medical home that includes care coordination and care management, enhanced access to primary care, coordination with community and public health resources, integration with behavioral health, and population health management. PCPRI differs from MA-PCMHI in its payment model and delivery system requirements and, while the PCPRI involves both the PCC Plan and the MCOs, PCPRI will not include patients within the primary care practices who are not covered by MassHealth.

The payment mechanism that supports the PCPRI delivery model is a Comprehensive Primary Care Payment (CPCP) combined with quality incentives and a shared savings / risk arrangement. The CPCP is a per-member-per-month, risk adjusted payment for a defined set of primary care services and medical home activities, with options for each provider to include some outpatient behavioral health services as well. This enhanced payment mechanism will afford providers the flexibility to deliver primary care in the most effective way, independent of the rigid structure required in fee-for-service billing. Innovations in primary care delivery may include, for example, improving access through phone and email services, expanding the care team to include community health workers, and group or family visits.

The PCPRI's quality incentive is an annual payment for improving the delivery of primary care services, as determined by performance against specified quality indicators. The program's shared savings / risk arrangements allow providers to share in MassHealth's savings on non-primary care spending if the actual costs of care fall below MassHealth's expected costs over a specified time period. PCPRI offers providers options with varying levels of shared savings and shared risk in order to make the model flexible enough to accommodate providers at different stages of readiness for accountable care models.

To transform the health care delivery system for members, the PCPRI builds on the MA-PCMHI structure by adding detailed requirements for behavioral health integration as a key focus of the PCPRI delivery system. PCPRI providers are required to form relationships with behavioral health providers and negotiate terms of interaction, including information sharing protocols, mechanisms for engaging in provider-to-provider consultations, and tools for aligning treatment plans. The initiative establishes milestones for practices to reach in medical home transformation over the course of two years, rather than a general series of requirements to be met simultaneously.

To support providers in managing care and costs, MassHealth anticipates providing timely data for care coordination and cost management, and offering targeted technical assistance to providers. MassHealth is still evaluating the results from MA-PCMHI, and will continue to use those insights in the development of PCPRI and other alternative payment models.

2) Pursuing a Future ACO Initiative

The authority to engage in shared savings and shared risk –based payment arrangements with providers will establish the foundation for the Commonwealth to fully implement both the PCPRI and a future accountable care organization model currently in development. MassHealth is in the early stages of developing a global payment model, but we have outlined the basic principles of what would constitute such an arrangement. A global payment model would build on Primary Care Payment Reform, maintaining the emphasis on medical home transformation and behavioral health integration. However, we would consider making three key changes to the model:

- Contracting directly with an ACO to allow hospitals and other non-primary care provider types to participate in the alternative payment model and align around coordinated care across the delivery system.
- Adjusting the payment model to encourage providers to take on higher levels of risk. Primary Care practices alone may not be in a position to take on significant shared risk on the total cost of care. We would want to move toward symmetrical (upside and downside) risk as a key component of our global payment model, although we have yet to define the details of that structure.
- Modifying the quality metrics and clinical delivery model requirements to extend to the “medical neighborhood,” not just the medical home. This may include, for example, adding hospital-based quality metrics or requiring specific protocols of interaction between specialists and primary care physicians.

In the coming months, MassHealth plans to work with our state stakeholders and federal partners to more fully define this new accountable care model.

Pediatric Asthma Pilot Program

The Commonwealth requests continued authority to implement a Pediatric Asthma Pilot Program for MassHealth members aged two through eighteen with high risk or poorly controlled asthma who are enrolled in selected PCC Plan practices. These members will receive a comprehensive, chronic disease management approach to asthma through an integrated delivery system to prevent the need for hospital admissions and emergency department visits and improve health outcomes. The payment mechanism for the program is a bundled payment for services, such that MassHealth can evaluate the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation as demonstrated by improved health outcomes at the same or lower cost.

For the pilot program, the Commonwealth shared protocols with CMS in early January 2013 and has responded to CMS questions in subsequent months. On April 12, 2013, the Commonwealth issued a Request for Responses to procure MassHealth PCC Plan primary care practice sites to participate in the pilot program. The Commonwealth received responses from seven PCC Plan practice sites. An evaluation committee reviewed the responses and recommended that EOHHS contract with four practice sites. Taken together, this group of selected practice sites is diverse in terms of practice structure and practice affiliation. Based on MassHealth member data for these four practice sites, the Commonwealth estimates that at least 200 MassHealth members will qualify for and be enrolled in the pilot program.

The pilot program will be implemented in two phases, with each phase expected to last from one to two years. Phase 1 will begin once the Commonwealth receives CMS approval and PCC Plan provider contracts for the selected practice sites are amended. During Phase 1, participating PCCs will receive a per member, per month bundled payment that will pay for asthma mitigation services not currently paid

for by the PCC Plan for high-risk asthma patients, including home visits and care coordination services provided by qualified community health workers, along with supplies and services to mitigate the effects of environmental asthma triggers.

The Commonwealth will evaluate Phase 1, as described in the evaluation plan, when it has at least one full year of data documenting the results of Phase 1. If the evaluation determines that the pilot program resulted in improved health outcomes at the same or lower cost, the Commonwealth will request CMS approval for Phase 2, which the Commonwealth would like to begin in 2015.

During Phase 1, the Commonwealth will consult with participating practices regarding the development of a Phase 2 bundled payment methodology. The Commonwealth plans to evaluate existing specifications to determine the precise bundle of ambulatory services that will be included in this Phase 2 bundled rate, such as the Minnesota Baskets of Care and the Prometheus projects. The Commonwealth also plans to evaluate alternative payment methodologies for Phase 2, including risk adjustment and/or a method for sharing savings between the Commonwealth and participating practices.

