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

SECTION 1115 DEMONSTRATION AMENDMENT

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Section 1 Introduction

The MassHealth 1115 Demonstration has been an essential vehicle for state health care reforms in Massachusetts since 1997, including Massachusetts' groundbreaking 2006 reform that paved the way for near-universal health insurance coverage and significant improvements in access to affordable health care. Key elements of the state health care reform, known as Chapter 58, included expansions of public health coverage programs, the formation of a health insurance exchange known as the Commonwealth Health Insurance Connector Authority (Health Connector), the creation of the Commonwealth Care program to provide subsidies for low-income individuals to purchase health insurance through the Health Connector, a requirement that all adult residents purchase health insurance if it is affordable, and obligations for employers to contribute to the cost of their employees' health insurance. The 1115 Demonstration has played a key role in providing federal authority and support for these reforms, including most notably, the Commonwealth Care program that now provides affordable health insurance for more than 200,000 low-income adults.

Massachusetts' health care reform has yielded unparalleled rates of health insurance coverage while meaningfully improving access to care and narrowing health disparities across demographic lines. According to the most recent data, 439,000 more Massachusetts residents now have health insurance compared to 2006.[1] The overall insured rate in Massachusetts is 96.9 percent, the highest rate in the country, and the insured rate for children is over 98 percent.[2] While the overwhelming majority – 80 percent – of Massachusetts residents have employer-sponsored insurance or other private insurance, the expansion of public programs under the Demonstration has played a critical role in increasing insurance for those who do not have access to employer-sponsored insurance and who would otherwise be unable to afford coverage.

Access to insurance has also translated into increased access to care, particularly for low-income residents and racial and ethnic minorities. For example, the number of adults who report having unmet health care needs due to cost has dropped by 25 percent since 2006, and among low-income adults this number has dropped by 42 percent.[3] In addition, the gap between whites and non-whites in access measures such as having a usual source of care has narrowed significantly since health care reform.[4]

It is not surprising, therefore, that public support for state health care reform remains high. Two-thirds of adults in Massachusetts support the reform, including most businesses.[5] Nearly 90

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[1] Massachusetts Division of Health Care Finance and Policy, Key Indicators, June 2011.
Note that many of the statistics cited in this section are gleaned from the Blue Cross Blue Shield of Massachusetts Foundation's report *Health Reform in Massachusetts: Expanding Access to Health Insurance Coverage: Assessing the Results, March 2013*.

[2] Massachusetts Center for Health Information and Analysis, Massachusetts Health Insurance Survey, January 2013.

[3] Urban Institute, Massachusetts Health Reform Survey, 2010 and 2012.

[4] Urban Institute, Massachusetts Health Reform Survey, 2010.

[5] Urban Institute, Massachusetts Health Reform Survey, 2012.

percent of doctors believe that the reform improved, or did not affect, the quality of care in Massachusetts.[6]

The success of health care reform in Massachusetts also contributed to the fact that the federal health care reform law, the Patient Protection and Affordable Care Act of 2010 (ACA), takes a very similar approach. As in Massachusetts, the ACA includes the creation of state health insurance exchanges, subsidies for low- and moderate-income individuals to purchase health insurance, an individual mandate to purchase insurance, shared responsibility requirements for employers, and expansions of public health insurance programs. Massachusetts is therefore well positioned to implement the ACA when its major provisions go into effect on January 1, 2014.

Nevertheless, implementation of the federal health reform law will bring considerable changes to the configuration of subsidized coverage in Massachusetts and to the 1115 Demonstration. More than 240,000 individuals currently enrolled in a Demonstration program will become eligible for Medicaid State Plan coverage due to the ACA's expansion of Medicaid to adults with incomes up to 133 percent of the Federal Poverty Level (FPL). Another 150,000 individuals enrolled in a Demonstration program will become eligible for federal Advance Premium Tax Credits (APTCs), and in some cases Cost Sharing Reductions (CSRs), for the purchase of Qualified Health Plans (QHPs) through the Health Connector as Massachusetts' ACA-compliant Exchange.[7] Some Demonstration programs will no longer be necessary, while others will be restructured to fill in the gaps where certain groups might otherwise be adversely affected by the shift to the ACA.

