

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

MassHealth Section 1115 Demonstration Amendment Request

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Contents

Introduction..... 2

Proposed MassHealth Reforms 4

Aligning coverage for non-disabled adults with commercial plans..... 4

Adopting widely-used commercial tools to obtain lower drug prices and enhanced rebates 8

Improving care, reducing costs and achieving administrative efficiencies..... 11

Supporting access to health care for veterans and their families..... 14

Summary of waiver and expenditure authorities requested 14

Budget Neutrality..... 16

Evaluation..... 17

Public Process 20

Introduction

Massachusetts has a longstanding commitment to universal health care coverage. Working with the federal government, we have made considerable progress toward the goal of near universal health care coverage for our residents. 99 percent of our children and youth, and more than 96 percent of all of our residents have health care insurance, the highest percentages in the country.¹ Our state-based Marketplace, known as the Health Connector, established in 2006 under Massachusetts' comprehensive state health care reform law, administers a robust individual and small group insurance exchange with nine carriers participating. Today, more than 250,000 individuals have health care coverage through the Health Connector, including 193,000 low to moderate income residents who receive federal and state subsidies. MassHealth, our Medicaid and Children's Health Insurance Program, covers 1.9 million individuals, or nearly 30 percent of the Commonwealth's residents.

Massachusetts attributes much of its success in expanding health coverage to strong state bipartisan collaboration, commitment to innovation, and to the federal-state partnerships that have supported the Commonwealth's reform efforts.

However, at 40 percent of the Commonwealth's budget, MassHealth's continued growth will constrain the state budget unless significant reforms are implemented and key aspects of the program are restructured. In recent years, Massachusetts has seen a steady increase in the number of residents enrolled in MassHealth, despite near universal health care coverage, steady population numbers, and low unemployment. This is explained, to a considerable degree, by reductions in the percentage of residents covered through commercial insurance. Changes in the makeup of the economy, increased cost of health care, expansion of high deductible commercial health insurance and the high cost of insurance for small employers are all contributing factors to the shift from the commercial market to public coverage.

The Baker-Polito administration has implemented reforms to make the MassHealth program sustainable. We have reduced annual growth in program spending from double digits to single digits without reducing benefits or eligibility, in large part due to focused efforts to improve program integrity and strengthen eligibility systems and processes. In addition, we have initiated the restructuring of the existing MassHealth program into an innovative accountable care program under the recently approved five-year 1115 demonstration agreement with the Centers for Medicare and Medicaid Services (CMS), which will shift the majority of our managed care eligible members into Accountable Care Organizations (ACOs).

¹ <http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf>

In August, 17 ACOs across the state signed contracts with MassHealth. These ACOs are expected to cover more than 850,000 MassHealth members. The ACO program will promote integration and coordination of care for members, while holding providers accountable for their quality and cost. MassHealth's ACOs will integrate their efforts with community-based health and social service organizations to improve behavioral health, long-term supports and health-related social needs for MassHealth members as appropriate.

To build on this restructuring, additional federal flexibility is needed for further reforms in MassHealth and the commercial insurance market that support long-term fiscal sustainability. Massachusetts is committed to reforming MassHealth in a manner that protects coverage gains and aims to improve the quality and integration of health care delivery, particularly for our members with the most complex needs.

MassHealth's requests for flexibility through this amendment request include:

- ***Aligning coverage for non-disabled adults with commercial plans***
 1. Enroll non-disabled adults with incomes over 100% FPL in subsidized commercial plans through the state's exchange (the Health Connector)
 2. Align MassHealth benefits for all non-disabled adults in a single plan that is benchmarked to commercial coverage, by enrolling non-disabled parents and caretakers with incomes up to 100% FPL in MassHealth's CarePlus Alternative Benefit Plan
 3. Eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector
- ***Adopting widely-used commercial tools to obtain lower drug prices and enhanced rebates***
 4. Select preferred and covered drugs through a closed formulary that assures robust access to medically necessary drugs
 5. Procure a selective and more cost effective specialty pharmacy network
- ***Improving care, reducing costs and achieving administrative efficiencies***
 6. Implement narrower networks in MassHealth's Primary Care Clinician (PCC) Plan to encourage enrollment in ACOs and Managed Care Organizations (MCOs)
 7. Remove barriers to effective behavioral health care by waiving federal payments restrictions on care provided in Institutions for Mental Disease (IMDs)
 8. Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers are participating in a single MassHealth ACO

9. Implement the cost sharing limit of five percent of income on an annual basis rather than a quarterly or monthly basis
10. Maintain cost sharing greater than five percent of income for members over 300% FPL eligible exclusively through the demonstration
11. Limit premium assistance cost sharing wrap to MassHealth enrolled providers (waiver required by State Plan Amendment 16-0011)
- ***Supporting access to health care for veterans and their families***
 12. Disregard as countable income state funded veteran annuities paid to disabled veterans and to Gold Star parents and Gold Star spouses when determining MassHealth eligibility

In parallel with this request, Massachusetts will submit a 1332 waiver with an additional set of flexibility requests that promote market stability and seek relief from certain ACA requirements for the private health insurance market. These include a request to establish a premium stabilization fund in lieu of cost sharing reductions, permission to administer the federal small business health care tax credit, transitional relief regarding reviving the state's employer shared responsibility program and continuing to use specific state based rating factors. Massachusetts will also continue discussions with CMS to pursue flexibility to enable MassHealth to better manage care and costs for dually eligible members using 1115A waiver authority.

Proposed MassHealth Reforms

Aligning coverage for non-disabled adults with commercial plans

Non-disabled adults are the most economically mobile group among Medicaid members and do not have disabilities that require the unique services offered in Medicaid on a long-term basis. They are more likely than other groups to be employed, to experience income growth over time, and to enter the commercial health insurance market. As a result, we believe that benefits and coverage for non-disabled adults should better align with commercial health insurance. Achieving this alignment will also help to address the significant shift we have seen over the last several years from private to public coverage. As we consider ways to align with commercial coverage, Massachusetts is committed to maintaining near universal, high quality, affordable coverage for all of our low-income residents. To that end, Massachusetts proposes three reforms, described in detail below.

