

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



SECTION 1115 DEMONSTRATION PROJECT EXTENSION REQUEST
HEALTH CARE REFORM SUSTAINABILITY

Submitted: December 21, 2007

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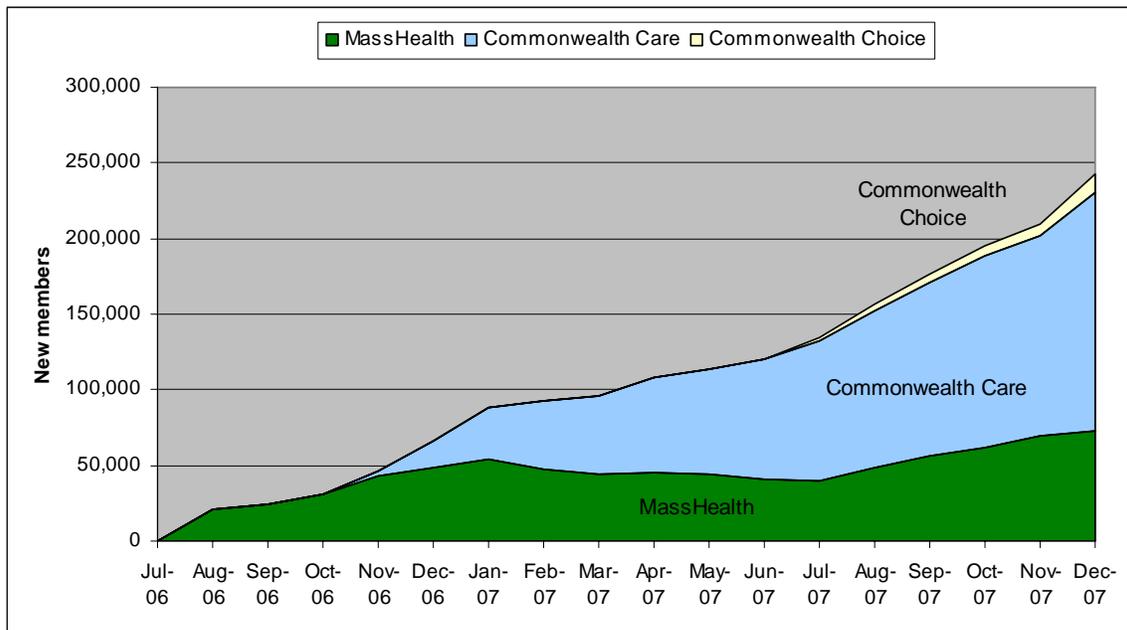
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Section 1 Introduction

In June of 2007, the Massachusetts Executive Office of Health and Human Services (EOHHS) submitted to the Centers for Medicare and Medicaid Services (CMS) a request to extend its Section 1115 Demonstration Project (the Demonstration) beginning on July 1, 2008. The June submission described the central role that the Demonstration plays in the Commonwealth's efforts to cover the uninsured and the importance of continued federal commitment to and investment in Massachusetts' landmark health care reform initiative through renewal of the Demonstration. Massachusetts is in the critical early years of its comprehensive coverage initiative, with hundreds of thousands of individuals newly insured, and has implemented innovative policies for health insurance affordability, minimum standards for coverage, insurance market reform, and mandatory health insurance. This reform was possible because State leaders came together on a bipartisan basis more than three years ago to develop and enact the health care reform law. These leaders and the Patrick Administration remain committed to fully implementing the initiative, which has become a national model for reform, and to providing the policy and financial support needed to reach the goal of providing coverage to nearly all Massachusetts residents.

The June extension request provided a detailed update on the status of the implementation efforts and its success in expanding health insurance coverage to low-income individuals and individuals for whom employer-based or private health insurance coverage is out of reach. As of December 1, 2007, approximately 293,000 people have enrolled in health insurance in Massachusetts since July 2006. Approximately 160,000 people have enrolled in Commonwealth Care, the subsidized health insurance program authorized through the Demonstration and offered through the Commonwealth Health Insurance Connector Authority (the Connector). MassHealth expansions and enhanced outreach activities have added 70,000 children and adults to the program; approximately 50,000 of these individuals through direct coverage and approximately 20,000 through premium assistance for private insurance coverage. In addition, 63,000 have enrolled in private insurance either directly through private carriers or through Commonwealth Choice, a program that has enrolled 7,000 residents by helping individuals and small group employers purchase affordable quality health insurance products, including products tailored for young adults. The Commonwealth expects that a total of over 300,000 people will have enrolled in these health insurance options by January 1, 2008—roughly 100,000 in commercial health plans—due to a focused outreach and enrollment effort by MassHealth, the Connector and their partners to encourage people to enroll in insurance before the December 31 deadline to satisfy the health insurance mandate for the 2007 tax year. Figure 1 shows the MassHealth, Commonwealth Care and Commonwealth Choice health care reform enrollment trends, but does not include the individuals who have enrolled in private insurance directly through private carriers.

Figure 1: Health Care Reform Enrollment Success



In the June submission, the Commonwealth requested additional time to develop its Demonstration extension financing proposal, including the federal budget neutrality calculation required for all Demonstration proposals. With barely one year of data from Commonwealth Care (implemented on October 1, 2006) and comprehensive reform to the state’s uncompensated care pool (now called the Health Safety Net Trust Fund (HSNTF)) beginning on October 1, 2007, the Commonwealth required additional time to finalize HSNTF eligibility and payment policies, refine spending projections, and develop a sound budget neutrality calculation. This submission, therefore, contains a Demonstration budget neutrality proposal through State Fiscal Year (SFY) 2011, the fourteenth year of the Demonstration program, which demonstrates that the program will be budget neutral to the federal government through the requested extension period.

In designing Massachusetts’ health care reform coverage initiative, policy makers explicitly recognized that the effort to provide affordable health insurance coverage to the state’s uninsured would necessarily be followed by a focused effort to ensure its long-term sustainability. From the beginning, the primary objectives of the initiative were to facilitate access to affordable comprehensive health insurance coverage and foster the use of insurance, thereby increasing access to primary and preventive care and minimizing the cost-shifting between the uninsured and the insured. With more transparency and efficiency around the delivery of care, the Commonwealth would be able to develop a more rational, systemic, and effective approach to containing health care costs and providing efficient, quality care.

Across the country, in both the public and private sectors, the growth in health care spending at current levels has become unsustainable. In Massachusetts, with the highest per capita health care spending in the nation, health insurance premium increases significantly higher than the national average, and an unprecedented deliberate effort to cover nearly all state residents, maintaining the status quo will jeopardize the early success of the plan to achieve universal coverage. In the next phase of its health care reform effort, Massachusetts will be uniquely situated to contribute its experience to national discussions on health care cost containment and value, quality improvement and health care reform sustainability.