The ACA will also create new options for populations outside of the current Demonstration to obtain affordable health coverage. Lawfully present non-citizens who have enrolled in coverage through the Commonwealth Care program with state-funded subsidies will soon have access to federally-supported APTCs and CSRs through the Exchange. In addition, the Commonwealth estimates that over 100,000 uninsured individuals, including many who receive services for which hospitals and health centers are reimbursed through the Health Safety Net, will enroll in MassHealth or in QHP coverage through the Exchange.

The proposals outlined in this Amendment Request are intended both to conform to the changes under the ACA and to support the Commonwealth's ability to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration. Additional details and context related to MassHealth's plans for the transition to ACA implementation are included in the attached Roadmap to 2014: Affordable Care Act Transition Plan, consistent with the requirements of STC 60 of the current Demonstration approval documents.

In addition to implementing the expansion and redesign of subsidized coverage under the ACA, Massachusetts seeks to amend the Demonstration to bolster the state's efforts to advance delivery system transformation, payment reform and cost containment. With the passage in 2012

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[6] SteeleFisher GK, et. al., "Physicians' Views of the Massachusetts Health Care Reform Law — A Poll", NEJM, Oct 21, 2009.

[7] These estimates were developed by the Commonwealth and include "Aliens With Special Status" enrolled in Commonwealth Care, for whom Federal Financial Participation is not authorized under the Demonstration but who will be eligible to receive federal subsidies through the Exchange.

of *Chapter 224: An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation* (known simply as "Chapter 224"), Massachusetts reaffirmed its commitment to transform the health care delivery system by moving the market away from fee-for-service payments and towards a system capable of delivering better health care and better value for all residents of the Commonwealth. Among other provisions, Chapter 224 establishes a statewide health care cost growth target, requires state programs to lead by example in moving toward alternative payment methodologies, increases transparency and protections for consumers regarding health care costs and quality, and commits significant resources to investing in both community-based public health initiatives and the health care delivery system.

Just as the 1115 Demonstration played a key role in realizing the goals of Chapter 58, Massachusetts anticipates that the Demonstration will be instrumental in ensuring the success of Chapter 224. With this amendment, MassHealth requests authorities that support the Commonwealth's initial implementation of Chapter 224 and lay the groundwork for continued support in the next renewal of the Demonstration that begins in July 2014.

Specifically, the Commonwealth requests waiver authority to launch the Primary Care Payment Reform Initiative, MassHealth's alternative payment model that allows primary care providers to assume accountability for the cost and quality of care through a shared savings arrangement. The Commonwealth also proposes to extend and expand upon its expenditure authority for Designated State Health Programs to support the state's investments in ongoing programs and new initiatives that support the triple aims of better health, better care, and lower costs.

Section 2 Requested Changes to the MassHealth Demonstration

The Commonwealth is requesting authorization to make a number of changes to its Demonstration in order to implement the ACA. Many of these changes are intended simply to conform to the requirements of the ACA, while others are intended to protect members from potential adverse consequences of the shift to the ACA or to maintain or improve upon the alignment of policies between MassHealth and the Health Connector with the aim of promoting streamlined eligibility processes and continuity of care.

A. Changes Related to Eligibility and Enrollment

1. The Commonwealth requests to amend the authority related to the calculation of financial eligibility in accordance with the ACA requirement to use Modified Adjusted Gross Income (MAGI). The Commonwealth will use MAGI for all non-exempt groups, including Breast and Cervical Cancer Treatment Program and HIV-Family Assistance members.

   In addition, the Commonwealth requests authority to utilize MAGI income counting methodologies, including the five percent income disregard, for disabled adults under MassHealth Standard and CommonHealth in order to avoid disadvantaging disabled adults compared to non-disabled adults. However, the Commonwealth requests to use non-tax filer household composition rules for all disabled adults, regardless of tax filer status. The use of non-filer household composition rules will ensure that disabled adults are not adversely

affected by the fact that they may be claimed as dependents on a parent's or caretaker's taxes and therefore have other family members' income counted toward the calculation of their FPL. Non-filer household composition rules also are largely similar to the rules MassHealth currently uses for household composition and therefore promote continuity for disabled members.