In Phase 2, pilot program services will include both the high-risk asthma mitigation services from Phase 1 plus a bundle of ambulatory asthma services that are necessary for the effective treatment and management of pediatric asthma. For example, Phase 2 pilot program services may include certain Medicaid State plan services with utilization that is particularly sensitive to uncontrolled asthma (e.g., treatment provided by physicians, nurse practitioners and hospitals, medical equipment such as a nebulizer, spacer, peak flow meter, etc.). The participating practices will be responsible for providing all of the Phase 2 services directly or through subcontracts. The Commonwealth expects to include in the Phase 2 bundled payment certain ambulatory services currently paid for by the PCC Plan. The Phase 2 plan will include a mechanism to ensure there will be no duplication of payments.

To defray the provider costs of implementing the financial, legal and information technology system infrastructure required to manage a global, per member per month payment and coordination of patient care, participating providers are eligible for up to \$10,000 per practice site for the sole purpose of infrastructure changes and interventions related to this pilot program. The amount of infrastructure support is variable up to the maximum amount, depending on the provider's readiness, the Commonwealth's review and finding of such readiness, and CMS' concurrence on the use of the proposed funding for the practice.

Safety Net Care Pool

The years 2005 and 2006 were a watershed period for MassHealth. As state leaders were determining the best path to ensure universal access to health insurance—deliberations that culminated in the enactment of Chapter 58 in 2006—negotiations over renewal of the Demonstration between the Commonwealth and CMS led to creation of the Safety Net Care Pool (SNCP). The SNCP reflects the ongoing state-federal partnership by providing critical funding for the Commonwealth Care program,

the Designated State Health Programs, the Health Safety Net, hospital expenditures by the Department of Public Health and the Department of Mental Health, and other supplemental payments to safety net providers. Through these expenditures, safety net providers are supported in their efforts to provide health care for the newly insured and uninsured low-income residents.

The SNCP expenditure programs not only provide security for safety net providers – such as hospitals, community health centers, and others –they also promote investments in delivery system and payment reforms. Many of these providers are considered “doubly disadvantaged,” where their high public payer population and low commercial payer populations lead to limited budgeting flexibility. Due to spending constraints, safety net providers have difficulty making new investments in critical reforms. The SNCP supports reform through programs such as the Delivery System Transformation Initiatives and the Infrastructure and Capacity Building Grant program. By making these investments, MassHealth demonstrates its commitment to safety net providers and to systemic reforms that increase quality and lower health care costs.

The ACA creates new opportunities for the Commonwealth’s health care system. The state must make some important adjustments to its SNCP in order to comply with the federal statute. Despite the changes to the SNCP’s current structure, it is imperative that Massachusetts sustains and makes progress on the goals of universal coverage, high quality care and lowered costs.

The Commonwealth requests the following authorities for the SNCP:

- Elimination of the Provider Sub-Cap;
- Continued expenditure authority for existing Designated State Health Programs, and new authority for additional programs; and
- Continued authority for the Delivery System Transformation Initiatives, Supplemental Payments for Cambridge Health Alliance and the Infrastructure and Capacity Building Grants program.

Appendix C lists the requested SNCP funding for this Demonstration renewal period.

1) Provider Sub-Cap

Massachusetts proposes to eliminate the Provider Sub-Cap that has served as an upper limit on certain payments to providers under the Safety Net Care Pool. The amount of the annual Provider Sub-Cap has been determined by the Commonwealth’s annual Disproportionate Share Hospital (DSH) payment allotment. However, pursuant to the terms of the FY2012-2014 extension of the Demonstration, the Commonwealth is developing a cost limit protocol whereby, starting in FY 2015, Safety Net Care Pool payments that are now subject to the Provider Sub-Cap will be limited to the provider-specific costs of uncompensated care for Medicaid and uninsured patients. These provider-specific cost limits will result in a de facto overall limit on the provider payments that are currently subject to the sub-cap, making the Provider Sub-Cap redundant.

Eliminating the Provider Sub-Cap is also important to mitigate the potential negative impact of the ACA's DSH reductions for federal fiscal years 2014 through 2020. Providers that receive Safety Net Care Pool payments are overwhelmingly those that serve a disproportionate share of Medicaid and uninsured patients. These providers have played an important role in the success of Massachusetts' health insurance expansion by providing care for a large number of the newly insured population and by assisting many uninsured individuals to access Medicaid benefits and other subsidized coverage through their outreach and enrollment efforts. Safety net hospitals experienced a significant increase in Medicaid patient care volume in the years following Massachusetts' health care reform. With the implementation of the ACA and the continued expansion of coverage, these providers' roles in providing care and performing outreach and enrollment functions will only grow. It is therefore imperative to maintain support for these providers through the Safety Net Care Pool.

2) Designated State Health Programs

The Commonwealth requests to extend and expand upon its expenditure authority for Designated State Health Programs (DSHP) to support Massachusetts' investments in state health programs that are important to the success of both national and state health care reform. Massachusetts is at a critical juncture as the state seeks simultaneously to partner with the Obama administration to fully realize the goals of the ACA and to implement the next phase of state health care reform, as envisioned in Chapter 224. Both of these endeavors require significant investments of federal and state Medicaid resources at a time when the economy is continuing to recover slowly and demands on the state budget are high. Despite the fiscal challenges, Massachusetts has renewed its commitment to universal, high-quality and affordable health care and has charted a path to tackle long-term health care cost growth.

The Commonwealth therefore requests federal support for DSHP expenditures for fiscal years 2015 through 2019, including three categories of expenditures, as described below.

- i) Massachusetts requests expenditure authority for health programs previously authorized as DSHP, such as programs administered by the Massachusetts Department of Public Health, the Department of Mental Health, the Department of Corrections, the Department of Elder Affairs, and the Executive Office of Health and Human Services.

The Commonwealth requests to restore claiming authority for these programs to \$360 million annually for fiscal year 2015 through fiscal year 2019.