As such, this proposal includes a framework for how the Commonwealth will build upon its ongoing efforts to control the growth in MassHealth and Commonwealth Care spending, while improving the quality of care for individuals served by these programs. The Commonwealth will align these efforts with a broader effort in the state to “bend the trend” in the growth of health care spending, to expand access to primary care and care coordination, and to measure and publicly report upon quality of care. The Commonwealth fully recognizes the challenges inherent in such an endeavor, and that any success in this area will require collaboration among payers, purchasers, consumers and providers of health care, as well as long-term commitment from all partners. While the Commonwealth faced a similar challenge in expanding affordable coverage options to the uninsured, containing the growth in health care spending over time is particularly daunting and may require incremental efforts that gradually move the system toward comprehensive change. It is imperative that all stakeholders in Massachusetts’ health care reform effort continue to work together to ensure the long-term sustainability of the coverage initiative and improve the quality of care delivered. There is widespread recognition in the Commonwealth that the next phase of health care reform will involve a concerted effort to contain health care costs across the system. MassHealth is committed to doing its part.

Section 2 Federal Budget Neutrality Projection

Section 1115 of the Social Security Act requires that demonstration waivers be budget neutral to the federal government. That is, the state must show that, over the approved period(s) of the demonstration program, federal Medicaid spending under the waiver will not exceed what the federal government would have spent in the absence of the waiver. The Commonwealth has shown over the past eleven years of the MassHealth Demonstration that the budget neutrality test has been met in each Demonstration term.

In Attachment A, the Commonwealth presents its budget neutrality calculation, including the renewal period July 1, 2008 through June 30, 2011. The calculation demonstrates that the MassHealth Demonstration will remain budget neutral over the next three years as we continue the groundbreaking work of health care reform in Massachusetts.

The budget neutrality construct reflects an enormous amount of work by the Commonwealth, in consultation with a wide array of partners, to craft a budget-neutral spending strategy that will help sustain our efforts to ensure that Massachusetts' citizens have access to affordable, quality health insurance over the long term. While only certain components of the comprehensive reform plan are linked to the Demonstration, these components represent key spending or growth areas. Most notable is the Commonwealth Care program, the subsidized premium assistance program for low-income uninsured individuals at or below 300% of the federal poverty level (FPL). As noted earlier, in just over one year this program has enrolled nearly 160,000 individuals.

In developing its budget neutrality calculation, the Commonwealth carefully examined both the base per member per month (PMPM) amounts and populations to ensure that they accurately reflect the current environment. The Commonwealth factored specific spending items resulting from extraordinary events, such as court-mandated Medicaid services and substantial Medicaid provider rate enhancements mandated in Massachusetts health care reform law¹, into the without-waiver PMPMs. The Commonwealth also re-categorized certain categorically eligible Title XIX (Medicaid) populations in order to prevent their expenditures from inappropriately eroding budget neutrality savings that are necessary for expansion to non-Medicaid populations.

The Commonwealth looks forward to detailed discussions and negotiations with CMS about the many specific elements of the budget neutrality calculation. Fundamental components of the budget neutrality calculation for the MassHealth Demonstration over the next extension period follow.

1. Reducing the rate of spending growth in MassHealth

The health care reform waiver amendment approved by CMS in July 2006 provided the Commonwealth with a powerful vehicle to expand access to affordable health insurance coverage in Massachusetts. In the time since that approval, the Commonwealth has experienced enormous success in enrolling uninsured residents into comprehensive health plans. To ensure long-term success, we must direct our full attention to containing the unsustainable growth in health care costs in our Medicaid program, as a part of broader systemic change, that will otherwise overwhelm our state budget and make continued budget neutrality in the Demonstration impossible.

To this end, the Commonwealth has set a goal for itself in the next extension period to reduce the rate of growth of aggregate Demonstration expenditures by 1% in state fiscal year (SFY) 2010 (compared to the growth rate in SFY 2009), and an additional 1% in SFY 2011 (compared to the growth rate in SFY 2010). By building these growth reduction targets into budget neutrality spending assumptions, the Commonwealth affirms cost containment as a financial imperative of the Demonstration. While the

¹ Chapter 58 of the Acts of 2006 (Chapter 58), *An Act Providing Access to Affordable, Quality, Accountable Health Care*.

Commonwealth is not relying solely on this cost containment target to meet the Demonstration's budget neutrality requirement, the Commonwealth anticipates more than \$200 million in savings from reducing the rate of growth of Demonstration spending over the extension period.

An articulation of the Commonwealth's cost containment framework and specific descriptions of cost containment strategies that MassHealth and, in some areas, Commonwealth Care will employ to achieve the Demonstration spending growth reduction are found in Section 3. That framework includes:

- using value-based and cost-based purchasing principles to ensure efficiency and accountability in what the Commonwealth and CMS are purchasing;
- expanding access to primary and preventive care services to ensure people are learning and adopting healthy lifestyle behaviors, obtaining necessary screenings, and receiving culturally appropriate care;
- providing active care management and care coordination services to high-cost or high-utilizing members to ensure their conditions are optimally managed and that they are receiving only medically necessary and appropriate care in the appropriate setting; and
- enhancing the Commonwealth's investment in health information technology to support health care system change and improvement.

2. Continuing to redirect spending from uncompensated care to insurance coverage

CMS and the Commonwealth established the Safety Net Care Pool (SNCP) in the last extension of the MassHealth Demonstration for the express purpose of reducing the rate of uninsurance in Massachusetts. Through the SNCP, the Commonwealth can use state and federal Medicaid dollars to expand coverage to more people by redirecting public funds from uncompensated care to subsidized health insurance premiums for low-income individuals. The SNCP also recognizes the need to preserve an appropriate level of funding for a safety net system of providers of health services for individuals not served by the insurance system, and for unreimbursed Medicaid services. This continued support for safety net providers is essential in a rationalized and stable health care system, and will help prevent further cost-shifting between the uninsured and insured.