2. The Commonwealth requests to continue using MassHealth's current premium billing family groupings for the purposes of calculating member premiums or premium assistance, notwithstanding the use of MAGI family groupings for eligibility determinations. This policy will simplify premium billing and premium assistance for members, as MassHealth's current premium billing family groupings generally reflect families living together in the same household, as compared with MAGI household composition rules, which are driven by tax filing relationships.

3. The Commonwealth requests to modify its authority for retroactive eligibility for annual renewals to allow MassHealth to provide retroactive eligibility when reinstating a member who was terminated for failure to return the annual eligibility prepopulated form-and subsequently submits the form within 90 days after termination (a "reconsideration period"). In that circumstance, if the submitted information indicates the individual is still eligible, benefits will be reinstated retroactive to the date of termination. If verifications were required with the prepopulated form and the form is returned within the reconsideration period, the individual will receive an additional 90 day verification period from the date the returned pre-populated form is processed and an eligibility determination is made to submit the verifications. This reconsideration period will promote continuity of coverage and prevent unnecessary gaps in insurance in the context of an individual mandate to maintain insurance coverage or face tax penalties.

   An applicant who terminates for failure to provide information or verification will be granted 10 days retroactive coverage from the date the verifications are returned if the verifications are submitted within 12 months from the date the application was received.

4. The Commonwealth requests authority to allow hospital-determined presumptive eligibility to provide benefits for 90 days duration. In addition to children, pregnant women, parents and caretaker relatives, and the new childless adult group under the ACA, MassHealth plans to allow hospitals to make presumptive eligibility determinations for unborn children (covered under CHIP), the Breast and Cervical Cancer Treatment Program and HIV Family Assistance program under the Demonstration. The Commonwealth requests authority to grant pregnant women full Standard benefits through hospital-determined presumptive authority. Hospitals will not be authorized to make presumptive eligibility determinations for individuals who were enrolled in MassHealth within the prior 12 months.

   The Commonwealth furthermore plans to limit hospital presumptive eligibility determinations for any individual to only once in a 12-month period, unless the individual is transitioning from QHP coverage through the Health Connector, or if the individual self-attests pregnancy.

5. The Commonwealth requests authority to establish automatic MassHealth eligibility for individuals receiving Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI) or Emergency Aid to Elders, Disabled and Children (EAEDC), without regard to MAGI or other eligibility processes.

6. For 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 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.

7. The Commonwealth requests to add the ACA Medicaid Expansion group of adults ages 19 to 64 with incomes up to 133 percent FPL to the Demonstration. These individuals will be enrolled in one of two Alternative Benefit Plans under the Medicaid State Plan.

   Nineteen and 20 year olds, individuals who otherwise would be eligible for the Breast and Cervical Cancer Treatment Program or the HIV-Family Assistance Program, and individuals receiving services from the Department of Mental Health or on a waiting list to receive such services, will be eligible for an Alternative Benefit Plan (ABP), referred to here as “ABP 1,” that is identical to Standard, plus any additional required Essential Health Benefits.[8] Nineteen and 20 year olds in ABP 1 will be entitled to all services available to children under the State Plan, including EPSDT. Individuals enrolled in ABP 1 will be required to enroll in managed care and may select among MassHealth’s Primary Care Clinician (PCC) Plan and MassHealth’s contracted managed care organizations (MCOs).

   ACA Expansion adults ages 21 to 64 who do not fall into any of the special categories described above will be eligible for MassHealth CarePlus, a new benefit plan that includes the Essential Health Benefits and will be described in detail in MassHealth’s State Plan Amendment (SPA) submission to CMS. MassHealth proposes to include diversionary behavioral health services, as defined in the Demonstration, in the CarePlus benefit plan. Individuals enrolled in MassHealth CarePlus will be required to enroll in managed care through a health plan contracted by MassHealth.

   MassHealth will provide premium assistance for individuals in ABP 1 or MassHealth CarePlus if they have access to private health insurance that is considered cost effective.

[8] MassHealth is preparing a State Plan Amendment (SPA) to implement the Alternative Benefit Plans and will describe any additional Essential Health Benefits not otherwise covered under MassHealth Standard in the SPA.