- ii) Massachusetts requests expenditure authority for state-supported subsidies for individuals with incomes up to 300 percent of the Federal Poverty Level (FPL) who enroll in insurance through the Health Connector marketplace. These state subsidies will supplement federal premium tax credits and cost sharing reductions that will also be available for qualified plans purchased through the Health Connector. The combination of federal and state subsidies will make subsidized coverage for this population as affordable for them as it is today under Commonwealth Care. The state subsidies will include a premium assistance component, as

indicated in MassHealth's June 14, 2013 Amendment request, and a cost sharing reduction component.

As previously agreed with CMS, FFP under the Demonstration will only be available for the premium assistance portion of state subsidy expenditures for citizens and qualified aliens in calendar year 2014. Massachusetts proposes to expand its expenditure authority to also include state-supported cost sharing reductions, as well as both premium assistance and cost sharing reductions for Lawfully Present immigrants, starting on January 1, 2015. Point-of-service cost sharing reductions will play a critical role in making health care truly accessible to lower-income enrollees. Like the state-supported premium assistance payments for which CMS has agreed to provide FFP, these cost sharing reductions are intended to maintain the affordability levels that Massachusetts has established in Commonwealth Care under the Demonstration. Furthermore, while Massachusetts historically has provided Commonwealth Care coverage for qualified immigrants at full state cost, the ACA will make available federal premium tax credits and cost-sharing reductions for Lawfully Present immigrants through state-based marketplaces such as the Health Connector. Consistent with this recognition for Lawfully Present immigrants, we propose that federal matching funds should also be available for state-supported subsidies to maintain affordability for this population.

The Commonwealth requests authority to claim qualified expenditures for state premium assistance and cost sharing subsidies, estimated at up to \$145 million in state fiscal year (SFY) 2015 and \$230 million in state fiscal year 2016, growing at approximately 3.5 percent per year thereafter. The requested expenditure authority for SFY 2015 represents only half a year's spending for cost sharing reductions and subsidies for Lawfully Present immigrants, starting January 1, 2015. In addition, due to the fact that spending for these state subsidies is driven by enrollment growth and changes in commercial health insurance costs, the Commonwealth requests that DSHP expenditures for state affordability subsidies not be capped. Instead, we propose that federal matching funds be available for any qualified expenditures under this authority, notwithstanding any Safety Net Care Pool cap or DSHP sub-cap that applies to other DSHP-authorized program expenditures. This is important to provide surety during the transition period to the ACA environment.

- i) Massachusetts requests expenditure authority for new state health programs associated with Chapter 224 and related efforts to advance Massachusetts' ambitious health care reform and cost containment agenda, including:
 - Prevention & Wellness Trust Fund
 - E-Health Institute
 - Community Hospital Acceleration, Revitalization, and Transformation Grants

- Health Connector Employer Wellness Program Rebates
- State Employee Wellness Programs
- Center for Health Information and Analysis health care transparency programs

The Commonwealth requests authority to claim expenditures for these programs up to an estimated \$100 million annually in fiscal year 2015 through fiscal year 2019.

3) Delivery System Transformation Initiatives

The Commonwealth proposes to extend its expenditure authority for the Delivery System Transformation Initiatives (DSTI). This program is funded through the Safety Net Care Pool and was established in 2011 as the Commonwealth continued to promote high quality, integrated and efficient care at Massachusetts safety net hospitals. While many providers have had the resources and capacity to make significant investments in system transformation, safety net providers are doubly disadvantaged by their high public and low commercial payer mix. DSTI funding has provided safety net providers with the resources and support necessary to begin to advance improvements in their operations, while maintaining critical services for MassHealth members.

Seven hospitals were qualified to participate in DSTI based on their high Medicaid and low commercial payer mix. Specifically, in order to qualify, hospitals were required to have a Medicaid payer mix one standard deviation above the statewide mean and a commercial payer mix one standard deviation below the statewide mean. These participating hospitals include Boston Medical Center, Cambridge Health Alliance, Holyoke Medical Center, Lawrence General Hospital, Mercy Medical Center, Signature Healthcare Brockton Hospital and Steward Carney Hospital.

When DSTI launched at the beginning of the current Demonstration renewal period, each of the seven participating hospitals established unique DSTI programs that sought to fulfill four objectives: development of a fully integrated delivery system; improvement of health outcomes and quality; movement towards value-based purchasing and alternatives to fee-for-service payments; and population-focused improvements.

Semi-annual and annual progress reports for state fiscal years 2012 and 2013 demonstrate that providers receiving DSTI funding have taken critical steps toward system transformation. Examples of the work that each hospital has undertaken during the current demonstration period so far are highlighted below. Some examples include:

Boston Medical Center's Re-Engineered Discharge Process (Project RED). Boston Medical Center's (BMC's) Project RED aims to decrease preventable hospital readmissions and returns to the emergency department by educating patients about their hospital and post-hospital care and ensuring a smooth discharge transition. In the second year of the initiative, Project RED was expanded into the daily workflow of a dedicated inpatient unit, allowing BMC to better integrate the program and create staffing efficiencies. An initial internal analysis shows that the readmission rate for patients enrolled in

the Project RED program at BMC declined 27 percent, while the readmission rate for adult medical Medicaid patients not enrolled in the program declined 15 percent. With continued DSTI support, BMC will take lessons learned from Project RED and develop an approach for reducing readmissions more broadly across the hospital, while continuing to meet the unique needs of the low-income population.

Cambridge Health Alliance (CHA) Patient-Centered Medical Home Initiative. CHA is advancing the patient-centered medical home (PCMH) model in its primary care system, as a foundation for improving population health and panel management in alternative payment models consistent with the Triple Aim goals. Building on a detailed gap assessment for four primary care sites in year one, in year two CHA completed a gap closure plan, filed National Committee for Quality Assurance (NCQA) PCMH applications, and recently received NCQA Level 3 recognition for all four sites, bringing half of CHA primary care centers into this model. By the end of FY14, CHA will have applied or re-applied for NCQA medical home status for seven primary care centers that care for 50,000 patients. Continued DSTI funding will enable CHA to expand the medical home model across CHA's entire primary care system.