The budget neutrality calculation reflects careful consideration of how the Commonwealth will direct SNCP funds in the extension period. Since its inception, the structure and intent of the SNCP has been that certain direct funding to institutions for care to the uninsured necessarily will decrease as more of the uninsured enroll in health plans. The Commonwealth has had incredible success over the last year in enrolling uninsured residents into subsidized private insurance plans through Commonwealth Care. Due to this success, spending projections assume that the Commonwealth will direct an increased share of SNCP funds towards premium assistance. As such, the proposed

budget neutrality calculation reflects the inverse relationship between Commonwealth Care spending and spending for uncompensated care by redirecting more uncompensated care dollars to Commonwealth Care over time. Specifically, the Commonwealth continues the Chapter 58-prescribed reduction of Section 122 Safety Net Health System payments in SFY 2009 and phases them out in SFY 2010. However, the Commonwealth proposes for SFYs 2010 and 2011 to retain the Section 122 payment methodology or a similar safety net health system-based methodology to help ensure that its critical safety net providers, particularly Cambridge Health Alliance—the Commonwealth’s only non-state-owned government health system—are able to fulfill their essential missions and remain stable and financially solvent institutions. Additionally, as authorized, the Commonwealth will continue a necessary and appropriate level of support to safety net hospitals and community health centers that care for individuals who are not served by the insurance system, and for unreimbursed Medicaid services.

3. Normalizing SNCP expenditure treatment in the Demonstration by eliminating the SNCP “sub-cap”

The Commonwealth proposes to treat for budget neutrality purposes the SNCP spending in the same way that all other spending allowable by Expenditure Authority in the Demonstration is treated. SNCP spending, especially for Commonwealth Care, should be allowed to grow to the extent there is budget neutrality room available, and should not be restricted by a Demonstration budget neutrality sub-cap.

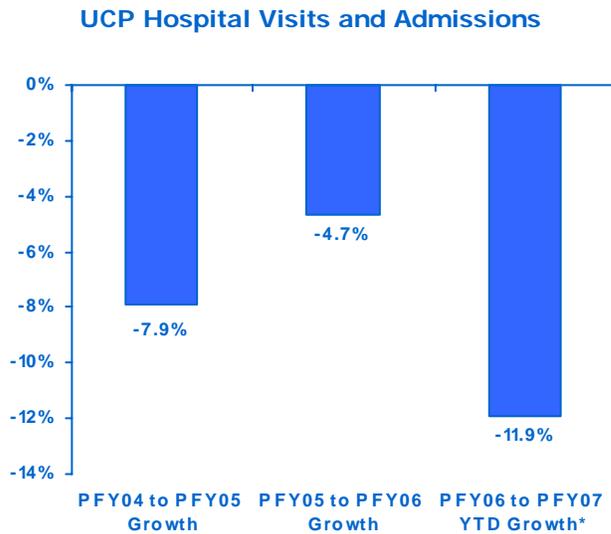
The special terms and conditions (STCs) of the Demonstration for the period July 1, 2005 through June 30, 2008 set a cap on SNCP available funds at \$1.34 billion annually for each year of that Demonstration term, with no inflation factor. The SNCP cap was useful in the absence of any experience with the new financing concepts encompassed in the SNCP, in that it clearly identified specific Demonstration dollars that were available at that time under budget neutrality that the Commonwealth could use for SNCP spending. Those available dollar amounts included the Commonwealth’s annual federal disproportionate share hospital (DSH) allotment previously authorized under the Medicaid state plan and the SFY 2005 supplemental payment amounts to Boston Public Health Commission and Cambridge Public Health Commission managed care organizations.

As we enter the second full Demonstration term of the SNCP, with full implementation of health care reform underway, it is important that the STCs of the upcoming Demonstration term reflect the increasing maturity of the SNCP concept, as well as the value of enrollment and spending experience in determining appropriate spending levels. Commonwealth Care expenditures must be allowed to increase at the rate necessary to maintain and build on insurance coverage gains. Given the expected growth in Commonwealth Care enrollment during the renewal period, and despite ongoing redirection of state dollars for uncompensated care to coverage, the success of

Commonwealth Care is such that SNCP spending will outpace the SNCP spending level approved in the previous Demonstration term.

SNCP spending on uncompensated care in the current Demonstration period has declined significantly since the beginning of health care reform, as Commonwealth Care enrollment increased (See Figure 2). The Commonwealth anticipates further decline with the implementation of the new HSNTF regulations that went into effect in October 2007, but will not be able to measure the effects of these reforms until early 2008. In transitioning the Uncompensated Care Pool to the HSNTF, the Commonwealth aligned policies to support achievement of its health care reform goals. Residents are not able to access the HSNTF for care without being comprehensively screened first for eligibility for MassHealth and Commonwealth Care. Efforts will also intensify going forward to screen for access to affordable employer-sponsored insurance. The Commonwealth is in the process of enhancing efforts in all publicly subsidized health programs to ensure that individuals fully access private health insurance options to minimize crowd-out as we expand coverage and provide a safety net of care. Going forward, the Commonwealth will direct spending that otherwise would have been required for uncompensated care to Commonwealth Care.

Figure 2: Uncompensated Care Pool (UCP) Hospital Visits and Admissions



*Growth rate reflects October-August data in both periods

In sum, the Commonwealth’s proposed budget neutrality model for the extension period calls for spending included under the current SNCP construct to continue to be subject to the MassHealth Demonstration budget neutrality cap, but eliminates the SNCP expenditure “sub-cap” in the next Demonstration term. The SNCP sub-cap, set at SFY 2005 spending levels, becomes an unnecessary and arbitrary limit on Demonstration spending, and a counterproductive constraint on expansion success.

4. Accurately reflecting EPSDT costs for base and 1902(r)(2) children in the budget neutrality ceiling

The budget neutrality ceiling (also known as the waiver expenditure target) for the MassHealth Demonstration is set from trended “without waiver” Medicaid per member per month (PMPM) costs for the following Medicaid Eligibility Groups (MEGs): base families; base disabled; 1902(r)(2) children; 1902(r)(2) disabled; and Breast and Cervical Cancer Treatment Program (BCCTP). These are populations who would be eligible for Medicaid under Title XIX in the absence of the Demonstration. Base families, base disabled (including Massachusetts Commission for the Blind-eligibles), 1902(r)(2) children, and 1902(r)(2) disabled MEGs’ base year per capita costs were calculated for SFY 1994 using actual allowable benefit services, determined on an accrual date of service basis. The Commonwealth added BCCTP to the Demonstration in SFY 2003 using SFY 1998-1999 PMPM costs. Base without waiver expenditures are trended for each year of the Demonstration at a specified rate to determine the budget neutrality ceiling for Demonstration spending.

All individuals under age 21 in the Demonstration included in the waiver expenditure target are eligible under Title XIX, and are therefore eligible for early and periodic screening, diagnosis, and treatment (EPSDT) services. As mandatory services under Medicaid, EPSDT costs are presumed to be included in the base year expenditures from which the budget neutrality ceiling is trended.