MassHealth will provide wraparound benefits and assistance with cost sharing to ensure that these individuals have access to health coverage and cost sharing equal to what they would receive if they were enrolled in direct coverage. For members ages 21 and above, cooperation with the Commonwealth to obtain or maintain available health insurance will be treated as a condition of eligibility.

8. The Commonwealth requests to treat 19- and 20-year-olds with incomes up to 150 percent FPL as children under the Demonstration, in accordance with a State Plan Amendment that MassHealth plans to submit. Consistent with the requirement to provide EPSDT to 19- and 20-year-olds in the ACA Medicaid Expansion group, MassHealth plans to treat all 19-and 20-year-olds in the Medicaid State Plan (up to 150 percent FPL) as children, including for the purposes of benefits, cost sharing and premium assistance.

9. The Commonwealth requests to add to the Demonstration the new mandatory Former Foster Care Children's group up to age 26. Like the Independent Foster Care Adolescents up to age 21 who are currently covered under the Demonstration, individuals in the new former foster care group will be eligible without regard to income or assets and will be enrolled in MassHealth Standard. Eligibility for both groups of former foster care children may be determined based on referral from the Massachusetts Department of Children and Families in lieu of application.

10. The Commonwealth requests authority to continue defining the age of a dependent child for purposes of the parent and/or caretaker relative coverage type as a child who is less than age 19.

11. The Commonwealth requests to amend the authorities for the Breast and Cervical Cancer Treatment Program and the HIV-Family Assistance program to make these coverage types available only for adults over 133 percent FPL, who are not otherwise eligible for State Plan coverage as part of the ACA Medicaid Expansion. Maintaining authority for this Demonstration program will enable individuals with HIV or breast or cervical cancer to continue receiving the same level of benefits and cost sharing for which they are eligible prior to ACA implementation.

    The Commonwealth further requests to amend the authority for the Breast and Cervical Cancer Treatment Program to allow eligible men with breast cancer to enroll and to allow a diagnosis from independent physicians to establish clinical eligibility, provided the individual meets all other eligibility criteria.

12. The Commonwealth requests to end the authorities for MassHealth Essential, MassHealth Basic, Commonwealth Care and the Medical Security Plan, effective December 31, 2013, as these programs will no longer be necessary under the ACA. Individuals enrolled in these Demonstration programs will be eligible either for Medicaid State Plan coverage or for QHP coverage through the Health Connector. The new ACA coverage options will provide benefits that are commensurate, and in some cases richer, compared with the coverage that these populations receive under the Demonstration.

13. The Commonwealth requests to replace the authority for the Insurance Partnership program with authority to provide premium assistance to qualifying employees of small employers. Under the ACA, many current Insurance Partnership enrollees will be eligible either for Medicaid State Plan coverage or for QHP coverage through the Health Connector. However, some Insurance Partnership enrollees with incomes over 133 percent FPL may not be eligible for QHP coverage due to access to affordable Minimum Essential Coverage (MEC) as defined in the ACA. In order to ensure that such individuals receive continued assistance, MassHealth proposes to provide premium assistance for individuals with incomes between 133 and 300 percent FPL who work for small employers, have access to employer-sponsored insurance (ESI) and who are ineligible for other coverage through MassHealth or the Health Connector.

    MassHealth plans to discontinue the employer subsidy that has been part of the Insurance Partnership program, in light of changes to state and federal employer responsibility provisions and the availability of federal tax credits and state wellness rebates to certain small businesses that purchase insurance for their employees through the Exchange.

B. <u>New Authorities to Promote Continuity</u>

1. In order to align MassHealth eligibility procedures with the Health Connector, the Commonwealth requests authority to provide a 90-day post-eligibility verification period, termed a "provisional eligibility" period. Self-attestation will be accepted for all eligibility factors except for disability status. If MassHealth is unable to verify self-attested eligibility factors through federal and state data hubs, or if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, MassHealth will require verification from the individual post eligibility determination. Necessary verifications will be required within 90 days of the eligibility determination in order to maintain enrollment. The Citizenship and Immigration Reasonable Opportunity Period will also be aligned for 90 days.

