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September 8, 2017

Seema Verma
Administrator
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request to Amend Massachusetts' Section 1115 Demonstration: MassHealth (11-W-00030/1)

Dear Administrator Verma:

In my capacity as Secretary of the Executive Office of Health and Human Services for the Commonwealth of Massachusetts, I am submitting to the Centers for Medicare and Medicaid Services (CMS) a request to amend the Massachusetts Section 1115 Demonstration Project (11-W-00030/1).

Massachusetts believes strongly in providing health care coverage for its residents. Today, more than 257,000 individuals have health care coverage through the Health Connector, our state-based marketplace, 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.

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, in part, 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.

On June 26 2017, Massachusetts submitted an amendment request for flexibilities on provisional eligibility and non-emergency transportation. The request we submit today builds on the request from earlier this summer by seeking broader flexibility to further align coverage with commercial plans and make other changes to make the Medicaid program more sustainable. MassHealth's requests for flexibility through this amendment include requests to align coverage for certain non-disabled adults with commercial plans, to adopt widely used commercial tools to lower drug prices and enhance rebates, and requests to improve care, reduce costs and achieve administrative efficiencies. Massachusetts is committed to reforming MassHealth in a manner that protects coverage gains, maintains one of the nation's most robust Medicaid programs, and aims to improve the quality and integration of health care delivery, particularly for our members with the most complex needs.

In parallel with this request, Massachusetts will submit a 1332 waiver, as well as letters to Secretary Price and Secretary Mnuchin for additional flexibilities that promote market stability and seek relief from certain ACA requirements for the private health insurance market.

Thank you for your consideration of this amendment request. We appreciate your continued partnership on our 1115 Demonstration as we work to advance our shared goals for health care reform.

Sincerely,

[redacted]

Marylou Sudders

cc: Daniel Tsai, Assistant Secretary for MassHealth and Medicaid Director
Louis Gutierrez, Executive Director of the Massachusetts Health Connector
Brian Neale, Deputy Administrator and Director for the Center for Medicaid and CHIP Services
Judith Cash, Acting Director, State Demonstrations Group
Rich McGreal, Associate Regional Administrator, Boston Regional Office
Julie McCarthy, Massachusetts State Lead, Boston Regional Office

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

MassHealth Section 1115 Demonstration Amendment Request

September 8, 2017

Contents

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 incent 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 to100% 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

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

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, 2017[3] 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.

State Contact

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Federal Budget Neutrality Summary

Room Under the Budget Neutrality Cap	$ 33,247,706,241

	Total				
State Fiscal Year	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	SNCP Expenditures	Variance
Fourth Waiver Extension Period					
SFY12 Actual	$ 9,367,766,216	$ 6,149,878,281			$ 3,217,887,934
SFY13 Actual	$ 10,066,274,983	$ 6,157,848,070			$ 3,908,426,914
SFY14 Actual	$ 11,274,623,010	$ 6,806,222,911			$ 4,468,400,099
SFY12-14 SNCP				$ 2,894,075,555	$ (2,894,075,555)
	$ 30,708,664,210	**$ 19,113,949,262**		**$ 2,894,075,555**	**$ 8,700,639,392**
Fifth Waiver Extension Period					
SFY15 Actual	$ 13,440,309,010	$ 7,088,284,915		$ 2,059,841,867	$ 4,292,182,229
SFY16 Actual	$ 14,771,924,032	$ 7,732,569,871		$ 1,267,141,867	$ 5,772,212,294
SFY17 Projected	$ 15,628,437,067	$ 7,663,425,129		$ 1,142,241,867	$ 6,822,770,072
SFY15-17 SNCP					$ -
	$ 43,840,670,109	**$ 22,484,279,914**		**$ 4,469,225,600**	**$ 16,887,164,595**
Sixth Waiver Extension Period					
SFY18 Projected	$ 17,436,617,134	$ 7,913,480,070	$ 6,672,368,790	$ 1,871,000,000	$ 979,768,274
SFY19 Projected	$ 17,801,836,774	$ 8,021,061,935	$ 6,911,799,035	$ 1,693,000,000	$ 1,175,975,804
SFY20 Projected	$ 18,234,125,871	$ 8,064,093,002	$ 7,168,438,876	$ 1,525,000,000	$ 1,476,593,994
SFY21 Projected	$ 19,515,489,238	$ 8,385,794,576	$ 7,868,562,467	$ 1,450,000,000	$ 1,811,132,195
SFY22 Projected	$ 20,925,361,031	$ 8,720,486,390	$ 8,638,442,654	$ 1,350,000,000	$ 2,216,431,987
SFY18-22 SNCP					$ -
	$ 93,913,430,048	**$ 41,104,915,974**	**$ 37,259,611,820**	**$ 7,889,000,000**	**$ 7,659,902,254**
Total	**$ 168,462,764,366**	**$ 82,703,145,150**	**$ 37,259,611,820**	**$ 15,252,301,155**	**$ 33,247,706,241**