Holyoke Medical Center's Health Information Exchange (HIE). Holyoke Medical Center (HMC) is advancing an ambitious plan to create a HIE, which would not have been possible without DSTI funds. The HIE, which goes far beyond current Meaningful Use requirements, integrates both affiliate and independent providers and provides seamless interoperability and access to patient data between the emergency department and 40 community physicians. Community providers embraced HMC's vision for this expansive approach that will enable health information to follow the patient, support clinical decision-making, improve care coordination, and reduce the duplication of tests. In the upcoming Demonstration renewal term, HMC plans to expand connectivity to non-affiliated practices, health centers and hospitals in its service area, as well as initiate a connection to the Massachusetts Health Information Highway (the Mass HIway).

Lawrence General Hospital's Physician Hospital Organization (PHO) Initiative. Lawrence General Hospital (LGH) used DSTI funds to bring its disparate, independent physician group practices, solo practitioners, and the independent local health center together under an umbrella entity, the Physician Hospital Organization (PHO). More than 320 physicians joined the PHO and for the first time are working together on clinical integration, engaging in dialogue about referral patterns, preventing "leakage" to higher cost providers, contracts, payment systems and technology initiatives. LGH intends to continue this project to invest in referral systems and data analytics, steps that will enhance the PHO's capacity to enter into contracts with health plans as an entity, and accept alternatives to fee-for-service payments.

Mercy Medical Center's Aligning Systems to Improve Health Outcomes & and Quality. Mercy Medical Center (Mercy) is designing and implementing an innovative, patient-centered, care coordination and management system called Care Logistics™. This system integrates hospital system workflows to reduce the time to place patients in available beds, treat patients and discharge them safely to the appropriate level of care. Mercy completed a comprehensive assessment of its current care management processes, based on interviews of 261 hospital staff from 39 departments. The hospital is developing a new care

coordination model that reconfigures eleven major hospital departments linked by “spokes” into a cohesive “Care Coordination Center” hub. These changes are fostering greater team work, improved patient flow, and enhanced quality. In the next renewal period, Mercy will continue to develop and refine this new organizational structure.

Signature Healthcare Brockton Hospital’s 360° Patient Care Management. Signature Healthcare created a patient care management program for its most seriously ill Medicare managed care population. These patients receive care from a multidisciplinary team, including a physician, nurse practitioner, case manager, pharmacist and physical therapists, as well as community partners such as visiting nurses and hospice. By coordinating the right care delivered in the right place at the right time, the program has resulted in a significant reduction in acute admissions, skilled nursing admissions and the use of long-term care hospitals for this patient population. Signature Healthcare will use ongoing DSTI funding to continue this program for the managed Medicare managed care population and expand the program to other populations.

Steward Carney Hospital’s Community Health Worker Initiative. Steward Carney Hospital (Carney) has found tremendous benefit in participating in the DSTI program, strengthening its position as an integrated provider in the Dorchester by enhancing care management and care transitions capabilities. A key component of Carney’s success is the addition of bilingual community health workers (CHWs) operating as patient navigators. CHWs interface with patients entering the hospital through the Emergency Department (ED) and serve as navigators for those patients to get linked in to regular primary and preventive care. Carney’s CHWs have successfully connected hundreds of ED patients with regular primary care practitioners (PCPs) and succeeded in bridging gaps regarding follow-up care, rescheduled appointments, and changes in insurance. Carney’s CHW program informs a broader strategy to create a health care system that engages with patients in a more culturally competent manner, resulting in higher patient satisfaction and appropriate use of medical services.

The Commonwealth proposes that the DSTI investments that have been made to the seven participating safety net providers continue in the Demonstration renewal term. Continued investments are essential to sustaining and building on early successes to realize additional progress in the safety net providers’ delivery and payment systems. As these DSTI investments have only been fully implemented for two years, there is much more work to be done to realize the long-term goals of system transformation. In the Demonstration renewal term, the Commonwealth and participating safety net providers seek to leverage DSTI funds to advance and sustain new models of care delivery that emphasize greater clinical integration and care management, as well as to advance payment models that align incentives more effectively at the provider level.

Massachusetts DSTI initiatives are on track in making essential foundational progress, revealing great promise, early results, and learning from initial activities. Yet DSTI initiatives are ongoing, and there is significant value in continuing DSTI to yield further advances. Learning from current DSTI initiatives has provided meaningful insights about spreading transformation and additional areas of focus for future

DSTI activities. Unlike other states that have received initial approval for five-year hospital incentive programs, Massachusetts' DSTI program was initially approved for three years, due to the length of the Demonstration renewal term. While the three-year period offers an opportunity to show important initial progress in the DSTI initiatives, more time is needed to solidify this early success and to realize greater results.

Based on the foundational work so far, continued support of DSTI in the proposed five-year Demonstration renewal term will propel continuing progress and innovation among the seven participating hospitals. For the five-year renewal period, the Commonwealth envisions that this new phase of DSTI work will involve a combination of:

- Continuing initiatives that require greater time beyond the current three-year term to reach transformational goals as they move into the critical implementation phase,
- Expanding initiatives either in scale, scope, focus, or patient populations, consistent with quality improvement approaches that spread best practices and innovations, and
- Implementing new initiatives.

New initiatives may include, for example, efforts to integrate primary care and community health, as called for by the Institute of Medicine, and to partner with patients in engaging effectively in their own health. Other new initiatives may focus on priority areas for the Commonwealth and the federal government such as behavioral health and physical health integration, patient safety, effective care transitions including for high risk populations inclusive of those with behavioral health needs, and substance abuse screening and interventions.