In January 2006, the U.S. District Court ruled in the class action lawsuit, *Rosie D. et al. v. Mitt Romney et al.*, that the Massachusetts Medicaid program had not fully met its obligations under EPSDT for children with serious emotional disturbances (SED). Specifically, the Court cited the state for “insufficient behavioral health screenings, assessments, and treatment service coordination for as many as 15,000 children in Massachusetts with serious emotional disturbances” and for “insufficient home-based behavioral support services for children with SED.” In July 2007, the Court entered a Judgment based on the Remedial Plan proposed by the Defendants.

The Judgment requires service enhancements to ensure that children eligible for MassHealth Standard and CommonHealth are provided:

- behavioral health screenings by primary care providers and pediatricians using a MassHealth approved standardized screening tool; and
- clinicians who provide behavioral health services using a standardized behavioral health assessment, called the Children and Adolescent Needs and Strengths (CANS) tool, to support treatment decisions.

The Judgment also calls for MassHealth to provide specific services for EPSDT-eligible children with SED, including intensive care coordination, crisis management services and home and community-based services.

The Court's ruling in effect means that historical state and federal EPSDT expenditures have been below Medicaid entitlement levels for children in the Demonstration base. Trended per capita costs for base and 1902(r)(2) children, therefore, have been inappropriately low since base year 1994.

The MassHealth program is taking all necessary steps to ensure that all Title XIX-eligible children with SED receive the full benefits of EPSDT entitlement. To the extent that the Commonwealth implements processes and services that will increase EPSDT-related utilization and expenditures, they must be reflected not only in actual expenditures under the Demonstration, but also in the base costs that comprise the budget neutrality ceiling. The state and federal governments must acknowledge these costs as "without waiver" mandatory Medicaid expenditures for Medicaid-eligible children. Therefore, the Commonwealth's attached budget neutrality calculation includes increased average EPSDT costs for each EPSDT-eligible child in the base for the new Demonstration term starting in SFY 2009.

5. Incorporating Chapter 58-mandated Medicaid provider rate increases into the base

Chapter 58 outlined a comprehensive approach to health care reform in Massachusetts that included substantial adjustments to Medicaid acute hospital and physician payment rates to help ensure that Medicaid reimbursement and rate methodologies provide fair compensation for MassHealth services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care.

These legislatively-mandated increases were unanticipated and represent a departure from the normal incremental year-to-year growth in provider rates, and reasonably would have occurred irrespective of the existence of the MassHealth Demonstration. As such, the President's budget trend rate does not account for these Medicaid provider rate adjustments. This necessary, yet extraordinary, Medicaid provider rate recalibration has "without waiver" impact that the Commonwealth reflects through resetting the base PMPMs, starting in SFY 2009, to the extent that the rate increases are attributable to base Demonstration populations.

6. Ensuring appropriate treatment of categorically eligible Medicaid populations

Another element of the budget neutrality submission ensures that the "without-waiver" side of the equation gives full recognition to eligibility expansions that would meet the Medicaid definition of a "categorical" population. In the current Demonstration period, the Commonwealth is disadvantaged to the extent that all Commonwealth Care individuals, and certain members in MassHealth Basic and Essential, irrespective of their categorical status, are shown as a cost on the "with-waiver" side, without a corresponding PMPM allowance on the "without-waiver" side. This fundamental flaw in the way the budget neutrality cap was constructed artificially limits the extent to which Massachusetts can continue on the path of decreasing the rate of uninsurance. The Commonwealth

understands that spending on non-categorically eligible populations would continue to be limited to the degree that there is room in the budget neutrality agreement.

Specifically, the Commonwealth's submission does not continue Demonstration expansion treatment for pregnant women, parents, disabled persons, or persons aged 19 and 20 enrolled in Commonwealth Care or any other program under the Demonstration. As these include populations allowed under Title XIX as optional categorical groups under section 1905(a)(i) of the Social Security Act, and groups eligible for less restrictive methodologies allowed by section 1902(r)(2), their expenditures should not be charged against budget neutrality savings. Therefore, the attached budget neutrality calculation includes these expenditures on both "waiver" and "without waiver" sides of the equation.

7. Continued flexibility for Designated State Health Programs

Federal reimbursement for the Designated State Health Programs (DSHP) is an essential component of the partnership between the Commonwealth and CMS to support the important coverage initiative that is currently in place and growing. These programs represent formerly fully state-funded health programs for which CMS provides federal Medicaid reimbursement, at a level commensurate with specific federal dollars in the Commonwealth's health care system prior to health care reform, as authorized by the Demonstration's Expenditure Authority. The non-federal share of these programs, authorized each year through the state budget process, is an appropriation of state dollars from the Commonwealth's general fund. Under the DSHP construct authorized in the current Demonstration term, DSHP spending in the SNCP decreased from the authorized \$385 million in SFY 2007 to \$213 million in SFY 2008. In SFY 2008, the Commonwealth unfortunately was unable to utilize fully the authorized amount of DSHP (\$385 million) as originally planned—even though the Commonwealth continued to incur state expenditures for these programs at or above the originally approved annual level. This dynamic is due to the flat annual cap in spending on SNCP program components and because the enrollment growth in Commonwealth Care rightfully consumed a larger portion of the allotted SNCP spending room. The Commonwealth believes this dynamic produces an unintended financial disincentive to successful enrollment into the health care reform coverage programs.

The Commonwealth, therefore, includes a DSHP spending level of \$385 million in each year of the next Demonstration term. During the Demonstration extension period, the continued success of the state's and CMS's efforts to reduce the level of uninsured in the Commonwealth will require the stabilization of DSHP at \$385 million per year. This, in addition to the Commonwealth's redirection of Section 122 Safety Net Health System funding starting in SFY 2010, will allow the Commonwealth and CMS to continue moving quickly toward a fully insured Commonwealth, and reinforce the MassHealth Demonstration as a model for federal-state cooperation on health insurance coverage.

8. Baseline budget neutrality assumptions

Other baseline assumptions used in the budget neutrality calculation presented in Attachment A include:

- Base year remains at SFY 1994
- President's budget trends for SFY 2008-2011 are:
 - 6.42% for Base families and 1902(r)(2) children
 - 7.61% for Base disabled, 1902(r)(2) disabled and BCCTP
- Base caseload trend is 1.5% for SFY 2009 (above SFY 2008), and 1.1% for SFYs 2010 and 2011
- Adequate federal funding for the Massachusetts SCHIP is assumed to be available throughout the waiver extension period

With respect to SCHIP, Massachusetts has been explicit with CMS and HHS officials that failure to reauthorize SCHIP fully and at sufficient levels of funding will destabilize a program that serves over 90,000 low-income children. In developing its comprehensive health care reform plan, the Commonwealth expanded SCHIP to children at or below 300% FPL, while creating the subsidized Commonwealth Care program for their parents and other uninsured low-income adults. This combination of Demonstration and SCHIP authority creates seamless, integrated coverage for low-income families, rather than forcing parents to find multiple sources of coverage in order to support an entire family. CMS approved a SCHIP amendment concurrent with the health care reform waiver amendment in July 2006. In both expansion programs, the Commonwealth incorporated, and CMS approved, stringent "anti-crowd-out" provisions, including a six-month period of uninsurance before an individual can be eligible for the programs, to help ensure that these publicly-supported programs were not substituting for existing private coverage.