   This 90-day provisional eligibility period is intended to mirror the 90-day post-eligibility "inconsistency period" that is required for QHP enrollment. Given MassHealth's estimates that between 75,000 and 100,000 individuals will be in households with both MassHealth and QHP members, it is critical that eligibility policies and procedures are as closely as aligned as possible. In this case, the proposed 90-day provisional eligibility period will simplify verification procedures for applicants and reduce the likelihood that eligible individuals will fail to enroll because of administrative factors.

   The Commonwealth furthermore requests to implement provisional eligibility with certain limitations:

   a) An individual may receive provisional eligibility only once in a 12-month period, unless the individual is transitioning from a Qualified Health Plan (QHP) with an Advanced Premium Tax Credit (APTC), or if the individual self-attests pregnancy.

b) An individual who was in a hospital-determined presumptive eligibility period at the time of application must submit all required verifications by the end of the 90 day presumptive eligibility period in order to maintain enrollment.

2. The Commonwealth requests authority to extend MassHealth coverage to the end of the month for a member whose eligibility has been redetermined, resulting in a shift from MassHealth to subsidized non-group QHP coverage offered through the Health Connector. If the individual's MassHealth termination otherwise would have been effective on or before the 15th of a given month, then MassHealth coverage will be extended to the end of that month. If the termination otherwise would have been effective on or after the 16th of a given month, then MassHealth coverage will be extended to the end of the following month. This policy will allow individuals whose coverage is changing enough time to complete the steps necessary to enroll in a QHP and make a transition with no gap in coverage, since QHP enrollment begins on the first of the month, whereas MassHealth coverage currently could end at any time during the month, forcing gaps in coverage as members transition between programs.

C. Temporary Authority Requests for Transition Period

1. The Commonwealth requests authority to use an administrative process to transition members enrolled in Demonstration programs into coverage under the State Plan effective January 1, 2014. MassHealth proposes to use information already available in its eligibility system, MA21, to identify all individuals currently enrolled in a Demonstration program who are eligible for new State Plan coverage and issue new eligibility determinations for these individuals without requiring members to reapply or provide additional information. Specifically, the Commonwealth requests authority to implement this transition process for eligible members currently enrolled in MassHealth Essential, MassHealth Basic, MassHealth HIV-Family Assistance, MassHealth Breast and Cervical Cancer Treatment Program, MassHealth Insurance Partnership, Commonwealth Care, and for individuals for whom acute hospitals and community health centers may receive payments through the Health Safety Net.

   The Commonwealth will begin claiming enhanced Federal Financial Participation (FFP) at the approved levels ("Newly Eligible FMAP" or "Expansion State FMAP") for individuals in the ACA Medicaid Expansion group as of January 1, 2014, based on the eligibility determination made according to the administrative process described above.

2. Rather than waiting to apply MAGI methodologies to current members until the later of March 31, 2014, or the individual's regularly scheduled 2014 annual review, the Commonwealth requests authority to begin applying MAGI methodologies as of January 1, 2014, to determine eligibility for current members in a MAGI eligibility group and disabled adults under the Demonstration (since MassHealth proposes to use MAGI income counting methodologies for disabled adults). If, on or after January 1, 2014 but before the individual's regularly scheduled 2014 annual review, a member reports a change in circumstance that may affect eligibility or reports access to health insurance, or a periodic data match indicates such a change in circumstance, or, in a case where MassHealth provides premium assistance, a change in a member's primary health insurance policy, MassHealth may require the

individual to submit additional information in order to make a full MAGI-based eligibility determination. This eligibility determination will result in a new anniversary date for annual eligibility reviews thereafter.

This policy will enable MassHealth to use up-to-date information provided about members in mixed households when other family members apply for QHP coverage during the initial ACA open enrollment period in October through December 2013. Furthermore, this approach is the only feasible way to process changes in circumstance affecting member eligibility after the new Health Insurance Exchange/Integrated Eligibility System (HIX/IES) system is implemented. All member data for MAGI groups will be converted to the new system on or about January 1, 2014, and therefore it will not be possible to update eligibility using the old system and non-MAGI rules.

In Massachusetts' case, members generally will not be adversely affected by the application of MAGI methodologies as of January 1, 2014, because MAGI is not a more stringent methodology than the gross income methodology that MassHealth currently uses for members enrolled in the Demonstration. Instead, the use of MAGI methodologies will allow some current members to receive richer benefits as of January 1, 2014, if they qualify.