The Commonwealth requests expenditure authority of \$262 million annually in each of the five fiscal years of new Demonstration term. The request represents an increase over the current annual funding level, reflecting the Commonwealth's ongoing commitment to support delivery system transformation at the seven DSTI-eligible hospitals. The proposed five-year extension of DSTI will offer the opportunity to more fully realize the potential impact of the DSTI initiatives and the longer-term trajectory required of continuous and ongoing transformation. These continued DSTI investments are critical to ensure lasting improvements in care delivery to patients and payment to safety net providers.

4) Supplemental Payments for Cambridge Health Alliance

Improving health and health care for Demonstration populations is contingent on the contributions of the Commonwealth's largest and most concentrated Medicaid safety net systems. As Massachusetts' successful coverage expansions are transitioned to other states through the ACA and the Commonwealth initiates state-led payment reform and cost containment, providers like Cambridge Health Alliance (CHA) will play a prominent role in advancing promising delivery system transformation and emerging public payer alternative payment models that better align health outcomes with the payment system. The Commonwealth proposes continued support for CHA, Massachusetts' only public acute hospital system and an essential partner in serving Medicaid and uninsured populations. This

funding will support CHA's unique and critical role in the Medicaid delivery system, its robust model of care for particularly vulnerable patient populations, and its ongoing transformation.

CHA's health care services and its care model are aligned with the Triple Aim goals of better health, better care, and cost-effectiveness and position CHA well to make meaningful progress with new care delivery and payment models. However, CHA faces financial disadvantages and unique circumstances due to its commitment to providing services on which the public and government rely: extensive behavioral health services, primary care, and community-based ambulatory and hospital care. Although aligned with the value premise that the future health care system must focus on wellness and on cost-effective and coordinated care, CHA's services are not well reimbursed in the usual reimbursement system.

CHA is distinguished from other Massachusetts providers by the following:

- CHA has the highest concentration of patients participating in Demonstration programs of any acute hospital in the Commonwealth (50%) about three times the acute hospital average (18%) and over two times the average of the state's disproportionate share hospitals (23%);¹¹
- Thirteen percent of CHA's gross patient service revenue is from services to the uninsured, 4.6 times greater than the statewide acute hospital average;¹²
- CHA provides 12% of all uninsured care provided by acute hospitals in the state of Massachusetts despite providing 4% of all acute hospital inpatient and outpatient care statewide;¹³
- CHA provides 11% of all Medicaid and low-income statewide psychiatric inpatient care in the state, despite providing 1.5% of all medical and behavioral health inpatient care in the state;¹⁴
- CHA plays a regional role in access to nationally-recognized behavioral health services for pediatrics, adolescents, adults and geriatrics, with 43% of its inpatient patient days and about 105,000 outpatient visits for behavioral health;¹⁵
- About 60% of CHA's total patient revenue is from Medicaid, Commonwealth Care and uninsured payers; government payers, including Medicare, account for 82% of CHA's revenue;¹⁶
- Among Massachusetts hospitals, CHA has the highest concentration (57%) of Medicaid and low-income public payer populations among its 665,000 patients who receive outpatient services;¹⁷
- CHA, through its fully integrated and owned primary care sites and health centers, is an ongoing force in improving primary care access for underserved patients, growing primary care panel patients by 40% during the period spanning Massachusetts' health reform;¹⁸ and

¹¹ Comparative payer mix data is based on FY 2011 Gross Patient Service Revenue from Massachusetts' Hospital Statement of Costs, Revenues, and Statistics (DHCFP-403). Medicaid and low-income public payer populations include Medicaid fee-for-service, Medicaid managed care, residually uninsured and Commonwealth Care.

¹² Ibid.

¹³ Based on FY 2011 encounters from Massachusetts' Hospital Statement of Costs, Revenues and Statistics (DHCFP-403).

¹⁴ Ibid.

¹⁵ Cambridge Health Alliance Internal Statistics, SFY 2012.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Ibid.

- CHA’s community teaching programs are oriented to training future generations of physicians and clinicians in critical shortage professions such as primary care and behavioral health in new PCMH and medical and behavioral health integration models of care.

CHA has made important strides during the current Demonstration renewal period, upon which the Commonwealth and CHA intend to build in the upcoming renewal term. As a critical access point for Medicaid and low-income patient populations, CHA is advancing a PCMH model of care in its primary care system as a foundation of its efforts to develop the capabilities for improving population health and panel management under alternative payment methods. CHA has achieved the highest level of NCQA medical home recognition (Level 3) for six of its core primary care sites, upon which it plans to expand in the upcoming term. CHA is also participating in the MA-PCMH and was recently recognized by the Robert Wood Johnson Foundation as one of thirty outstanding primary care practices in the country through the *Primary Care Team: Learning from Effective Ambulatory Practices (LEAP)* program. This year, CHA was recognized for its public health and clinical care collaborations with the City of Cambridge, through the inaugural Robert Wood Johnson Foundation Roadmaps to Health Prize, awarded to six communities across the country for outstanding community partnerships that help residents live healthier lives.

CHA also has furthered its participation in alternative payment models, including for Medicaid and Commonwealth Care managed care, dual eligible populations and the Medicare Shared Savings Program, which together comprise about 38% of CHA’s panel of primary care patients in government payers. Additional collaborations, including for Demonstration populations, are on the near-term horizon.

CHA has demonstrated substantial improvements in the performance of its public hospital delivery system and on cost containment. Building on its partnership with EOHHS in successfully implementing a major services reconfiguration in 2009 – 2010, CHA has worked consistently to contain costs and hold annual inflation below industry trends. Given the pace of change in health care, renewed financial improvement initiatives are imperative to CHA’s safety net system sustainability and ongoing services to its communities. In its services reconfiguration, CHA consolidated its clinical services footprint while preserving core services needed by its communities. It also increased efficiencies, transitioning from three to two inpatient hospital facilities, “right-sizing” mental health services, and consolidating primary care clinics, while retaining the essential primary, behavioral health, and acute continuum of care. CHA’s reconfiguration was seen not as an endpoint but as a platform for new health care delivery and payment models that afford sustainability for safety net systems and populations. CHA’s efforts have resulted in expense reduction and mitigation and improvement in revenues; underlying challenges and payment disparities that CHA faces within the current payment system persist, however.