1. *Enroll non-disabled adults ages 21 to 64 with incomes over 100% of the FPL into subsidized health plans through the Health Connector*

We propose to shift coverage for non-disabled adults ages 21 to 64 with incomes over 100 percent of the FPL, including ACA expansion enrollees and parents and caretakers,

to subsidized commercial plans through the Health Connector. We estimate that this population is comprised of approximately 40,000 ACA expansion enrollees and approximately 100,000 non-disabled parents and caretakers with incomes over 100% of the FPL. This change would be effective in January 2019.

Non-disabled adults with incomes over 100% of the FPL are similar in many respects to individuals currently enrolled in commercial health insurance plans. Their needs can be met in commercial health insurance products with appropriate affordability protections. In addition, this group of individuals is most likely to move between MassHealth and Health Connector coverage today as their income fluctuates. Shifting this population to the Health Connector will improve continuity and reduce churn by allowing adults to stay in the Health Connector as long their income remains above 100% of the FPL. This approach is consistent with the pre-ACA coverage structure in Massachusetts under state health reform, when lower income adults were covered through the Connector in a program called Commonwealth Care, which was nearly identical to the current subsidized coverage offerings through the Connector.

The coverage available to this population through the Health Connector is comprehensive and affordable. Qualified Health Plans through the Health Connector are required to cover the Essential Health Benefits as well as state-mandated benefits. Massachusetts has a uniquely robust affordability structure for lower income Marketplace enrollees, including a state premium and cost sharing wrap program known as ConnectorCare, which supplements federal subsidies. Individuals transitioning to the Connector will have access to a range of commercial health insurance options, including at least one \$0 premium plan option. Their total annual out of pocket expenses will be capped at \$1,250 annually for an individual (\$2,500 for a family), and Massachusetts' experience is that average co-pays for the population at this income level are much lower (~\$200-300 per year). Many of the health insurance carriers available through ConnectorCare are also MassHealth Managed Care options.

In addition, while Qualified Health Plans do not include dental coverage, these individuals will have access to dental services through the Health Safety Net program, which reimburses hospitals and community health centers for uncompensated care for eligible low-income patients. Alternatively, enrollees can purchase separate dental insurance for approximately \$30 a month through the Health Connector.

The following populations would remain eligible for MassHealth:

- Individuals who are disabled or medically frail;
- Pregnant women;
- Populations that would have been eligible for MassHealth prior to the ACA based on HIV status or in the breast or cervical cancer treatment program;

- Veterans who are not eligible for federal subsidies through the Marketplace due to enrollment in veterans' health coverage.

Members will have an opportunity to identify themselves for a formal disability determination if they have not already done so. Anyone determined disabled based on federal or MassHealth processes, as well as those determined by MassHealth to be medically frail, would remain in MassHealth coverage and would continue to have access to medically necessary long-term services and supports (LTSS).

2. Consolidate coverage for non-disabled adults ages 21 to 64 with incomes <100% FPL in coverage that aligns more closely with commercial coverage

For non-disabled adults with incomes up to 100 percent of the FPL who would remain in MassHealth, we propose better aligning coverage with commercial plans. Given the high potential for income fluctuation and shifts between MassHealth and commercial coverage for non-disabled adults, aligning coverage for this population with commercial plans will promote continuity for members. In addition, these policies will help to stem the enrollment shift from the commercial market to public coverage in Massachusetts.

Therefore, MassHealth proposes to enroll all non-disabled adults up to 100 percent of the FPL, including parents and caretakers, in a common Alternative Benefit Plan (ABP) known as MassHealth CarePlus. MassHealth CarePlus is currently available to ACA expansion enrollees ages 21-64 and would be extended to include non-disabled parents and caretakers ages 21-64 as well. CarePlus benefits are similar to those in MassHealth Standard except that they do not include LTSS (individuals who need LTSS because they are disabled or medically frail will not be affected by this population shift). Massachusetts has also submitted an 1115 demonstration amendment to eliminate coverage for non-emergency medical transportation for non-disabled adults, with the exception of transportation to substance use disorder (SUD) treatment services. We estimate that approximately 230,000 non-disabled parents and caretaker relatives would shift from MassHealth Standard to MassHealth CarePlus. This change would be effective in January 2019.

Pregnant women and members with HIV or breast or cervical cancer would remain in MassHealth Standard. In addition, members will have an opportunity to identify themselves for a formal disability determination if they have not already done so, and anyone determined disabled would remain in MassHealth Standard. MassHealth will also continue to allow medically frail individuals to opt into MassHealth Standard coverage.

3. *Eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector*

Federal rules require MassHealth to cover emergency services for individuals who would otherwise be eligible for Medicaid State Plan coverage, but for their immigration status. However, many of these individuals are also eligible for comprehensive, affordable coverage through the Health Connector with the benefit of both federal and state subsidies. MassHealth is currently providing redundant coverage for these individuals, given that all Qualified Health Plans cover emergency services. Therefore MassHealth proposes to eliminate its redundant MassHealth Limited coverage for adults who are also eligible for subsidized ConnectorCare coverage with a \$0 premium and only nominal cost sharing.

For this population of adults up to 133% of the FPL, ConnectorCare coverage is comprehensive and affordable. Qualified Health Plans must provide the Essential Health Benefits. Under Massachusetts' unique program combining state and federal subsidies, all eligible enrollees up to 133% of the FPL have access to at least one \$0 premium plan option; those under 100% FPL have co-pays equivalent to MassHealth co-pay levels, and those between 100 and 133% FPL have co-pays that meet the state's affordability standards and are capped at \$1,250 annually (though, as noted above, most people's co-pays at this income level are \$200-\$300 a year). In this context, MassHealth Limited coverage is redundant and unnecessary. In addition, eliminating MassHealth Limited coverage when Connector coverage is available will further incentivize eligible individuals to enroll in and utilize the comprehensive coverage option available to them, furthering the Commonwealth's goal of universal coverage.