3. The Commonwealth requests authority to suspend annual redeterminations from September 1, 2013 until December 15, 2013 in order to minimize confusion for members and to direct operational resources to the transition. The Commonwealth proposes to continue processing change of circumstance requests during this time.

D. New Authorities to Implement Alternative Payment Models

1. The Commonwealth requests authority to implement the Primary Care Payment Reform Initiative (PCPR). Chapter 224, Massachusetts' sweeping 2012 health care cost containment legislation, calls on MassHealth to swiftly transition its members to alternative payment methodologies (APMs). Chapter 224 requires that 25 percent of members be participating in APMs by July 2013, 50 percent by July 2014, and 80 percent by July 2015. In order to meet this legislative mandate, the Commonwealth seeks authority to implement PCPR in its managed care programs, including the PCC Plan and the MCO programs.

   The goal of PCPR is to improve access, patient experience, quality and efficiency through the patient-centered medical home model, which includes care coordination, care management, and better integration of primary care and behavioral health services. The payment methodology of PCPR includes a Comprehensive Primary Care Payment, a quality incentive payment, and a shared savings/risk payment. The Comprehensive Primary Care Payment is a per-member-per-month (PMPM) risk adjusted payment for a defined set of primary care services and medical home activities. The shared savings/risk payment sets a target for non-primary care medical spending and allows providers to share in the savings if actual expenditures are below the target. There are also options for providers to share in a higher percentage of the savings in return for taking on the risk of sharing in losses if actual expenditures exceed the spending target.

PCPR will be implemented across MassHealth's managed care programs and will include all members with a participating primary care provider.

E. Changes to the Safety Net Care Pool

1. 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 state 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 up to $270 million in DSHP expenditure authority for the second half of state fiscal year 2014.

   This request includes three categories of expenditures, as described below.

   a) Massachusetts requests expenditure authority for health programs previously authorized as DSHP, such as programs administered by the 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 approximately $180 million for the second half of state fiscal year 2014.

   b) Massachusetts requests expenditure authority for premium assistance payments made by the Health Connector on behalf of citizens and qualified aliens with incomes up to 300 percent FPL who are enrolled in a QHP and receiving "State Wrap" subsidies.

      The Health Connector will provide state-supported subsidies, referred to as State Wrap, for individuals up to 300 percent FPL who enroll in certain QHPs that are qualified by the Health Connector as Wrap plans. The State Wrap will supplement federal subsidies available in the Exchange. These combined federal and state subsidies are intended to make subsidized coverage for this population as affordable for them as it is today under Commonwealth Care. While State Wrap will include a premium assistance component and a cost sharing reduction component, FFP under the Demonstration will only be available for the premium assistance portion of State Wrap expenditures. In addition, while the Commonwealth will provide State Wrap to all eligible individuals enrolled in QHP coverage regardless of immigration status, FFP under the Demonstration will only be available for expenditures on behalf of citizens and qualified aliens.

      The Commonwealth requests authority to claim qualified expenditures for State Wrap starting January 1, 2014, estimated at up to $55 million in state fiscal year 2014.

c) 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 Fund
- E-Health Institute
- Distressed Hospital Trust Fund
- Health Care Payment Reform Fund
- Health Care Workforce Transformation Fund
- Health Connector Employer Wellness Program Rebates
- State Employee Wellness Programs
- DPH Pharmacy Expansion (TBD)

The Commonwealth requests authority to claim expenditures for these programs up to an estimated $35 million in the second half of state fiscal year 2014.

2. The Commonwealth requests to increase the total Safety Net Care Pool expenditure cap from $4.4 billion to $4.67 billion to reflect the authority to claim FFP for State Wrap expenditures up to $55 million in SFY14 as described above.

3. The Commonwealth requests to extend the deadline to January 31, 2014, for MassHealth and CMS to reach agreement on a Cost Limit Protocol for Safety Net Care Pool provider payments subject to the provider cap. While significant progress has been made on the development of the protocol, discussions between MassHealth and CMS have advanced at a slower than expected pace. MassHealth proposes to extend the deadline to allow the Commonwealth and CMS to continue working in good faith toward a mutually agreeable methodology for implementing provider-specific cost limits.