* Calculation will vary based on annual Federal DSH Allotment

Federal Budget Neutrality - Cap

ACA Changes 1/1/14

	Total WY15-SFY12	Total WY16-SFY13	Total WY17-SFY14 Q1&Q2	Total Y17-SFY14 Q3&Q4	Total WY18-SFY15	Total WY19-SFY16	Total WY20-SFY17	Total WY21-SFY18	Total WY22-SFY19	Total WY22-SFY20	Total WY22-SFY21	Total WY23-SFY22	
TOTAL EXPENDITURES WITH DSH	**$ 9,367,766,216**	**$ 10,066,274,983**	**$ 11,274,623,010**		**$ 13,440,309,010**	**$ 14,771,924,032**	**$ 15,628,437,067**	**$ 17,436,617,134**	**$ 17,801,836,774**	**$ 18,234,125,871**	**$ 19,515,489,238**	**$ 20,925,361,031**	
in Waiver, not in S-CHIP													
MEMBER MONTHS													
Base Populations Member Months (1)	*actual*	*actual*		*actual*	*actual*	*actual*	*partial projection*	*projected*	*projected*	*projected*	*projected*	*projected*	MM growth rate:
Families (4)	7,980,378	8,209,463		8,339,714	9,311,598	9,997,890	10,003,603	10,285,704	9,737,880	9,198,120	9,455,668	9,720,427	2.8%
Disabled (3)	2,814,110	2,900,636		2,921,439	2,924,123	2,900,565	2,901,101	2,991,885	3,075,657	3,161,776	3,250,306	3,341,314	2.8%
MCB	-	-		-	-	-	-	-	-	-	-	-	
Total Base	10,794,488	11,110,098		11,261,153	12,235,721	12,898,455	12,904,704	13,277,589	12,813,538	12,359,896	12,705,974	13,061,741	
1902(r)(2) Expansion Member Months (2)	*actual*	*actual*		*actual*	*actual*	*actual*	*partial projection*	*projected*	*projected*	*projected*	*projected*	*projected*	
Kids (1)	112,645	######## ######		117,346	169,244	290,435	397,953	409,096	420,551	432,326	444,431	456,875	2.8%
Disabled (2)	184,855	######## ######		204,066	221,611	248,922	249,587	261,028	268,336	275,849	283,573	291,513	2.8%
Breast and Cervical Cancer Treatment Program (8)	4,593	4,385		4,066	6,543	12,250	14,084	14,478	14,883	15,300	15,728	16,168	2.8%
Total 1902(r)(2)	302,093	304,060		325,478	397,398	551,607	661,624	684,602	703,770	723,475	743,732	764,556	
				actual	*actual*	*actual*	*partial projection*	*projected*	*projected*	*projected*	*projected*	*projected*	
Category 8 (new population-was Hypothetical)				1,720,774	3,969,519	4,309,177	4,365,546	4,497,111	4,428,948	4,364,311	4,486,511	4,612,133	2.8%
Total Waiver Member Months	11,096,582	11,414,159		13,307,405	16,602,638	17,759,239	17,931,874	18,459,302	17,946,256	17,447,682	17,936,217	18,438,430	2.8%
PER MEMBER PER MONTH COSTS (PMPM)													
Base Population PMPM													
Families	$ 562.02	$ 591.81		$ 623.17	*$ 655.57*	*$ 689.66*	*$ 725.53*	*$ 760.26*	*$ 789.96*	*$ 820.97*	*$ 853.67*	*$ 887.89*	
Disabled	$ 1,224.88	$ 1,298.38		$ 1,376.28	*$ 1,442.34*	*$ 1,511.57*	*$ 1,584.13*	*$ 1,880.01*	*$ 1,980.83*	*$ 2,089.53*	*$ 2,207.00*	*$ 2,334.26*	
MCB													
1902(r)(2) Population PMPM													
Kids	$ 457.59	$ 480.02		$ 503.54	*$ 526.70*	*$ 550.93*	*$ 576.27*	*$ 607.27*	*$ 630.64*	*$ 655.14*	*$ 680.85*	*$ 707.87*	
Disabled	$ 959.04	$ 1,016.59		$ 1,077.58	*$ 1,129.30*	*$ 1,183.51*	*$ 1,240.32*	*$ 1,293.33*	*$ 1,339.59*	*$ 1,387.51*	*$ 1,437.16*	*$ 1,488.60*	
Breast and Cervical Cancer Treatment Program	$ 3,674.67	$ 3,869.43		$ 4,074.51	*$ 4,290.46*	*$ 4,517.85*	*$ 4,757.30*	*$ 4,956.78*	*$ 5,137.11*	*$ 5,324.12*	*$ 5,518.07*	*$ 5,719.24*	
Category 8 (new population-Hypothetical)				*$ 461.23*	*$ 485.67*	*$ 511.42*	*$ 538.52*	*$ 566.85*	*$ 591.02*	*$ 616.84*	*$ 643.79*	*$ 671.93*	