MassHealth will continue to provide MassHealth Limited coverage during a 90-day enrollment period after an individual is determined eligible for ConnectorCare. In addition, the Health Safety Net is available to reimburse for any other MassHealth-covered service provided at a hospital or community health center during this 90-day ConnectorCare enrollment period.

During the initial transition period leading up to implementation of this change, Massachusetts will open a Special Enrollment Period for MassHealth Limited members who are eligible for ConnectorCare but unenrolled, augmented with an outreach and enrollment campaign to ensure members enroll in ConnectorCare coverage. In addition to our own direct outreach efforts, MassHealth and the Health Connector plan to provide small grants to community organizations and providers for outreach and enrollment activities for this transition, particularly focusing on members for whom English is not their first language.

Adopting widely-used commercial tools to obtain lower drug prices and enhanced rebates

Rapidly growing pharmaceutical spending poses an important risk for the financial sustainability of MassHealth. Since 2010 MassHealth drug spending has risen at a compound annual growth rate of 13%. If growth in drug costs continues at the current trajectory it may crowd out important spending on health care and other critical programs.

MassHealth is committed to ensuring patients have access to the highest standard of care available, and we believe we can continue to provide this access while driving down unreasonably high drug costs. MassHealth seeks to use all available tools to manage the rapid growth of drug costs—including a current initiative to negotiate advantageous supplemental rebates with manufacturers. However, the state currently lacks basic formulary management tools available to commercial payers. Whereas commercial payers can elect whether or not to cover drugs based on clinical efficacy and affordability, MassHealth is required to cover any drug for which the manufacturer participates in the federal Medicaid rebate program. Eliminating the requirement to cover any such drug will improve our ability to negotiate additional supplemental rebates. In addition, maintaining an open formulary with coverage for nearly all drugs makes MassHealth's coverage appear attractive when compared to commercial plans, incentivizing consumers to seek MassHealth coverage even when other employer-sponsored insurance options are available to them. This is an important concern to MassHealth, given the significant shift we have seen over the last several years from commercial insurance to Medicaid coverage in Massachusetts.

We seek to guarantee our members' access to high quality, medically necessary care, while minimizing unnecessary spending on drugs whose incremental clinical value is unproven. To that end, we request a waiver of the permissible coverage restriction requirements for outpatient drugs in two additional instances, as described below.

4. Select preferred and covered drugs through a closed formulary that assures robust access to medically necessary drugs

4a. Adopt a commercial-style closed formulary with at least one drug available per therapeutic class

Adopting a closed formulary with at least a single drug per therapeutic class would enable MassHealth to negotiate more favorable rebate agreements with manufacturers. For each therapeutic class, the state could offer manufacturers an essentially guaranteed volume in exchange for a larger rebate. At present MassHealth has limited ability to offer such volume deals to manufacturers, given the requirement to cover all drugs in the Medicaid rebate program. In recent years the majority of commercial

pharmacy benefit managers (PBMs) have adopted such closed formularies, which allow them to customize their drug offerings based on clinical efficacy and cost considerations. As an example, for 2017 CVS Health excluded from its formulary 35 additional products—some because a less expensive, medically equivalent drug had become available and some because the drugs were hyperinflationary, having dramatically increased in price without clear justification. Medicare Part D commercial plans are also permitted to employ such closed formularies (as authorized under 42 CFR 423.120) with at least two drugs per therapeutic class. Medicare Part D plans may also include just a single drug per class if only one drug is available, or if only two drugs are available but one drug is clinically superior. Given that Medicare and other commercial plans are permitted to adopt closed formularies, we believe Massachusetts should have the same flexibility for Medicaid.

Maintaining the highest standard of patient care and ensuring access to medically necessary medications will remain a paramount concern even with introduction of a closed formulary. In selecting drugs available in each therapeutic class, MassHealth will ensure that the selected drugs meet the clinical needs of the vast majority of members and that they are cost effective. In addition, MassHealth will maintain an exceptions process to cover drugs that are not on the formulary when medically necessary, including but not limited to exceptions to address adverse drug reactions, drug interactions or specific clinical needs of a patient. The exceptions process will be similar to the existing clinical review process used for situations such as determining coverage of non-preferred products or off-label indications.

MassHealth's review process for all drugs includes a careful assessment of clinical trial results, published literature, guideline consensus, comparisons with other related drugs, modeling of the expected patient populations who would benefit from the drug, and coverage by other payers.

4b. Exclude from the formulary drugs with limited or inadequate evidence of clinical efficacy

Many drugs coming to market through the FDA's accelerated approval pathway have not yet demonstrated clinical benefit and have been studied in clinical trials using only surrogate endpoints. Massachusetts seeks the ability to use its own rigorous review process, in partnership with the University of Massachusetts Medical School, to determine coverage of new drugs and to guarantee that patients access clinically proven, efficacious drugs. Through this process, the state could avoid exorbitant spending on high-cost drugs that are not medically necessary. The 21st Century Cures Act was intended to expedite the drug approval process by reducing the level of evidence required for drugs to reach the market and allowing doctors, patients, and payers to decide whether to purchase them. Unfortunately, current rules do not allow

Medicaid programs to exercise discretion about whether these drugs should be covered without being fully clinically proven.

MassHealth proposes to utilize the flexibility granted under the waiver to exclude drugs with limited or inadequate clinical efficacy from its primary formulary. Limited or inadequate clinical efficacy may be defined as when one or more of the following conditions exist:

- Primary endpoints in clinical trials have not been achieved;
- Only surrogate endpoints have been reported;
- Clinical benefits have not been assessed;
- The drug provides no incremental clinical benefit within its therapeutic class, compared to existing alternatives.