Section 3 Budget Neutrality Impact

Budget neutrality prior to amendment

The Commonwealth's projected budget neutrality cushion as of the quarterly report for the quarter ending December 31, 2012, is $8.6 billion, or approximately 28% of projected without waiver expenditures for SFY 2012-2014. This projection incorporates actual expenditures and member months through SFY 2012 as reported through the quarter ending December 31, 2012, combined with the MassHealth budget forecast for SFY 2013-2014 and Commonwealth Care and Health Safety Net (HSN) information from the SFY 2013 budget and SFY 2014 Governor's proposed budget.

This budget neutrality projection reflects significant realized and anticipated savings. This room can be attributed to savings realized to date resulting from lower than anticipated enrollment and utilization.

Effect of amendment

The amendment will result in a shift in the structure of budget neutrality under the Demonstration. Expenditures for certain hypothetical populations will now shift into the base as

the ACA Medicaid Expansion group becomes a State Plan population, and 19- and 20-year-olds up to 150 percent FPL also move into the State Plan. At the same time, certain "with waiver" Eligibility Groups will end after December 31, 2013, and the Commonwealth will have lower expenditures for Demonstration populations that shift to QHP coverage and receive State Wrap. The Commonwealth expects an increase in enrollment and PMPM amounts with expanded coverage and richer benefits packages for certain populations under the ACA. Despite the costs that will be incurred due to ACA expenditures, projections show the Commonwealth will maintain room under the budget neutrality ceiling.

The Commonwealth proposes that the "without waiver" projected PMPM costs for ABP 1 be calculated separately for the four subgroups within this coverage type: 19- and 20-year-olds, individuals otherwise eligible for the Breast and Cervical Cancer Treatment Program (BCCTP) or the HIV Family Assistance program, and individuals eligible to receive services from the Department of Mental Health. The "without waiver" costs for 19- and 20-year-olds will be the trended baseline PMPM amounts as outlined in the current Demonstration SFY14/DY17 for CommCare-19- and 20-year-olds. The without waiver costs for individuals otherwise eligible for BCCTP will be the trended baseline PMPM amount as outlined in the current Demonstration SFY14/DY17 for BCCTP. The PMPM for individuals eligible to receive services from the Department of Mental Health and individuals with HIV are based on FY2014 forecasted expenditures for the current Basic and HIV-Family Assistance populations, respectively.

The Commonwealth further proposes that the projected without waiver PMPM cost for the MassHealth CarePlus eligibility group be the SFY14/DY17 trended baseline PMPM amounts outlined in the Demonstration for the hypothetical CommCare-133 population.

As reflected in the accompanying budget neutrality workbooks, this amendment would increase the without waiver cap as populations shift into the base from certain Demonstration-only and hypothetical eligibility groups. As such, after integrating the proposed amendment, the Commonwealth and the federal government would continue to realize savings on the Demonstration, achieving a projected $9.7 billion cushion by the end of SFY 2014.

Section 4 Public Process

The public process used prior to submitting this amendment conforms with 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. In addition, because the amendment impacts eligibility, benefits and delivery systems, the Commonwealth has implemented many of the transparency and public notice requirements outlined in 42 CFR § 431.408, although the regulations are not specifically applicable to Demonstration Amendments. The Commonwealth remains committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

The public is kept apprised of the development of many of the policies contained in the Amendment through the state budget process and legislation to be filed by Governor Patrick. The

Governor's budget narrative, which accompanied the Governor's budget proposal filed in January 2013, included a detailed description of ACA implementation plans and programmatic changes coming to Demonstration programs. In addition, the Governor introduced a legislative package in early May 2013 that will make necessary State legislative changes to implement changes in the MassHealth program related to the ACA. Both the budget and legislation will go through significant public input as part of the legislative process required for passage.

The Commonwealth released the Amendment for a thirty day public comment period starting on May 1, 2013 by posting the Amendment, the Transition Plan, the Budget Neutrality spreadsheets, and a Summary of the Amendment (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) and the Commonwealth's ACA implementation website (www.mass.gov/nationalhealthreform). The announcement and links to documents were included in four EOHHS ACA implementation weekly email updates that were distributed broadly to stakeholders. Notice of the Amendment and the public comment period was also provided through an announcement in the Massachusetts Register, published on April 26, 2013, and in the Boston Globe, the Worcester Gazette and Telegram, and the Springfield Republican, published on May 4, 2013.