TOTAL EXPENDITURES (Member Months x PMPM)													
Base Population Expenditures													
Families	$ 4,485,132,071	$ 4,858,442,008		$ 5,197,059,780	*$ 6,104,449,369*	*$ 6,895,192,124*	*$ 7,257,887,052*	*$ 7,819,782,079*	*$ 7,692,519,384*	*$ 7,551,349,699*	*$ 8,072,019,413*	*$ 8,630,710,214*	
Disabled/MCB	$ 3,446,947,506	$ 3,766,127,740		$ 4,020,717,649	*$ 4,217,583,779*	*$ 4,384,418,144*	*$ 4,595,719,308*	*$ 5,624,786,664*	*$ 6,092,367,801*	*$ 6,606,625,767*	*$ 7,173,415,594*	*$ 7,799,481,158*	
1902(r)(2) Population Expenditures													
Kids	$ 51,545,264	$ 53,233,562		$ 59,088,401	*$ 89,141,295*	*$ 160,009,695*	*$ 229,329,969*	*$ 248,431,674*	*$ 265,217,369*	*$ 283,233,639*	*$ 302,589,550*	*$ 323,406,086*	
Disabled	$ 177,283,342	$ 191,909,072		$ 219,897,337	*$ 250,266,153*	*$ 294,601,782*	*$ 309,567,479*	*$ 337,595,010*	*$ 359,460,045*	*$ 382,744,238*	*$ 407,540,659*	*$ 433,946,263*	
Breast and Cervical Cancer Treatment Program	$ 16,879,239	$ 16,965,651		$ 16,567,294	*$ 28,072,473*	*$ 55,343,704*	*$ 67,001,807*	*$ 71,764,295*	*$ 76,455,617*	*$ 81,458,979*	*$ 86,788,194*	*$ 92,468,639*	
Category 8 (New Adult population)				$ 793,671,386	$ 1,927,894,411	$ 2,203,779,118	$ 2,350,935,264	$ 2,549,191,049	$ 2,617,596,251	$ 2,692,097,815	$ 2,888,363,536	$ 3,099,033,221	
Total Base + 1902 (r)(2) Expenditures + Benchmarks	**$ 8,177,787,423**	**$ 8,886,678,034**		**$ 10,307,001,847**	**$ 12,617,407,480**	**$ 13,993,344,566**	**$ 14,810,440,879**	**$ 16,651,550,771**	**$ 17,103,616,467**	**$ 17,597,510,138**	**$ 18,930,716,946**	**$ 20,379,045,580**	
Hypothetical Population Expenditures			WY17-SFY14 Q1&Q2	WY17-SFY14 Q3&Q4									
CommonHealth hypothetical (including 65+)	$ 79,202,469	$ 83,910,244	$ 34,662,566	$ 34,662,566	$ 164,547,988	$ 116,136,585	$ 150,582,753	$ 203,955,104	$ 218,803,518	$ 241,096,883	$ 258,469,241	$ 277,115,433	
CommCare Parents hypothetical	$ 43,815,208	$ 42,057,862	$ 31,002,402										
Essential 19-20 hypothetical	$ 26,479,824	$ 27,288,877	$ 13,832,815										
CommCare 19-20 hypothetical	$ 28,367,949	$ 24,914,545	$ 12,943,670.00										
CommCare <133% FPL hypothetical	$ 387,422,325	$ 363,321,426	$ 191,892,964.00										
CommonHealth Medicare Cost Sharing					$337,358	$347,479	$357,904	$368,641	$379,580	$390,846	$402,824	$414,908	
TANF/EAEDC					$378,111,525	$311,069,055	$260,948,538	$270,864,582	$281,012,907	$294,915,062	$309,976,073	$325,474,877	
			Hypotheticals Q1&Q2	*+ Hypotheticals Q3&Q4*									
Total Base + 1902 (r)(2) + hypotheticals	**$ 8,743,075,198**	**$ 9,428,170,988**	**$ 284,334,417**	**$ 10,341,664,413**	**$ 12,781,955,468**	**$ 14,109,481,151**	**$ 14,961,023,633**	**$ 16,855,505,875**	**$ 17,322,419,985**	**$ 17,838,607,021**	**$ 19,189,186,186**	**$ 20,656,161,013**	
				Full year WY17-SFY14									
DSH	$ 624,691,018	$ 638,103,995		$ 648,624,180	$ 658,353,542	$ 662,442,881	$ 667,413,434	$ 581,111,259	$ 479,416,788	$ 395,518,850	$ 326,303,052	$ 269,200,018	
TOTAL EXPENDITURES WITH DSH*	**$ 9,367,766,216**	**$ 10,066,274,983**		**$ 11,274,623,010**	**$ 13,440,309,010**	**$ 14,771,924,032**	**$ 15,628,437,067**	**$ 17,436,617,134**	**$ 17,801,836,774**	**$ 18,234,125,871**	**$ 19,515,489,238**	**$ 20,925,361,031**	