Members would continue to have access to the latest drugs that provide proven additional clinical benefits. Whenever a new drug is proven to have incremental clinical value relative to peer drugs in its therapeutic class, it would be covered. In addition, breakthrough drugs with proven clinical benefit in new therapeutic classes would be covered. Only in cases where the incremental clinical benefit is undemonstrated would the state consider excluding a drug from its standard formulary. Members could still request coverage of non-formulary drugs, using the exceptions process as described above.

New drugs approved under the FDA's accelerated approval pathway can be particularly costly and would be ideal for more rigorous evaluation of coverage and potential labeling as non-formulary where appropriate. In addition, re-formulations of older, existing drugs—for example Tirosint (levothyroxine) and Doryx (doxycycline)—that provide no incremental clinical benefit might be labeled non-formulary as well. While commercial payers can exercise discretion to exclude drugs from their formularies in such situations, MassHealth currently does not have this latitude.

5. Procure a selective and more cost effective specialty pharmacy network

The use of selective specialty pharmacy networks has become standard practice for commercial health plans, including MassHealth managed care organizations, which cover over 800,000 MassHealth members. However, without a waiver MassHealth is currently unable to procure a selective network for specialty pharmacy for members in its PCC Plan and through fee-for-service. MassHealth is seeking a waiver so that it can procure a high-quality, cost effective pharmacy network for specialty pharmacy that will provide continued access to specialty prescriptions drugs at a lower cost to MassHealth. Members will be able to access specialty prescription drugs through the selected pharmacies' locations and, as needed, through mail order or home delivery. This

approach will both yield cost savings and better align MassHealth coverage with commercial health plans, including its own contracted MCOs. MassHealth intends to design this procurement to ensure appropriate safeguards for members needing specialized services through specialty pharmacies (for example, for hemophilia) and that appropriate processes are put in place for members who are homeless or not stably housed.

Improving care, reducing costs and achieving administrative efficiencies

6. Implement narrower networks in MassHealth's Primary Care Clinician (PCC) Plan to encourage enrollment in ACOs and MCOs

Historically, MassHealth has had both MCOs and a PCC Plan as options for managed care eligible members, and MassHealth is in the process of implementing its full ACO program beginning in January 2018. While we anticipate that over 850,000 of MassHealth's 1.3 million managed care eligible members will be enrolled in ACOs, members whose primary care providers are not participating in an ACO will have the option of enrolling in the PCC Plan or in a traditional MCO. ACO-enrolled members will also have the opportunity to opt out if they prefer to change primary care providers.

In order to promote coordinated, integrated care, MassHealth seeks to encourage members to enroll in ACOs and MCOs rather than the PCC Plan. Currently, the PCC Plan has open provider networks (any willing and qualified provider), minimal utilization management, and limited care coordination outside of behavioral health. As we move toward a majority ACO structure for managed care eligible members, ACOs will rely on more integrated networks of providers to coordinate care for their attributed members. It is important to strengthen controls on both the networks and the management of the PCC Plan, thereby incenting members to enroll in more managed, integrated plan ACOs and MCOs. For example, we would procure a narrower, high value network of hospitals and possibly primary care providers. This approach also supports the alignment of MassHealth coverage with commercial coverage, in which more limited networks are the norm.

7. Remove barriers to effective behavioral health care by waiving federal payments restrictions on care provided in Institutions for Mental Disease (IMDs)

Massachusetts is seeking a waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64. This request aligns with the recent recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis.² The Commission urged the Trump administration to grant such waivers to all 50 states and emphasized that granting waivers to eliminate the IMD

² <https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf>

exclusion within the Medicaid program would be “the single fastest way to increase treatment availability across the nation.” These waivers are necessary to bolster Massachusetts’ ability to confront the opioid crisis and to strengthen the Commonwealth’s mental health and substance use treatment systems.

The opioid epidemic is both a Massachusetts and a national crisis. In Massachusetts, the majority of available inpatient detox services and psychiatric inpatient treatment are provided in freestanding psychiatric hospitals, many of which are IMDs. The current IMD restrictions act as a barrier to MassHealth’s ability to provide the most appropriate, least restrictive and most cost effective care for members with significant behavioral health needs. While Massachusetts already has waivers to pay for certain services in IMDs under the current 1115 (e.g., diversionary and SUD services), we are requesting a broader waiver for IMD, including of the 15-day limit in CMS’ 2016 managed care rule. This flexibility will allow the Commonwealth to deploy all available provider capacity to ensuring MassHealth members have access to medically necessary treatment for mental health conditions and substance use disorder, which are often co-occurring. Our request is to expand authority to claim for expenditures for services delivered in IMDs by eliminating caps that currently are imposed under our Safety Net Care Pool expenditure authority, as well as the limits in the managed care rule. The proposed expenditure authority would be outside of the Safety Net Care Pool and therefore would not be subject to a specific expenditure cap beyond general budget neutrality limits.

8. Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers are participating in a single MassHealth ACO

In certain area(s) of the state, a majority of primary care providers (PCPs) will be participating in a single MassHealth ACO. This ACO will be required to provide coordinated, integrated care for its members with access to a robust network of PCPs, specialists and other providers. However, other managed care options in such area(s) will not have a large enough pool of PCPs to meet network adequacy requirements for PCPs within MassHealth’s time and distance standards.

Therefore, MassHealth requests a freedom of choice waiver to not provide two or more managed care enrollment options in such area(s). Instead, the single ACO would provide high-quality care with a choice of several PCPs to members in such area(s). MassHealth also requests a freedom of choice waiver to allow the PCC Plan not to have two PCPs within the time and distance standards in order to enroll someone into it. MassHealth will not auto-assign members to the PCC plan if these adequacy standards are not met, but members who are already in the PCC Plan with a PCP who is not

participating in the ACO will be allowed to remain enrolled, and members who proactively choose to enroll in the PCC Plan and select an available PCP with an open panel will be allowed to do so.

9. Implement the cost sharing limit of five percent of income on an annual basis rather than a quarterly or monthly basis

Massachusetts seeks flexibility to allow for administrative simplification in the implementation of the ACA's cost sharing limit of five percent of income. Specifically, we seek flexibility to implement the cost sharing limit on an annual basis rather than a quarterly or monthly basis. This aligns with standard practice in the commercial insurance market and will significantly simplify administration of this requirement.