CHA continues to be an essential provider in Massachusetts’ safety net health care system for Medicaid, uninsured and low-income individuals. The Commonwealth and the federal government have long recognized, through approved Demonstration renewals, the need to provide special recognition of the

unique public safety net requirements CHA faces and the challenges of financing of those requirements. CHA's payments support the overall Massachusetts Medicaid health care financing structure.

Accordingly, the Commonwealth requests expenditure authority to continue funding to support and sustain CHA's role as an essential public safety net system for Medicaid at \$312 million annually in each of the five years of the Demonstration renewal. Like previous payments to CHA, the non-federal share of these amounts will be provided by CHA through permissible intergovernmental transfers.

During SFYs 2015 through 2019, the proposed funding will be payable as Public Hospital Safety Net System Funding that recognizes CHA's essential role in the community-based delivery system for Medicaid and vulnerable populations, the ongoing performance improvements imperative to the public hospital safety net, and the unique public hospital financing of payments. In recognition of these unique circumstances, Public Hospital Safety Net System Funding is outside the scope of service payments for the provision of medical care and therefore exempt from limits under the current STC 49(c).

During SFYs 2016 through 2019, a portion of CHA's core Public Hospital Safety Net System Funding under the Demonstration will be structured as an incentive payment specific to CHA's public hospital system. As further steps in moving toward incentive-based payments, starting in SFY 2016, an increasing proportion of CHA's supplemental funds will be shifted each year into an incentive-based arrangement called a Public Hospital Incentive Initiative. By the end of the renewal term, the proportion of CHA's total patient operating revenue under incentive initiatives will nearly double (both under the Public Hospital Incentive Initiative and ongoing Delivery System Transformation Initiatives). The Public Hospital Incentive Initiative will focus on activities and innovations in several key areas of importance to the Commonwealth and the federal government, including community-based integrated medical and behavioral health care initiatives for Medicaid, low-income, and dual eligible populations.

5) Infrastructure and Capacity Building Grants

The Infrastructure and Capacity Building (ICB) grant program allows acute hospitals, critical access hospitals, and community health centers (CHCs) to apply for funding in order to develop and implement infrastructure and capacity building projects. These initiatives serve to support and strengthen providers that have limited capacity to initiate transformative projects with the goal of enhancing service and high-quality care to MassHealth members. With this additional support, participating providers are able to better keep pace with the rapidly-evolving healthcare landscape and serve MassHealth members with high quality care. Providers eligible for the ICB program are not eligible for DSTI.

The ICB grants are distributed through a competitive procurement process. Acute hospitals and CHCs are eligible to apply, and additional criteria may target funding. For example, specific funding was allocated toward critical access hospitals in the past to encourage their participation. In future years, the Commonwealth intends to create a second category of hospitals eligible for specific funding: those that have a Medicaid payer mix of one-half standard deviation above the state average and a commercial payer mix of one-half standard deviation below the state average. These hospitals are similar to

MassHealth's DSTI hospitals in their patient population and payer mix, yet they are not eligible to participate in DSTI. The ICB grant program provides the ideal opportunity for these hospitals to participate in DSTI-like projects and, given that providers eligible for DSTI are not eligible to apply for ICB grants, there is no overlap in funding or project scope.

Currently, providers have the opportunity to apply for projects that fall into five major categories: (i) developing a fully integrated delivery system; (ii) ability to move towards value-based purchasing and alternative payment methodologies; (iii) health outcomes and quality; (iv) outreach and enrollment; and (v) enhancing business strategy and operations capacity. These categories allow providers to make systemic transformations, which would be unattainable without support from MassHealth.

The projects that have been conducted since 2010 demonstrate that the ICB program has been successful in creating meaningful change for providers across the state. Some examples include achieving NCQA recognition for their Patient-Centered Medical Home models; establishing disease registries; creating a streamlined referral process for patients needing mental health services; analyzing Emergency Department visits and readmission and determining how primary care intervention can lower these rates; and focusing on outreach to groups that have difficulty accessing health care services.

The Commonwealth requests expenditure authority of up to \$45 million per year to continue and expand the current ICB grant program. The achievements listed above demonstrate the ability of the ICB program to advance systemic transformations that have positive outcomes for both MassHealth members and other residents of the Commonwealth. With enhanced funding, the ICB program can reach a greater number of providers and support initiatives that create broad changes in the health care system.

Express Lane Renewal

The Commonwealth implemented an Express Lane Eligibility renewal process at the end of September 2012 for families receiving both MassHealth and Supplemental Nutrition Assistance Program (SNAP) benefits. As the Commonwealth currently determines eligibility based on entire family groups, CMS approved a first-of-its-kind Express Lane renewal process for both parents and children. Through the Express Lane renewal process, MassHealth uses income findings from the Department of Transitional Assistance to renew health coverage for families eligible for subsidized insurance plans. Families with children under the age of 19 who have gross income as verified by MassHealth at or below 150 percent FPL and who are receiving SNAP benefits with SNAP-verified income of 180 percent FPL or lower (30 percentage points higher than the highest Medicaid income threshold for a child as allowed under the screen and enroll provision of Express Lane) are included in the Express Lane renewal process. These families are not required to return an annual eligibility review form if they do not have any changes in circumstance to report to MassHealth.