	MEGs	WY15-SFY2012	WY16-SFY2013	FY14 whole	WY17-SFY2014 Q1&Q2	ACA Changes Take Effect (1/1/2014) WY17-SFY2014 Q3&Q4	WY18-SFY2015	WY19-SFY2016	WY20-SFY2017	<<<based on actuals based on forecast>>> WY21-SFY2018
(1)	1902 (r) (2) Children	$ 55,564,358	$ 58,447,941	$ 63,780,279	$ 31,890,140	$ 31,890,140	$ 97,562,959	$ 116,587,763	$ 143,834,721	$ 149,012,771
(2)	1902 (r) (2) Disabled	$ 20,787,513	$ 21,635,867	$ 19,973,113	$ 9,986,556	$ 9,986,556	$ 46,997,688	$ 53,676,874	$ 52,791,103	$ 55,640,713
(3)	Base Disabled (includes Base MCB)	$ 1,247,702,158	$ 1,304,448,862	$ 1,250,131,167	$ 625,065,583	$ 625,065,583	$ 2,458,799,612	$ 2,392,210,306	$ 2,318,408,480	$ 2,415,987,557
(4)	Base Families	$ 2,294,757,881	$ 2,325,904,776	$ 2,296,444,416	$ 1,148,222,208	$ 1,148,222,208	$ 2,574,389,969	$ 2,635,891,646	$ 2,497,031,803	$ 2,579,351,280
(5)	E - Family Assistance	$ -	$ -	$ -	$ -	0	0	0	0	0
(6)	E - HIV/FA	$ 24,530,454	$ 26,236,814	$ 17,776,664	$ 8,888,332	$ 8,888,332	$ 8,108,182	$ 7,673,163	$ 7,444,261	$ 7,712,254
(7)	Basic	$ 166,286,424	$ 163,874,654	$ 70,970,541	$ 70,970,541			$ -		
(8)	BCCTP	$ 3,921,720	$ 3,593,147	$ 2,803,451	$ 1,401,726	$ 1,401,726	$ 4,009,533	$ 5,403,948	$ 5,671,508	$ 5,875,682
(9)	CommonHealth (hypothetical)	$ 79,202,469	$ 83,910,244	$ 87,280,637	$ 43,640,319	$ 43,640,319	$ 93,292,600	$ 101,088,737	$ 101,154,600	$ 105,236,761
(10)	Essential	$ 476,422,178	$ 517,418,371	$ 304,271,073	$ 304,271,073					
(11)	Insurance Partnership (IRP)	$ 22,079,592	$ 18,374,800	$ 11,463,694	$ 5,731,847	$ 5,731,847	$ 637,519	$ 206,468	$ 100,292	0
(12)	Medical Savings Plan (MSP)	$ 140,022,251	$ 67,599,624	$ 80,718,270	$ 80,718,270		$ 22,177,049			
(13)	Mental Health Special Program for Youth	$ -	$ -	$ -	$ -	0	0	0	0	0
(14)	CommonHealth Medicare Cost Sharing (133%-135% FPL)						$337,358	$347,479	$357,904	$368,641
(15)	TANF/EAEDC						$378,111,525	$311,069,055	$260,948,538	$270,864,582
(16)	SBE						$810,248	0	0	0
(17)	Duals with no resources test	$ 1,121,947,742	$ 1,109,386,640	$ 1,153,706,129	$ 576,853,065	$ 576,853,065				
(18)	Category 8: New Adult			$ 1,159,088,567		$ 1,147,365,896	$ 1,338,170,948	$ 2,038,433,319	$ 2,150,551,509	$ 2,233,837,564
(19)	LTSS (all MEGs)									
	Preliminary Total Expenditures	**$ 5,622,862,592**	**$ 5,667,856,926**	**$ 6,499,532,694**	**$ 2,888,764,352**	**$ 3,599,045,671**	**$ 7,023,405,190**	**$ 7,662,588,758**	**$ 7,538,294,719**	**$ 7,823,887,805**
	SUD Waiver (net cost)	$ -	$ -	$ -	$ -	0	$ -		$ 23,000,000	$ 55,167,284
	CommonHealth 65+								$ 15,709,953	$ 16,401,191
	CommCare Parents hypothetical	$ 42,057,862	$ 31,002,402	$ 15,501,201	$ 15,501,201					
	CommCare 19-20 hypothetical	$ 28,367,949	$ 24,914,545	$ 12,943,670	$ 12,943,670					
	CommCare <133 FPL hypothetical	$ 387,422,325	$ 363,321,426	$ 191,892,964	$ 191,892,964					