10. Implement cost sharing greater than five percent of income for members over 300% FPL eligible exclusively through the demonstration

Massachusetts covers certain members through the demonstration with incomes above 300% of the FPL. We seek the flexibility to require premiums and co-pays that may exceed five percent of these individuals' income. This request is intended to allow premiums at levels similar to MassHealth's current premium schedule for certain higher income members, including those whose premiums are already above five percent of income. Without this waiver, MassHealth would be required to reduce current cost sharing for members above 300% to below the federal limit on Medicaid cost sharing of five percent of income. At higher income levels, we believe it is reasonable and fair for these members to continue contributing more toward the cost of their care.

11. Limit premium assistance cost sharing wrap to MassHealth enrolled providers (waiver required by State Plan Amendment 16-0011)

MassHealth is working to maximize participation in its premium assistance program for employer sponsored commercial insurance or student health insurance when it is available and cost effective. This includes enforcing mandatory enrollment in an employer or student health insurance plan when adults have access to insurance through their employer or a spouse's employer. In addition, in order to ensure the cost effectiveness of the premium assistance program, we request a waiver to not provide a Medicaid cost sharing wrap when any member enrolled in premium assistance receives services from a provider that is not enrolled as a MassHealth provider. CMS informed Massachusetts that a waiver to maintain this practice is required in order to complete implementation of State Plan Amendment 16-0011 by December 31, 2017. We are requesting this authority through this waiver request, in lieu of submitting a separate 1915(b)(4) waiver.

Supporting access to health care for veterans and their families

12. *Disregard as countable income state funded veteran annuities paid to disabled veterans and to Gold Star parents and Gold Star spouses when determining MassHealth eligibility*

The Commonwealth is seeking authority to disregard veteran annuities received under Section 6b of Chapter 115 of Massachusetts General Law as a countable income for purpose of determining Medicaid eligibility. Section 6b authorizes a \$2,000 annual payment to disabled veterans and to Gold Star parents and Gold Star spouses.

This disregard will support continued access to affordable health coverage for veterans and their families.

As notes above, as an additional safeguard for veterans, MassHealth will exclude from the shift of non-disabled adults over 100 percent of the FPL to the Connector veterans who would be ineligible for federal subsidies due to enrollment in veterans’ health coverage.

Summary of waiver and expenditure authorities requested

The table below lists the waivers and expenditure authorities the Commonwealth is seeking to support the policies described above.

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
1. Enroll non-disabled adults (including ACA expansion enrollees and non-pregnant parents and caretakers) >100% FPL in subsidized commercial plans through the state’s exchange	Eligibility Waiver	§1902(a)(10)(A)(i)(8)
2. Align MassHealth benefits for all non-disabled adults in a single plan that mirrors commercial coverage, by enrolling non-disabled parents and caregivers with incomes up to 100% FPL in MassHealth’s CarePlus	Eligibility Waiver Comparability Waiver Waiver of assurance of transportation for NEMT benefits	§1902(a)(10) insofar as it incorporates Section 1931 §1902(a)(10)(B), 1902(a)(10)(A), insofar as it incorporates Section 1905(a) §1902(a)(4) insofar as it

MassHealth Section 1115 Demonstration Amendment Request

Alternative Benefit Plan		incorporates 42 CFR 431.53 and 42 CFR 440.390
3. Eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector	Eligibility Waiver	§1902(a) insofar as it incorporates Section 1903(v) of the SSA
4. Select preferred and covered drugs through a closed formulary that assures robust access to medically necessary drugs	Waiver of the permissible coverage restriction requirements for outpatient drugs	§1902(a)(54) insofar as it incorporates Section 1927(d)(1)(B); §1902(a)(14) insofar as it incorporates Section 1916 and 1916A; §1902(a)(23)(A)
5. Procure a selective and more cost effective specialty pharmacy network	Freedom of choice waiver	§1902(a)(23)(A)
6. Implement narrower networks in MassHealth's Primary Care Clinician (PCC) Plan to encourage enrollment in ACOs and MCOs	Freedom of choice waiver	§1902(a)(23)(A)
7. Remove barriers to behavioral health care by waiving federal payment restrictions on care provided in IMDs	Waivers of all IMD payment restrictions Expenditure authority for IMD payments	§1905(a)(29)(B)
8. Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers are participating in a single MassHealth ACO	Freedom of choice waiver	§1902(a)(23)(A)
9. Implement the cost sharing limit of five percent of income on an annual	Waiver of cost sharing limits	§1902(a)(14) insofar as it incorporates Section 1916 and 1916A

MassHealth Section 1115 Demonstration Amendment Request

basis rather than a quarterly or monthly basis		
10. Implement cost sharing greater than five percent of income for members over 300% FPL eligible exclusively through the demonstration	Change to current expenditure authority for CommonHealth	1115 Expenditure authority
11. Limit premium assistance cost sharing wrap to MassHealth enrolled providers (waiver required by State Plan Amendment 16-0011)	Waiver of premium assistance cost sharing wrap	§1902(a)(23)(A) §1902(a)(14) insofar as it incorporates Section 1916 and 1916A
12. Disregard as countable income state funded veteran annuities when determining eligibility for MassHealth	Eligibility waiver	§1902(r)(2)

Budget Neutrality

Budget neutrality prior to amendment

The Commonwealth’s projected budget neutrality cushion as of the quarterly report for the quarter ending March 31, 2017³ is approximately \$36 billion total, of which \$8.6 billion is attributable to the SFY 2018-2022 waiver period.⁴ This estimate incorporates projected expenditures and member months through SFY 2022 as reported through the quarter ending March 31, 2017, combined with the MassHealth budget forecast for SFY

³ The budget neutrality cushion as of the quarterly report for the quarter ending March 31, 2017 includes member month and actual expenditure data as reported in the CMS-64 report for the corresponding time period. Safety Net Care Pool spending included in the calculation reflects figures as reported in the budget neutrality agreement approved by CMS on November 4, 2016.