MassHealth has utilized the Express Lane renewal process for a large number of members.¹⁹ The agency selected approximately 55,546 children and 36,992 adults (36,451 families) for the Express Lane renewal process between October 2012 and June 2013. It is expected that an additional 10,709 children and 7,188 adults (7,053 families) will be selected by the end of the first full year the process has operated, in September 2013. The Commonwealth estimates that at that point approximately 40 percent of children and 34 percent of adult MassHealth members with incomes less than or equal to 150 percent FPL will have been selected for the Express Lane renewal process.

The Commonwealth is proposing to continue its current Express Lane renewal process for families with the following changes to account for implementation of the ACA on January 1, 2014:

- i) The Commonwealth Care program is Massachusetts' existing subsidized insurance program for eligible childless adults. On January 1, 2014 this program will end and many parents and caretaker relatives with income above 133 percent FPL will become eligible for Qualified Health Plans with premium tax credits. These adults will be subject to the annual review and open enrollment rules of the Health Connector's insurance exchange and will no longer be included in the Express Lane renewal process.
- ii) The current Express Lane renewal process for parents with income above 133 percent FPL who remain eligible for MassHealth will continue as it is today.
- iii) As the Commonwealth will be expanding the age of eligible children up to age 21, the appropriate Medicaid State Plan Amendment updates will be filed with CMS to extend the Express Lane process to these members.

The Commonwealth is also seeking authority to expand the Express Lane renewal process to childless adults receiving Medicaid benefits with MassHealth-verified income at or below 133 percent FPL and SNAP-verified income at or below 163 percent FPL. Approximately 80,255 households, consisting of 83,350 childless adults,²⁰ could be eligible for this expanded Express Lane renewal process.

Medicare Cost Sharing Assistance

For MassHealth Standard disabled or caretaker/parent elderly members at or under 133 percent FPL who are eligible for Medicare, the Commonwealth requests authority to pay the cost of monthly Medicare Part A and Part B premiums and the cost of deductibles and coinsurance under Part A and Part B. Coverage shall begin on the first day of the month following the date of the eligibility determination. For CommonHealth members with gross income above 133 percent FPL and less than 135 percent FPL, the Commonwealth will pay the cost of monthly Medicare Part B premiums under the Qualified Individual Program except that the Commonwealth will not extend payment if the Commonwealth

¹⁹ The data provided in this section does not include a small subset of adults and children receiving state-funded only benefits as well as households containing adults receiving traditional Medicaid benefits.

²⁰ This number includes adults in the ACA expansion group, disabled adults, and pregnant women who have no other children.

estimates that the amount of assistance provided to members during the calendar year exceeds the allocation under Section 1933 of the Social Security Act. Coverage may begin up to three months before the date of application. The Commonwealth requests authority to provide this Medicare cost sharing assistance to the Demonstration eligible members described without applying an asset test, consistent with the eligibility methodology implemented in this Demonstration.

Early Intervention / Applied Behavioral Analysis for Autism

MassHealth requests continued authority to implement the Demonstration program that authorized MassHealth coverage of enhanced early intervention program services including medically necessary Applied Behavioral Analysis-based (ABA) treatment services for children with autism spectrum disorders. Children up to three years old, who are eligible for both the Commonwealth's Early Intervention program and MassHealth, and who are not enrolled in the Commonwealth's 1915(c) Home and Community Based Services waiver through the Department of Developmental Services, are eligible for coverage of these services. MassHealth implemented coverage of these services effective July 1, 2012 through a Transmittal Letter that added a new service code and specified service definitions, clinical eligibility criteria, and coverage and reimbursement guidelines for providers. To ensure appropriate eligibility determinations, the project utilizes a methodology for determining eligibility created by the Department of Public Health.

As of July 2013, nearly 750 children had been served through the Demonstration project, with an increase in the number of children utilizing these services in SFY13 over SFY12. As the prevalence of autism spectrum disorders continues to increase,²¹ this project provides important services for a vulnerable pediatric population in Massachusetts. To meet the unique needs of these children, MassHealth wishes to maintain these critical services as part of the Commonwealth's overall early intervention programming.

Section 6 Public Notice and Comment Process

The public process used prior to submitting this Request conforms with the transparency and public notice requirements outlined in 42 CFR § 431.400 et seq., and the requirements of STC 14, 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 State's approved State plan. The Commonwealth remains committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

²¹ See, e.g., Stephen J. Blumberg, et al., "Changes in Prevalence of Parent-reported Autism Spectrum Disorder in School-aged U.S. Children: 2007 to 2011-2012," U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, March 20, 2013, available at: <http://www.cdc.gov/nchs/data/nhsr/nhsr065.pdf>.

The Commonwealth has released the Request for a thirty day public comment period starting on August 20, 2013 by posting the Request, the Budget Neutrality spreadsheets, and a Summary of the Request (including notice of the public hearing and the instructions for submitting comments) on the MassHealth Demonstration website (<http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html>). The announcement and links to documents were included in email updates that were distributed broadly to stakeholders. Notice of the Request and the public comment period are also provided through announcements in the Boston Globe, the Worcester Telegram and Gazette, and the Springfield Republican.

In addition to making the Request and supporting documents available online, MassHealth informed the public that paper copies were available to pick up in person at EOHHS' main office, located in downtown Boston.

The Tribal consultation requirements were met through providing a summary of the Request on a conference call with Tribal leaders or their designees and additional Tribal health contacts on July 31, 2013. A summary of the call has been provided via email, and the official renewal request Summary, including links to the documents and instructions for providing comment, will be provided.

The Commonwealth will host two stakeholder meetings, on August 27, 2013 in Boston (in conjunction with a meeting of MassHealth's Medicare Advisory Committee and Payment Policy Advisory Board), and August 29, 2013 in Worcester, to seek input on the Request. The meetings will include a presentation on the Demonstration waiver renewal requests.