	Essential 19-20 hypothetical	$ 30,362,148	$ 32,974,814	$ 18,875,307	$ 18,875,307	$ -				
	Misc (MH BPHC)	9,121	23	0	0	0	$ -			
	SHIP Continuous Eligibility								$ 1,310,400	$ 3,360,000
	PCPR (Primary Care Payment Reform)			$ 15,726,628	$ 7,863,314	$ 7,863,314	$ 47,273,429	$ 52,374,817	$ 67,503,760	$ -
	Medical Homes	$ 4,034,137	$ 4,803,119	$ 14,875,139	$ 7,437,570	$ 7,437,570				
	Pediatric Asthma	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Early Intervention Specialty Services	$ 4,400,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	Provisional Eligibility			$ 11,000,000		$ 11,000,000	$ 3,545,188	$ 3,545,188	$ 3,545,188	$ 602,682
	Pilot ACO shared savings									
	End-of-Month Coverage			$ 7,000,000		$ 7,000,000	$ 14,061,108	$ 14,061,108	$ 14,061,108	$ 14,061,108
	1915(c) adjustment									
	Total Projected Expenditures (non-SNCP)	**$ 6,149,878,281**	**$ 6,157,848,070**	**$ 6,806,222,911**	**$ 3,162,153,685**	**$ 3,632,346,555**	**$ 7,088,284,915**	**$ 7,732,569,871**	**$ 7,663,425,129**	**$ 7,913,480,070**
	Schedule C Total	**$ 7,472,802,633**	**$ 7,233,371,522**	**$ 7,961,152,443**	**$ 3,980,576,222**	**$ 3,980,576,222**	**$ 8,634,301,239**	**$ 8,648,501,199**	**$ 8,112,376,741**	
	Exclude Sch. C SNCP expenditures	$ (1,403,778,498)	$ (1,144,303,788)	$ (1,281,545,518)	$ (640,772,759)	$ (640,772,759)	$ (1,610,896,049)	$ (985,912,441)	$ (574,082,022)	
	Exclude Sch. C CC Hypo expenditures	$ (415,790,274)	$ (388,235,971)	$ (204,836,634)	$ (204,836,634)	$ -	$ -	$ -	$ -	
	Exclude Essential 19-20 Hypo expend.	$ (30,362,148)	$ (32,974,814)	$ (18,875,307)	$ (18,875,307)	$ -	$ -	$ -	$ -	
	BPHC	$ (9,121)	$ (23)							
	Subtotal: Non-SNCP non-Hypo Sch. C	**$ 5,622,862,592**	**$ 5,667,856,926**	**$ 6,455,894,984**	**$ 3,116,091,521**	**$ 3,339,803,463**	**$ 7,023,405,190**	**$ 7,662,588,758**	**$ 7,538,294,719**	
	Completion (claims run out)			$ 31,915,039	$ 31,915,039	$ -		$ -		
	Actual / Estimated P4P	$ 43,744,719	$ 37,500,000	$ 28,822,684	$ 14,411,342	$ 14,411,342	$ 31,999,528	$ 28,616,834	$ 21,253,812	
	CarePlus payments to plans			$ 11,722,671						
	Total expenditures not yet reported on Schedule C	**$ -**	**$ -**	**$ 43,637,710**	**$ 31,915,039**	**$ -**	**$ -**	**$ -**	**$ -**	
	Total Schedule C with Adjustments	**$ 5,622,862,592**	**$ 5,667,856,926**	**$ 6,499,532,693**	**$ 3,148,006,560**	**$ 3,339,803,463**	**$ 7,023,405,190**	**$ 7,662,588,758**	**$ 7,538,294,719**	
	Total from above (line 25)	**$ 5,622,862,592**	**$ 5,667,856,926**	**$ 6,499,532,694**	**$ 2,888,764,352**	**$ 3,599,045,671**	**$ 7,023,405,190**	**$ 7,662,588,758**	**$ 7,538,294,719**	
	Tie out	$ -	$ -	$ (0)	$ 259,242,209	$ (259,242,209)	$ -	$ -	$ -	
		0.00%	*0.00%*	*0.00%*			*0.00%*	*0.00%*	*0.00%*	