⁴ Note, CMS introduced a savings phase-out methodology to the Budget Neutrality calculation so that the Commonwealth may only carry forward 25% of selected population based savings each year between SFY18-22. An additional \$2.4 billion of the \$36 billion total, which was savings generated during SFY 09-11, was not carried forward to the Sixth Waiver Extension period of SFY18-22, which recognizes savings from SFY12 forward.

2018-2019. This budget neutrality calculation reflects significant realized and anticipated savings.

Effect of amendment

As reflected in the accompanying budget neutrality workbook, this amendment results in significant savings to the MassHealth program and would reduce the total populations and expenditures under the demonstration. The combined effect of these two dynamics would decrease the Commonwealth's budget neutrality cushion by approximately \$921 million for the SFY2018-2022 waiver period, from \$8.6 billion to approximately \$7.7 billion. The overall reduction is largely attributable to the shift in the adult, non-disabled population from MassHealth to the Connector. This shift will reduce both the members and associated expenditures within the budget neutrality calculation, though the Commonwealth will continue to generate room attributable to the additional amendments. Overall, after integrating the proposed amendments, the Commonwealth and the federal government would continue to realize savings on the Demonstration.

The attached budget neutrality workbook contains a data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. This analysis includes current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, by eligibility group.

Evaluation

The currently approved demonstration seeks to advance five goals:

- Goal 1: Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care
- Goal 2: Improve integration of physical, behavioral and long-term services
- Goal 3: Maintain near-universal coverage
- Goal 4: Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals
- Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services

The amendment's impact on the current demonstration's evaluation is described below:

Amendment requests #1, #2, #3 and #12 seek to advance Goal #3, to maintain near-universal coverage and support Hypothesis 3A, which posits that “the waiver’s investments in improved enrollment procedures and insurance subsidies will be associated with the continued maintenance of near-universal coverage in Massachusetts.” Enrolling non-disabled adults over 100% FPL into subsidized commercial plans through the state’s exchange (the Health Connector), covering non-disabled parents and caretakers under 100% FPL in the CarePlus program and eliminating duplicative Limited coverage for adults who continue to be eligible for affordable coverage through the Health Connector supports the state’s goal of maintaining near-universal coverage, while also helping to ensure the long-term financial sustainability of the state’s health coverage programs. Disregarding as countable income state funded annuities paid to disabled veterans and to Gold Star parents and spouses when determining MassHealth eligibility will also advance the goal of near-universal coverage.

Amendment requests #6 and #8 advance existing Goal #1 and support Hypothesis 1c as they encourage enrollment in the delivery system reforms models that promote integrated, coordinated care and specifically are designed to lead to stronger ACO and MCO program networks relative to the PCC plan network.

Amendment request #7 seeks to advance existing Goal #2 and supports Hypothesis 2a as it removes barriers to behavioral health care to address the opioid epidemic and strengthen the Commonwealth’s mental health and addiction treatment systems.

Amendment requests #9 and #11 are administrative simplification measures and are not tied to specific waiver goals.

Amendment requests, #4, #5, and #10 advance a new proposed Goal #6.

- Goal 6: Ensure the long-term financial sustainability of the MassHealth program and reduce the shift in enrollment from commercial health insurance to MassHealth through the alignment of coverage for non-disabled adults with commercial plans, adoption of widely-used commercial tools for prescription drugs and changes to cost sharing requirements for higher income members.

The Commonwealth’s recently submitted demonstration amendment requests to modify provisional eligibility for adults and eliminate coverage of non-emergency transportation for MassHealth CarePlus members also support this new goal.

Research questions for Goal 6 related to the items included in this waiver amendment request

What is the impact of the waiver's alignment of coverage for non-disabled adults with commercial plans, initiatives for prescription drugs and changes to MassHealth cost sharing requirements for higher income members?

- Hypothesis 6A: The alignment of coverage for non-disabled adults with commercial plans, the adoption of widely-used commercial tools for prescription drugs, and the waiver of federal cost sharing limits for higher income members will result in slowing the shift in enrollment from commercial health insurance (as a percentage of the state's population) to MassHealth primary coverage (as a percentage of the state's population) while maintaining overall coverage.
- Hypothesis 6B: The waiver's initiatives for prescription drugs will result in lowered expenditure growth rates compared to what prescription drug spending would be without the waiver without reducing access to medically necessary drugs.

In order to evaluate Hypothesis 6A, the change in MassHealth and commercial enrollment as percentages of the state's population during the waiver period (after the proposals are implemented) will be compared to the trends in these percentages prior to the waiver period (e.g., 2011-2017). MassHealth and secondary data sources will be relied upon for this analysis. Such data sources may include data sets and operational statistics from the U.S. Census, Massachusetts Center for Health Information and Analysis, the Massachusetts Health Insurance Survey, and MassHealth claims and encounter data.

In order to evaluate Hypothesis 6B, the Commonwealth's evaluator will compare expenditure growth rates for prescription drugs after the new purchasing strategies have been implemented to both historical growth rates and to projected expenditures in the absence of these new strategies, using historical experience and other states' experience as benchmarks to develop projected expenditures in the absence of these strategies. The evaluator will also conduct an assessment of drug classes affected by the closed formulary to confirm that members continue to have access to medically necessary prescription drugs.

Study Population

With the exception of the measure related to the statewide coverage rates, where the study population is residents of the Commonwealth, all waiver-eligible individuals will be studied. There is no comparison population for this evaluation component, whose purpose is to determine whether coverage percentages for MassHealth and commercial insurance have changed.

Public Process

The public process for submitting this amendment conforms with the requirements of STC 15, 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 Commonwealth's approved State Plan. In addition, the Commonwealth has implemented certain 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 is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Notice

The Commonwealth released the Amendment for a thirty day public comment period starting on July 20, 2017 by posting the Amendment, which included the Budget Neutrality Impact section, and a Summary of the Amendment (including the instructions for submitting comments) on the MassHealth Innovations website (www.mass.gov/hhs/masshealth-innovations/1115waiver). Notice of the Amendment and the public comment period was also published in the Boston Globe, the Worcester Telegram & Gazette, and the Springfield Republican on July 21, 2017.