Section 7 Budget Neutrality

Section 1115 of the Social Security Act requires the Commonwealth to demonstrate that federal Medicaid spending for the 1115 Demonstration does not exceed what the federal government would have spent in the absence of the Demonstration. Since the inception of the Demonstration, Massachusetts has met this budget neutrality test and has used program savings (budget neutrality "room") to invest in significant advances, such as the Commonwealth's landmark health care reform legislation in 2006 and growing expansion programs under the Demonstration. The changes proposed in this renewal request continue to meet budget neutrality requirements during the renewal period. The details of the budget neutrality calculation projections are presented in Appendix D.

Budget Neutrality Methodology

Massachusetts' budget neutrality calculation is detailed in Section XI and Attachment D of the current Demonstration's STC. The calculation demonstrates that gross spending under the Demonstration ("with waiver") is less than what gross spending would have been in the absence of a waiver (the "without waiver" limit). As part of the 2008 renewal, the Commonwealth and CMS agreed to reset the budget neutrality calculation at zero at the beginning of SFY 2009 so that no deficit or savings was

carried over from prior years. Accordingly, the budget neutrality demonstration includes "with waiver" expenditures and "without waiver" expenditure limit calculations beginning in SFY 2009.

The budget neutrality calculation for the 2014 renewal builds upon what was established in the 2011 renewal by incorporating population shifts and expenditure changes under the ACA. From SFY 2009 through the first half of SFY 2012, "with waiver" expenditures presented in the budget neutrality worksheets include actual gross expenditures. Beginning in the second half of SFY 2012 and continuing through SFY 2019, "with waiver" expenditures presented in the budget neutrality worksheets reflect projected expenditures based on the most recent MassHealth budget forecast, which incorporates ACA changes. Safety Net Care Pool expenditures are calculated separately and added to the other expenditures based on projections for the individual programs.

"Without waiver" expenditures are calculated by multiplying historical pre-waiver per member, per month (PMPM) costs, trended forward to the renewal period (based on the President's Budget trend rates defined in the current waiver for each existing population) by actual caseload member months for the base (non-expansion) populations.

Consistent with the recent amendment to the Demonstration, submitted to CMS in June 2013, the budget neutrality construct integrates the ACA expansion population of adults ages 19-64 earning up to 133 percent FPL. Per CMS direction, this population has been represented in the budget neutrality calculation as a singular group and treated as a so-called "hypothetical population." In order to calculate the enrollment and PMPM for this group, however, MassHealth developed a weighted average of the projected member months and PMPMs for the various component populations under the current Demonstration that will make up the ACA expansion population as of January 1, 2014. In effect, the ACA expansion population represents the combined projected enrollment and spending of the current MassHealth Essential, MassHealth Basic, Commonwealth Care, Medical Security Plan, and other small Demonstration populations, as well as expected new enrollees. As a hypothetical population, this population has a net zero impact on budget neutrality. The Commonwealth will not accrue budget neutrality savings under the Demonstration based on expenditures for this group, nor will expenditures for this group be counted against the budget neutrality limit under the Demonstration.

Budget Neutrality Impact

As noted above, the changes proposed in this renewal request continue to meet budget neutrality requirements during the extension period. The attached budget neutrality demonstration shows that projected expenditures under the life of the waiver from SFY2009 through the end of the Demonstration renewal request will be approximately \$33.7 billion less than projected expenditures in the absence of the Demonstration.

Moreover, as detailed in the Commonwealth's quarterly budget neutrality reports, the cushion has grown since our 2008 Demonstration renewal term. This is the result of program efficiencies that have maintained cost growth below anticipated trends. Realized and anticipated savings that continue to be

reflected in the current projection include creating consistency among providers in hospital rates, limiting current-year inflation in provider and MCO rates, enhancing compliance activities and utilization management, and other significant savings projects in the Governor's SFY 2014 budget, such as investments in health care access and quality and implementation of the health care cost containment law. The current budget neutrality statement reflects these successful ongoing efforts to implement cost containment initiatives across the MassHealth program in the current economic context.

The Commonwealth is proud of the extent to which this budget neutrality room represents ongoing and anticipated efforts to control health care costs in Massachusetts. The Commonwealth also recognizes that the renewal period may include a time when the Commonwealth's economic environment will support investment in the Demonstration programs beyond current projections, and is pleased that the budget neutrality calculation provides the potential to make such changes.

Section 8 Conclusion

Since it began in 1997, the MassHealth 1115 Demonstration has been a key part of Massachusetts' strategy to expand coverage to residents of the Commonwealth and to transform the way health care is organized, delivered and paid for. The Demonstration provided the foundation and structure for much of the Commonwealth's 2006 health care reform and, as the payer for one-fifth of the Massachusetts population, MassHealth is now positioned to lead the next phase of reform as the state makes a commitment to improve quality and contain costs through the provisions of Chapter 224.

During the coming renewal period, MassHealth will continue existing initiatives and introduce new ones that support the Demonstration's goals of maintaining universal coverage, redirecting spending from uncompensated care to insurance coverage, and advancing delivery system reforms and alternative payment methods, while keeping within budget neutrality constraints. The initiatives will reinforce the federal-state partnership by promoting many of the aims of the ACA, including increased accountability, integration of care, focus on the specific needs of particularly vulnerable populations, and support for safety net providers to transform their delivery models while maintaining critical services.

Massachusetts is eager to partner with CMS to move into the next phase of reform. This is a critical period for health care reform in Massachusetts, as the transformative vision of the ACA and Chapter 224 is implemented and refined. To ensure the Commonwealth has sufficient tools and flexibility to advance these important initiatives, Massachusetts requests that the Demonstration be renewed for five years, covering the period SFY2015-2019. Continuing MassHealth's successful partnership with CMS in a five-year commitment is both critical to realizing the vision and symbolic of the federal government's support. For the coming renewal period, this partnership is poised to lead the nation into the next phase of reform and serve as a model for other states once again.

We thank our federal partners at CMS in advance for their consideration of this important request.