In addition to making the Amendment 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 Amendment on a conference call with Tribal leaders or their designees and additional Tribal health contacts on April 26. A summary of the call was provided via email on April 30, and the official Summary, including links to the documents and instructions for providing comment, was sent on May 1.

The Commonwealth hosted a Stakeholder Meeting on May 17 to seek input on the Demonstration Amendment, in addition to the budget and legislative hearings mentioned above. The meeting included a presentation on the ACA implementation activities and the Amendment and Transition Plan. Questions and comments were solicited from the audience, and comments were primarily supportive. The main concern raised was the issue of limiting CarePlus enrollment to managed care organizations (addressed in greater detail below).

Finally, the Commonwealth received 18 comment letters, from consumer and legal advocates, health care provider organizations, social service providers, state legislators and individuals on or before May 30. The Commonwealth considered all comments and made certain changes to the submissions in accordance. Overall, the comments were supportive of the Amendment and Transition Plan. Proposals to improve continuity of care and ease of enrollment were repeatedly highlighted as aspects of the Commonwealth's plan that were particularly strong. Proposals that met with enthusiasm included maintaining or increasing the coverage and benefit levels for Demonstration populations, increasing coverage for members with disability determinations through the use of MAGI income counting methodology, and adopting the former foster care

youth coverage options. In addition, there was great support for policies that promote ease of enrollment, including the Single Streamlined Application, creation of a 90 day provisional eligibility period with self-attestations where data matches are not immediately available, and aligning procedures with the Health Connector.

The most consistent concern raised was in regards to mandatory enrollment in a managed care organization (MCO) for MassHealth CarePlus, as opposed to the Primary Care Clinician (PCC) Plan that MassHealth currently offers managed care enrollees in addition to MCO options. Commenters focused in particular on vulnerable populations including the HIV-positive community, homeless individuals, and members with significant behavioral health needs.

EOHHS proposes requiring MCO enrollment for CarePlus enrollees in order to advance the goal of coverage continuity. CarePlus was structured to provide continuity with plans offered by the Exchange, as data show that we can expect significant movement between the Exchange and MassHealth due to changes in income that commonly occur among the low-income population that will be served by CarePlus. Our contracts with CarePlus MCOs will include requirements that the MCOs develop robust policies and practices to promote continuity for members experiencing transitions, as well as to provide care management and coordination for populations with special health care needs.

In addition, we have taken steps to address the special needs of particular populations. EOHHS had already proposed that Department of Mental Health clients, as a medically frail population, receive full MassHealth Standard benefits. In response to comments we received, EOHHS is now proposing that the HIV positive population also receive full MassHealth Standard benefits. Enrolling these DMH clients and HIV members in ABP 1, which is equivalent to MassHealth Standard, also will protect continuity of care these populations by allowing them to remain enrolled in MassHealth's PCC Plan if they are already receiving care from PCC Plan providers. However, CarePlus will include the full range of behavioral health services offered by MassHealth, including diversionary behavioral health services. EOHHS will require that CarePlus MCOs provide robust services that support people experiencing substance use disorder, homelessness and behavioral health challenges, and that their provider networks ensure access to care for enrollees.

An additional question raised by a coalition of consumer advocates and providers was related to the reconsideration period described in the Amendment request, which will provide up to 90 days of retroactive coverage for members who are terminated for failure to return annual redetermination forms. The coalition was in favor of the provision and asked if 90 day retroactive eligibility could be instituted more broadly, including for new applicants. However, under the ACA, there will be very few barriers to applying for, obtaining and maintaining coverage, significantly minimizing the need for long periods of retroactive eligibility. Policies that will support obtaining and maintaining coverage include the use of the Single Streamlined Application, the opportunity to apply by telephone, paper, online or walk-in, the support of assisters and navigators, the availability of hospital-determined presumptive eligibility, and the proposal to establish a 90 day post-eligibility verification period. The Commonwealth therefore does not see a compelling reason to change MassHealth's longstanding 10 day retroactive eligibility policy at this time.