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 from the MassHealth Publications Unit, located in Quincy, Massachusetts.

Tribal Consultation

MassHealth provided a summary of the Amendment through an email to all Tribal leaders or their designees and additional Tribal health contacts on July 27, 2017 with a request for comments by August 26, 2017. The summary included links to the documents and instructions for providing comment.

Public Meetings

The Commonwealth hosted two listening sessions to seek input regarding the Amendment. Both sessions included a conference line, as well as Communication Access Realtime Translation services and American Sign Language (ASL) interpretation for individuals attending in person. The first listening session was held Friday, August 4, 2017 from 9-11 a.m. at 1 Ashburton Place, 21st Floor in Boston, MA. The second listening session was held on Wednesday, August 16, 2017 from 10 a.m. – 12 p.m. at the Castle of Knights, 1599 Memorial Drive in Chicopee, MA. Both sessions included a presentation on the proposed changes and an opportunity for public

testimony.

Public Comments

The Commonwealth received 49 comment letters from consumer and legal advocates, health care provider organizations, social service providers and individuals on or before August 21, 2017 and one letter just after the deadline. We were pleased with the high level of public engagement with these proposals and appreciate the thoughtful input and feedback provided in the comment letters. In response, we have made adjustments to certain proposals and have sought to clarify our intent with respect to others, as described below.

Below is a summary of comments received on each of the requests in the original proposal and the Commonwealth's response to these comments. Please note that the requests are not numbered to avoid confusion, as some of the requests have been removed or re-ordered in this final proposal.

Enroll non-disabled adults with incomes over 100% FPL in subsidized commercial plans through the state's exchange (the Health Connector)

The Commonwealth received several comments outlining concerns with regard to higher cost sharing that members would experience in ConnectorCare and about access to dental services. While ConnectorCare plans currently have a higher cap on members' out of pocket expenses than MassHealth has, average co-pays for the population at this income level are much lower (less than \$200 per year). EOHHS understands the concerns expressed about access to dental care and will continue to explore options to ensure that the non-disabled adult population with incomes over 100% FPL has appropriate access to dental services.

Certain commenters also expressed concerns about the potential impact to particularly vulnerable populations of moving out of MassHealth and into a commercial plan. The proposal now includes additional information to clarify which populations would remain eligible for MassHealth under this proposal, including individuals who are disabled, medically frail, pregnant have HIV or breast or cervical cancer, or who are veterans enrolled in veterans' health care coverage that makes them ineligible for federal subsidies through the Health Connector. In addition, the Commonwealth will continue to work with health insurance carriers to promote robust coverage access for behavioral health care and other important health care needs for this population.

Align MassHealth benefits for all non-disabled adults in a single plan that mirrors commercial coverage, by enrolling non-disabled parents and caregivers with incomes up to 100% FPL in MassHealth's CarePlus Alternative Benefit Plan

The Commonwealth received a number of comments about the potential impact on members of the elimination of non-emergency medical transportation and long-term services and supports (LTSS) as benefits for this population. Utilization of LTSS is very limited for the populations that would move to CarePlus. Prior to the shift, the Commonwealth will ensure that members and stakeholders have clear and accessible information about the process to identify as an individual with a disability or as medically frail, so that people who need access to LTSS can be redetermined and remain in MassHealth Standard coverage. EOHHS will continue to work with stakeholders to develop information and messaging about the change during the implementation process.

Modify premium assistance program for non-disabled adults with access to commercial insurance to reduce Medicaid wraps on top of the commercial plan while ensuring continued affordability for members.

The Commonwealth received a number of comments about this request to modify premium assistance. In particular, commenters were concerned about whether this change would affect access to behavioral health services. They also raised a number of operational questions. Under further evaluation, Massachusetts has decided to remove this request from our Demonstration Amendment request. We believe we can achieve the objective of this request, to a large extent, through improved coordination of benefits processes within the premium assistance program.

Implement ESI Gate that would allow non-disabled adults with access to affordable employer-sponsored or student-health insurance to enroll in MassHealth

This proposal was the subject of significant concern in many of the comments received by the Commonwealth. Commenters urged the Commonwealth to utilize its premium assistance program to maximize uptake of employer-sponsored insurance (ESI) rather than determining some individuals ineligible based on their access to ESI. The proposal was viewed by some commenters as a potential disincentive to employment and a barrier to access to health coverage. After careful consideration, EOHHS has decided to remove this request from the Demonstration Amendment request. Consistent with the comments from stakeholders, MassHealth will continue to maximize opportunities to provide premium assistance in lieu of direct coverage for individuals with access to ESI that is deemed cost effective.

Eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector

Comments received on the proposal to eliminate redundant MassHealth Limited coverage for adults who are also eligible for subsidized coverage through the Health Connector generally did not raise concerns with the proposed policy change. Rather, comments primarily focused on operational questions about how this provision will be implemented to minimize the number of individuals who fail to enroll in coverage through the Health Connector.

EOHHS is committed to a robust outreach and enrollment process. As noted in the proposal, there will be a special enrollment period created to facilitate this transition with proactive outreach to affected members that includes clear messaging and support for the enrollment process. In response to comments from advocates, the Commonwealth also plans to provide grants to community organizations and providers for outreach and enrollment activities, including efforts that focus specifically on members for whom English is not their first language. Grants will be targeted to regions where there is a high volume of individuals eligible for Health Connector coverage but unenrolled.