Massachusetts has been extremely successful in enrolling low-income children into SCHIP, including through premium assistance toward a child's private insurance coverage. The Commonwealth has covered well over 90 percent of SCHIP-eligible children at or below 200% FPL. Consequently, and unfortunately, the Commonwealth's SCHIP allotments simply have not been sufficient to support the level of enrollment seen in the program. Based on discussions with federal officials regarding the impact of delayed or insufficient SCHIP reauthorization in Massachusetts, the Commonwealth expects that CMS would protect it from any SCHIP-related impacts on the Demonstration's budget neutrality calculation if the Commonwealth needs to shift SCHIP-eligible children from SCHIP to the Demonstration, as authorized under our Demonstration terms and conditions. Therefore, the proposed Demonstration budget neutrality calculation assumes full reauthorization of SCHIP at sufficient funding levels through the Demonstration extension period.

In sum, the Commonwealth's analysis shows that successful negotiations with CMS on the budget neutrality terms for the MassHealth Demonstration, as proposed by the Commonwealth, would result in a budget neutrality cushion of approximately \$832 million through the end of the extension term, SFY 2011. The budget neutrality model the Commonwealth is presenting contains all of the elements necessary for continued success in the financial management of the Demonstration. The Commonwealth demonstrates in this model its commitment to do what is necessary to sustain and strengthen health care reform in Massachusetts. In its ongoing support for this important experiment, CMS, in partnership with the Commonwealth, will continue to provide critical contributions to the national dialogue on health coverage and health care costs.

Section 3 Building a Sustainable Program for the Future: Efforts to Contain Costs and Ensure Quality Care

Massachusetts prides itself on being home to some of the most renowned health care institutions in the country. It has one of the lowest uninsurance rates in the country, and some of the best quality care. Yet Massachusetts also is commonly found at the top of the list of states in terms of per capita health care spending and health insurance premium costs. Annual percentage increases in health insurance premiums in Massachusetts are significantly higher than the national average (8-12 percent in Massachusetts compared to 5-6 percent nationally), and continue to dramatically outpace general inflation rates and wage increases. Compounding the problem, and despite aggressive efforts to contain MassHealth spending growth, particularly in the pharmacy program, MassHealth spending consumes close to 30 percent of the state budget, diverting limited public dollars from other important spending priorities, such as education, infrastructure development, and public safety. But high health care costs do not necessarily equate to high quality care, and continued spending increases do not assure public payers, or taxpayers, that they are supporting an efficient health care delivery system.

Not surprisingly, with the Commonwealth's health insurance coverage initiative still in its early stages and Commonwealth Care enrollment growing rapidly, the long-term sustainability of the health care reform plan is in the forefront of most public discourse on the subject. The Commonwealth is fully engaged in the discussion and is committed to containing health care costs in Massachusetts and ensuring the long-term success of health care reform. Chapter 58, itself, laid the groundwork for a more coordinated approach to containing costs and improving quality of care through the creation of the Health Care Quality and Cost Council, the MassHealth Payment Policy Advisory Board, the Health Disparities Council, a Wellness program and a Medicaid pay-for-performance program, among other things. The Health Care Quality and Cost Council has established an aggressive goal to reduce the rate of growth in statewide health care expenditures to no more than the unadjusted Gross Domestic Product (GDP) growth rate by 2012.

Most recently, under Governor Patrick's leadership, nine state agencies signed the Healthy Massachusetts Compact, a collaboration among the state's Executive Office of

Health and Human Services, Executive Office of Administration and Finance, Group Insurance Commission, Commonwealth Health Insurance Connector Authority, Division of Insurance, Attorney General's Office, Massachusetts Health and Educational Facilities Authority, Massachusetts Development Financing Agency, and Department of Correction. The participating members have pledged to work together, using specified strategies, to achieve the following goals (see Attachment B):

- Ensure Access to Care
- Advance Health Care Quality
- Contain Health Care Costs
- Promote Individual Wellness
- Promote Healthy Communities

While these goals have always guided MassHealth's coverage and payment policies and practices, activities by state purchasers and regulators in these areas often have been piecemeal and not aligned appropriately with one another, or with the efforts of private sector purchasers. The Compact is an official commitment on the part of the participating state agencies to leverage their collective purchasing and regulatory power and to work with the private sector to improve and reform the health care system in Massachusetts, while promoting health and wellness. Where appropriate, the agencies will collaborate on initiatives, but in all instances the strategies will be coordinated with one another and aligned with broader state efforts, including the efforts of the Health Care Quality and Cost Council and activities in the private sector. The Compact formalizes an investment by the Patrick Administration in a statewide health care cost and quality strategy that is already underway. In two areas particularly, health information technology development and provider pay-for-performance initiatives, the state has been working with the private sector to align programs and incentives so that systemic changes in health care quality, purchasing and delivery can be achieved. The Commonwealth will continue and expand upon these activities. New areas of collaboration and coordination include strategic infrastructure and economic development activities to ensure community needs are met and coordinated purchasing and contracting strategies to ensure standardized quality monitoring, to demand efficiency and transparency in health care costs, and to promote wellness and culturally and linguistically appropriate care across programs. One specific initiative will seek to reduce the incidence of and better manage diabetes by coordinating purchasing, reporting and quality measurement activities among MassHealth, Commonwealth Care, the Group Insurance Commission, which purchases health insurance for state employees, private payers and other community-wide initiatives. The Compact is one component of a coordinated statewide strategy for comprehensive system reform.

MassHealth's framework for cost containment and quality improvement is a part of this broader effort to achieve the goals outlined above. It categorizes activities into four action areas, which define methods to address cost drivers in health care and mechanisms to ensure or create incentives for high-quality care. Those action areas are:

- Efficient and Fair Purchasing
- Access to Primary and Preventive Care
- Chronic and Complex Care Management
- Leveraging Technology and Increasing Transparency

Strategies in each of the four areas will include specific activities to identify, better understand and reduce racial and ethnic health disparities.