Select preferred and covered drugs through a closed formulary that assures robust access to medically necessary drugs

The Commonwealth received a number of comments about the impact of a closed formulary and the possibility of limitations on access to necessary drugs. The Commonwealth has added additional language to our request to further clarify our intention to continue providing medically necessary medications and details about an exceptions process to cover drugs that are not on the formulary when medically necessary, including but not limited to exceptions to address adverse drug interactions, specific clinical needs of a patient. The process for requesting exceptions will be similar to the current process to request prior authorization for a non-preferred drug on the MassHealth drug list. MassHealth will approach the process of implementing a closed formulary, if approved, with a strong emphasis on ensuring continued access, especially with respect to vulnerable populations who require medications to treat mental health and substance use, HIV, Hepatitis C, and other serious conditions.

In addition, EOHHS plans to continue to engage closely with stakeholders during the implementation process. As a first step, EOHHS has offered to host a meeting with subject matter experts from MassHealth and from the advocacy community to discuss the proposal in greater detail.

Procure a selective and more cost effective specialty pharmacy network

The Commonwealth received a number of comments with concerns about the impact of a specialty pharmacy network and has added additional language to its request to

provide additional implementation details. The Commonwealth also intends to design this procurement to ensure appropriate safeguards for members needing specialized services through specialty pharmacies (for example, for hemophilia) and that appropriate processes are put in place for members who are homeless or not stably housed.

As with the proposal to implement a closed formulary, EOHHS plans to meet with advocates to discuss this proposal in greater detail as part of an ongoing stakeholder engagement process.

Implement narrower networks in MassHealth's Primary Care Clinician (PCC) Plan to encourage enrollment in ACOs and Managed Care Organizations (MCOs)

The Commonwealth received a number of comments about a narrower network in the PCC Plan. Commenters were broadly supportive of MassHealth's ACO initiative and its goals to enroll members in more coordinated care options. However, some commenters expressed concern about the potential for confusion among members by implementing these changes concurrent with a major restructuring of the program into ACOs. In addition, certain commenters requested assurance that members would continue to have access to a range of providers, particularly for specialized needs.

EOHHS maintains that implementing a narrower network within the PCC Plan is an important step to support the success of the ACO program and therefore must be implemented concurrently; however the changes will not go into effect until the second year of the ACO program, after the initial transition. EOHHS will give careful consideration to the best approaches to communications with members and providers to avoid confusion. In addition, EOHHS will continue to work with stakeholders during the implementation process to ensure that appropriate provisions are in place that assure access to medically necessary services, including specialized services and services that meet the needs of particularly vulnerable populations.

Remove barriers to effective behavioral health care by waiving federal payments restrictions on care provided in Institutions for Mental Disease (IMDs)

The Commonwealth received strong support from commenters for waiving federal payment restrictions on care provided in IMDs. The Commonwealth was further encouraged by the recent recommendations of the President's Commission on Combating Drug Addiction and the Opioid Crisis, which supports this request and recommends that such waivers be granted for all states as a strategy to immediately increase access to substance use disorder treatment for Medicaid beneficiaries.

EOHHS views this request as critical as one of several reforms that support the Commonwealth's ability to confront the opioid crisis and strengthen its mental health and substance use disorder treatment system.

In addition, several commenters emphasized the importance of excluding IMDs from the caps imposed under the Safety Net Care Pool. This is consistent with EOHHS' intent, and we have updated the proposal to specify that the expenditure authority for care provided in IMDs is requested as a "regular" population-based expenditure authority rather than a Safety Net Care Pool authority focused on uncompensated care.

Waive requirements for multiple managed care options in certain area(s) of the state in which a majority of primary care providers are participating in a single MassHealth ACO

The Commonwealth received a few comments seeking clarification about the operational process for this request and the potential impacts to network adequacy. EOHHS will refine details related to this request as it completes its readiness review process for ACOs, including its review of network adequacy, as well as its MCO procurement. EOHHS will continue to share additional information with stakeholders as it becomes available. EOHHS is committed to ensuring that members have adequate access to services in every region of the state. EOHHS also notes that ACOs have robust requirements for network adequacy and care coordination.

Implement the cost sharing limit of five percent of income on an annual basis rather than a quarterly or monthly basis

The Commonwealth received several comments expressing concern about implementing the cost sharing limit on an annual basis rather than a quarterly basis. This request aligns with practices in the commercial insurance market and would continue MassHealth's practice of applying co-pay limits on an annual basis. In addition, this would significantly reduce co-pay reconciliations that may otherwise be needed, and will lessen the increase in the volume of notices going to members.

Implement cost sharing greater than five percent of income for members over 300% FPL eligible exclusively through the demonstration

The Commonwealth received several comments about implementing a cost sharing limit greater than 5% for members over 300% FPL, including suggestions for sliding scale

premiums, and concern that provider bad debt would increase at higher levels of cost sharing. Massachusetts has added clarifying language to its request to note that it is not intended to result in members paying higher costs. We are requesting this waiver to allow premiums to remain at levels similar to MassHealth's current sliding scale premium schedule for certain higher income members, instead of lowering these premiums to ensure that total cost sharing for higher income members is reduced to under five percent of income. EOHHS will also ensure that premium contributions remain below the Connector's affordability schedule at higher income levels. EOHHS will continue to work with stakeholders during the implementation process.

Recognizing the interest, questions and concerns expressed by commenters in response to certain of the requests, the Commonwealth intends to continue working with stakeholders throughout the implementation processes for the requests.

Conclusion

The proposed flexibilities described in the Demonstration Amendment request build on the Commonwealth's current efforts to restructure our delivery system as authorized under the current demonstration, and introduce reforms that support the long-term fiscal sustainability of the MassHealth program. These flexibilities will allow us continue to improve the quality and integration of care delivery, particularly for members with the most complex needs, while also addressing critical issues such as the opioid crisis, the rising costs of prescription drugs, and the ongoing shift in the percentage of Massachusetts residents enrolled in private insurance to public MassHealth coverage. These flexibilities reflect the Commonwealth's ongoing commitment to the goal of universal health care coverage, while taking the necessary steps to ensure the long-term sustainability of our program.

The Commonwealth appreciates this opportunity to amend our 1115 demonstration and to continue to work with CMS to improve health care outcomes for the people of the Commonwealth.

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