As described in Section 2, MassHealth has incorporated an aggressive cost containment goal into the proposed budget neutrality model.² While the Commonwealth has not tied each activity described below to a budget neutrality or cost containment number at this point, the Commonwealth is committed to pursuing these activities in the context of the broader Healthy Massachusetts Compact initiative and is confident in its ability to achieve its cost containment goal. In combination, these activities will improve the quality of care delivered to MassHealth and Commonwealth Care enrollees, ensure providers are paid fairly yet efficiently, and help ensure the long-term sustainability of the health care reform coverage initiative and the Demonstration program as a whole.

1. Efficient and Fair Purchasing

In establishing its provider payment rates and contracting with providers, MassHealth continually strives to pay fair and efficient rates within the confines of its budget appropriation. But concerns around getting “the biggest bang for the buck” and ensuring provider accountability for the care delivered have become increasingly important as health care costs continue to grow, federal and state budgets tighten, and the Commonwealth expands coverage to more people. In particular, enhanced coordination between MassHealth and the Connector around MCO contracting and provider payment rates will be essential to ensure the long-term sustainability of the health reform initiative. The move toward coordinated and value-based purchasing is more critical for Massachusetts now than ever before.

Key activities in this area include expanding pay-for-performance programs; increasing the use of evidence-based coverage policies; maximizing the value of managed care through contracting with competitive managed care organizations (MCOs) and developing an enhanced primary care clinician (PCC) plan; and conducting a rate review to ensure fairness and efficiency across the MassHealth program.

A) Expanding Pay For Performance Programs

MassHealth recently implemented an acute hospital Pay for Performance (P4P) initiative (Acute Hospital P4P), one of the first such Medicaid programs in the country. Chapter 58 includes significant rate increases for hospitals and physicians over a three-year period

² As noted earlier, the Commonwealth is not depending solely on this cost containment goal to satisfy the Demonstration’s budget neutrality test.

(SFYs 2007-2009) and, beginning in Year 2 (FY 2008), hospital rate increases will be contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic health disparities. The primary goals of the Acute Hospital P4P are to reward excellence and improvement in hospital quality and to reduce health disparities. MassHealth, in consultation with the Health Care Quality and Cost Council, the MassHealth Payment Policy Advisory Board, and industry quality experts, went through an intensive planning process to develop this program.

The selected benchmarks were drawn from national standards and include performance measures in five areas of strategic importance to MassHealth – Maternity and Newborn care, Pediatric Asthma, Community-Acquired Pneumonia, Health Disparities and Surgical Infection Prevention. Performance-based payment will reward hospitals that meet minimum thresholds, with additional payments to hospitals that demonstrate improvement above the threshold or meet or exceed best practice benchmarks. The SFY 2008 state budget set aside \$20 million of planned increased rates to hospitals for the P4P initiative, and in subsequent years MassHealth intends to increase the portion of the overall hospital budget reserved for incentive payments.

In the upcoming Demonstration period, MassHealth plans to expand the P4P model to other provider settings. Planning is underway to develop a P4P program for the PCC Plan. These measures will apply to PCCs who are in solo or group practices, acute hospital outpatient departments, and community health centers. Specific goals will include increasing the use of preventive services, increasing guideline-appropriate chronic care, improving access standards, addressing health care disparities and encouraging the development of IT systems that support health-IT initiatives. MassHealth anticipates additional P4P programs for nursing homes and managed care contracts. The goal, for all value-based purchasing programs, is to reward providers for excelling in or improving the quality of care delivered to MassHealth members.

B) Instituting Evidence-based Coverage Policies

An important element of MassHealth’s cost containment strategy is the expansion of its ongoing efforts to implement evidence-based coverage guidelines. National estimates indicate that roughly 20 to 30 percent of acute and chronic care is not clinically necessary.³ An evidence-based coverage strategy provides MassHealth with the appropriate tools to ensure that the program is paying for services that are clinically necessary for a member’s care – and not for services that are ineffective, inappropriate or unproven. More aggressive implementation of MassHealth’s evidence-based coverage strategy can help to significantly reduce the overuse and misuse of medical services, leading to improved quality of care for members and reduced costs to MassHealth.

³ E. C. Becher and M. R. Chassin, “Improving The Quality Of Health Care: Who Will Lead?”, *Health Affairs*, 20(5), 164-179, 2001.

The MassHealth Office of Clinical Affairs has published evidence-based coverage guidelines for 13 specific services to date. These guidelines support prior authorization requests and protocols governing, for example, bariatric surgery, breast reduction surgery, and organ transplants. With a renewed emphasis on establishing evidence-based coverage guidelines, MassHealth is evaluating efforts in other states and will maximize this strategy by identifying high-cost or commonly overused services. In all cases, as it did during the creation and implementation of the MassHealth Drug List, a successful model for clinically-based utilization management, MassHealth plans to engage providers and stakeholders in designing its evidence-based coverage guidelines. Additionally, the Connector is working to coordinate and align Commonwealth Care's utilization management and pharmacy management initiatives with those in MassHealth.

C) Maximizing the Value of Managed Care: Competitive MCOs and An Enhanced PCC Plan

Even before the inception of the MassHealth Demonstration in 1997, MassHealth has had a vibrant managed care program. MassHealth offers two models of managed care for most Demonstration populations, the state-run PCC Plan and five capitated health plans, four of which are full service MCOs and one of which is a behavioral health plan for PCC Plan members and children who are clients of the Commonwealth's Departments of Social or Youth Services. MassHealth is in the midst of re-procuring its MCO contracts. New MCO contracts will include state-of-the-art requirements to better ensure that plan members receive integrated care, with improved case and care management for individuals with certain chronic diseases. Competition based on quality will be a hallmark of the new contracts, with clearer performance expectations and stronger contract management provisions. As the Connector re-procures contracts with the Commonwealth Care and Commonwealth Choice health plans, bid specifications will include disease management and other performance requirements that are comparable to and coordinated with those in MassHealth.

MassHealth is also committed to developing the infrastructure necessary to enhance and support its PCC Plan. The PCC Plan will include active accountable network management for high volume PCCs and other provider types as well as the implementation of other focused care management strategies, including the targeting of the highest-cost members and members with certain diagnoses. As noted, MassHealth intends to include a performance-based incentive program for primary care clinicians and other providers as a part of the PCC Plan.

D) Ensuring Fair Provider Rates and Efficient Purchasing

Across the country, providers consistently protest about the sufficiency of Medicaid rates. This is an annual debate in Massachusetts, made difficult by limited public dollars and competing state spending priorities. Undoubtedly, fair and efficient provider compensation is important to be able to sustain a health care system that can support comprehensive health insurance coverage expansion and a residual safety net system for

those who remain uninsured. Recognizing such, Chapter 58 and subsequent legislation provided for important and substantial Medicaid rate increases to hospitals, physicians and community health centers to improve MassHealth provider payments relative to their associated costs. MassHealth believes a continued and open dialogue with providers on these issues and a thoughtful, long-term and holistic approach to assessing and establishing provider rates is needed—one that provides sufficient and predictable funding to providers, particularly providers of primary care services, and holds providers accountable for the care the Commonwealth purchases and they deliver.

Chapter 58 includes a provision establishing the MassHealth Payment Policy Advisory Board. The Board's charge is "to review and evaluate rates and payment systems by the office of Medicaid and recommend Title XIX rates and rate methodologies that provide fair compensation for MassHealth services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care." The Board began meeting in October of 2006 and has met quarterly over the past year.

In the context of the long-term sustainability of health care reform, MassHealth plans to use this and other forums to engage providers, particularly hospitals, health plans and physicians, in a process to ensure that MassHealth fee-for-service and managed care capitation rates, as well as Commonwealth Care MCO rates, adequately reimburse efficient, high-quality providers and encourage high value service provision.

Rate methodologies are only one aspect of effective purchasing strategies. MassHealth is examining the role that selective contracting arrangements could take in its future purchasing strategy. MassHealth is evaluating the benefits of creating a selective network for high-cost injected biotechnology drugs, which are a significant and growing cost driver in the program. MassHealth is also developing a method to selectively contract for the purchase of diabetes test strips. Currently, MassHealth pays for test strips at a fixed rate, determined by the Massachusetts Division of Health Care Finance and Policy. If MassHealth were to solicit competitive bids to select a preferred product, the manufacturer of this product would reduce the cost of the product to the Commonwealth by providing a rebate, and might also be required to package member services as a condition of the contract.

2. Access to Primary and Preventive Care

Health care reform dramatically increased access to health insurance coverage for Massachusetts' residents. An important corollary, however, is to ensure that insured individuals can find and access primary care providers in a timely and culturally appropriate manner. Like most states, Massachusetts has a shortage of primary care providers relative to its supply of specialists. Delay or avoidance of care in the primary care setting puts an individual's health at risk and often results in the need for emergency care or other costly or unnecessary procedures. Solutions to this problem involve payment policies and other incentives to encourage the recruitment and retention of a

primary care clinician workforce and the use of innovative primary care models by those clinicians to address the health needs of all Massachusetts residents.

The Commonwealth has partnered with the Massachusetts League of Community Health Centers to implement a program to use tuition reimbursement as an incentive for medical students to enter primary care. The program is jointly funded with state and private funds. Payment policies and coverage standards are also central to access. MassHealth authorizes nurse practitioners to act as primary care clinicians, but more can be done to encourage innovative approaches to delivering primary care. Reimbursement policies that encourage patient-centered, comprehensive care in a medical home are uncommon, but overdue.

As noted above, MassHealth will continue to operate its alternative managed care model, the PCC Plan, and is in the process of assessing other primary care case management models around the country to identify and implement, where appropriate, “best practices” for operating a top-of-the-line primary care case management program. Of particular interest are the Community Care of North Carolina Program, which uses a medical home model to help community providers manage patients by sharing in case management resources across a number of providers, and the Pennsylvania ACCESS Plus program, which supplements a traditional PCCM with data-driven case management and disease management enhancements.

Preventing chronic illness before it occurs is also an essential component of maximizing the promise of health insurance and the use of primary care, and will contain health care costs over the long term. During the current Demonstration period, MassHealth has implemented a Tobacco Cessation benefit for members, in close coordination with the state Department of Public Health, which includes both counseling services and tobacco cessation pharmacotherapy. The tobacco cessation benefit is one component of a broader initiative called MassHealthy, a MassHealth Wellness Program, authorized in Chapter 58. Phase 1 of MassHealthy, an education campaign to encourage MassHealth members to practice healthy behaviors and seek preventative care, is in place. Phase 2 of the Program will include concrete incentives for members who meet wellness goals by practicing healthy behaviors.

A primary focus of these efforts to enhance access to primary and preventive care will be to identify and reduce health care disparities. Research indicates that, particularly in combination with insurance coverage, use of a medical home promotes equity in health care and reduces racial and ethnic health disparities in quality and access.⁴ A medical home provides individuals with a usual source of primary care, using a personal physician working with a diverse health care team that includes a case manager, and an

⁴ A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, “Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey”, The Commonwealth Fund, June 2007.

ability to receive necessary screenings, treatments and procedures in a convenient and timely manner.

3. Chronic and Complex Care Management

MassHealth has several care management programs and is developing a more comprehensive care management approach, which will encompass members served by MCOs and in the PCC Plan, as well as dual-eligible members not presently in managed care. These initiatives are focused on ensuring that MassHealth provides the appropriate services to members at the appropriate time and on decreasing the under- or over-utilization of services. While care management by definition is focused on improving outcomes for members, cost savings may also result from the reduction of unnecessary care and from more positive health outcomes, reducing the need for higher-level interventions, such as hospitalization or nursing home placement.

The four full service MassHealth MCOs are contractually required to perform care management services, which include case and disease management programs. MCOs perform a Health Risk Assessment on each enrollee to determine whether s/he qualifies for any of the plan's care management programs. A care management coordinator, in conjunction with the enrollee's primary care physician, develops an individual care plan for each enrollee served by the care management programs. Each MCO is required to provide care management in at least four areas – asthma, maternal and child health (including EPSDT), HIV/AIDS and intensive case management for members with behavioral health issues. MassHealth MCOs provide additional care management programs for diabetes, depression, congestive heart failure, transplants, high-risk obstetrical care, cancer, smoking cessation and a host of other complex acute and chronic conditions.

As noted above, the Commonwealth will be re-procuring its managed care contracts during the term of this Demonstration renewal. MassHealth intends to broaden the scope of required care management programs and to attach significant financial incentives to positive clinical and cost outcomes that demonstrate specific measures of quality. The PCC Plan also utilizes care management for its members and is continually looking to improve these efforts through pilot programs. Programs currently administered by the PCC Plan include Tiered Case Management, which addresses individuals with behavioral health coordination needs; an Essential Care program, in which nurses and social workers assist members with understanding their needs and help them access services; and the Controlled Substances Management program, which provides pharmacy data to primary care clinicians with patients with high use of controlled substances. These efforts are important, but will become more coordinated and focused as MassHealth engages with other payers to coordinate appropriate clinical measures and identification techniques for individuals for whom case management is appropriate. As discussed above, the state is planning to enhance its PCC Plan and a large part of that enhancement will be a more focused care and disease management program for PCC Plan members.

Research has shown that intensive and focused care management for individuals with high health care costs can result in a 10-20 percent reduction in costs along with a 10-20 percent improvement in functional status.⁵ MassHealth has recently begun an effort to take a closer look at MassHealth members with the highest costs. An analysis of FY 2006 data found that MassHealth spent 42% of its budget on only 3% of its members. Most of these members have multiple chronic physical and behavioral health conditions and/or disabilities. Under this initiative, the MassHealth Office of Clinical Affairs identifies and analyzes these higher cost members to determine whether the care they are receiving is coordinated, effective and appropriate. In one example, direct communication and clinical collaboration between the MassHealth Deputy Medical Director and the treating physicians resulted in savings of \$6 million per year in hemophilia treatment costs, without compromising clinical outcomes. In another, we are analyzing the treatment of members seeking controlled substances from multiple providers to determine whether their diagnoses require high narcotic use. MassHealth will continue this work and create a sustained, intensive effort to generate savings for these highest cost members.

MassHealth is also looking at further possibilities for disease management for those with particular chronic conditions and costs just below those of the highest cost group. Using predictive modeling software to identify emerging high-cost cases will allow MassHealth to intervene with members before they become high-cost. Medical management algorithms of likely inpatient hospitalization candidates will allow targeting of appropriate services needed to decrease emergency room visits, inpatient hospitalizations and other avoidable health care needs and costs.

MassHealth and CMS/Medicare now collaborate on an innovative model of care for seniors with Medicare, known as the Senior Care Options (SCO) program. The SCO program is authorized under and governed by the Massachusetts Title XIX state plan, not this 1115 Demonstration. This SCO experience, combined with the data-mining now underway in MassHealth, will shape an overall initiative to identify care management approaches for disabled dually eligible members, served under the Demonstration, who now receive essentially uncoordinated care from disparate networks of providers. It is imperative to address the unique needs of the dually eligible population, whether in a capitated program or otherwise. MassHealth anticipates both cost savings and improved outcomes from better integration of benefits and care for disabled dual-eligible members as a result.⁶

⁵ Forman S, Kelliher M, and Wood G. "Clinical Improvement with Bottom-Line Impact: Custom Care Planning for Patients with Acute and Chronic Illnesses in a Managed Care Setting," *American Journal of Managed Care*, 1997, 3(7), 1039-1048.

⁶ An MCO in Oregon has recently reported reducing claims costs by 50% for a high-cost aged and disabled population compared to a similar population who did not receive comprehensive care management services from an MCO. Other states have reported more modest savings for an entire population.

4. Leveraging Technology and Increasing Transparency

Health care system change will require a health information technology (HIT) infrastructure that enables the implementation of electronic health record systems and health information sharing among provider and payer organizations. Massachusetts stands at the forefront of innovation in HIT, and the Commonwealth, MassHealth, and private organizations are all partners in the effort. The Massachusetts eHealth Collaborative, a coalition working to pilot interconnected HIT in three Commonwealth communities, is funded by a \$50 million grant from Blue Cross Blue Shield of Massachusetts. MassHealth is a member of the Massachusetts Health Data Consortium (MDHC), a consortium of health plans, institutions, providers and consumer groups dedicated to exploring HIT initiatives and improving HIT adoption. MassHealth is also a participant in the New England Healthcare Electronic Data Interchange Network (NEHEN), which has implemented a secure method for electronic exchange of HIPAA-compliant transactions. These HIT collaborations, and the broader vision they support, are a building block of reducing medical errors, improving clinical practice, and improving patient monitoring –all critical aspects of MassHealth’s cost containment and quality goals.

Recognizing the need for a statewide focus not solely on expanding insurance coverage but also on cost containment and quality improvement, Chapter 58 established the Health Care Quality and Cost Council, chaired by Dr. JudyAnn Bigby, Secretary of the Executive Office of Health and Human Services. Broadly speaking, the Council’s mission is to promote high-quality, safe, effective, timely, efficient, equitable and patient centered health care and to establish quality and cost benchmarks for the Commonwealth’s health care industry. In that larger sense, the Council is a leader in establishing the standards and defining the measures that will inform many of MassHealth’s own cost and quality initiatives. More specifically, the Council has the authority to collect claims and quality data from providers and payers, and is beginning to build an all-payer health information database for the Commonwealth. The Council’s emphasis on transparency of health care cost and quality data will increase the public’s access to quality and price information so consumers and purchasers of health care can make informed choices, and will create incentives for providers to compete based on cost and quality.

Like many Medicaid programs, MassHealth is undertaking a multi-year effort to develop a new Medicaid Management Information System (MMIS). The NewMMIS will transform MassHealth’s relationship with its providers and members, create new capacities for designing flexible benefit plans and payment methodologies, and facilitate information analytics and data sharing that is now impossible. In connection with the NewMMIS and the EOHHS Data Warehouse, MassHealth is also soliciting bids for an enhanced Surveillance and Utilization Review System (SURS) capacity that will enable real-time fraud detection and vastly improved predictive modeling capabilities. These IT systems are at the heart of MassHealth’s plans to improve efficiency in rates, to improve

primary care and the PCC Plan, and to perform the data analysis necessary to implement care coordination and disease management programs.

Section 4 Conclusion

As the Commonwealth and CMS embark together on the work necessary to renew Massachusetts' Demonstration program, it is clear that sustainability of this historic health care reform experiment in Massachusetts must be the focus. States across the country are looking at Massachusetts' model to see if it fails or succeeds, and people across the Commonwealth are depending on it to provide them with access to affordable quality care. So far, the experiment is working—hundreds of thousands of people have received affordable health insurance coverage through a public-private partnership model, unprecedented policies, such as affordability principles and an individual mandate, are being tested, and dollars already in the health care system are being redirected to more efficient uses. Additionally, because efforts by several organizations to measure the remaining uninsured have produced multiple surveys and disparate numbers, work is underway in the Commonwealth to ensure we have the best methodology possible for measuring and tracking the number of uninsured in Massachusetts so that we can accurately measure the impact of health care reform. Continued and ultimate success of health care reform is not possible without a conscious effort to contain costs and improve quality, continued investment of sufficient resources, and continued commitment from all partners in the endeavor, most importantly the Commonwealth and CMS.

List of Attachments:

Attachment A: Budget Neutrality Worksheets

Attachment B: Healthy Massachusetts Compact