	MEGs	WY22-SFY2019	WY23-SFY2020	WY24-SFY2021	WY25-SFY2022	projected growth %
(1)	1902 (r) (2) Children	$ 154,343,251	$ 159,829,962	$ 165,583,841	$ 171,544,859	3.6%
(2)	1902 (r) (2) Disabled	$ 57,628,439	$ 59,687,512	$ 61,836,263	$ 64,062,368	3.6%
(3)	Base Disabled (includes Base MCB)	$ 2,511,852,841	$ 2,611,539,059	$ 2,716,008,292	$ 2,824,656,563	4.0%
(4)	Base Families	$ 2,540,378,036	$ 2,510,136,039	$ 2,600,980,297	$ 2,695,061,926	3.8%
(5)	E - Family Assistance	0				
(6)	E - HIV/FA	$ 7,987,569	$ 8,270,343	$ 8,568,076	$ 8,876,527	3.6%
(7)	Basic					
(8)	BCCTP	$ 6,085,603	$ 6,301,249	$ 6,528,094	$ 6,763,105	3.6%
(9)	CommonHealth (hypothetical)	$ 109,456,133	$ 113,813,256	$ 118,418,216	$ 123,628,618	4.4%
(10)	Essential					
(11)	Insurance Partnership (IRP)	0				
(12)	Medical Savings Plan (MSP)					
(13)	Mental Health Special Program for Youth	0				
(14)	CommonHealth Medicare Cost Sharing (133%-135% FPL)	$379,580	$390,846	$402,824	$414,908	4.4%
(15)	TANF/EAEDC	$281,012,907	$294,915,062	$309,976,073	$325,474,877	
(16)	SBE	0	0	0	0	3.6%
(17)	Duals with no resources test					
(18)	Category 8: New Adult	$ 2,215,077,711	$ 2,202,940,829	$ 2,297,667,285	$ 2,396,466,978	4.3%
(19)	LTSS (all MEGs)					
	Preliminary Total Expenditures	**$ 7,884,202,069**	**$ 7,967,824,159**	**$ 8,285,969,261**	**$ 8,616,950,729**	
	SUD Waiver (net cost)	$ 57,539,477	$ 60,013,675	$ 62,594,263	$ 65,285,816	4.3%
	CommonHealth 65+	$ 17,122,844	$ 17,876,249	$ 18,662,804	$ 19,483,967	4.4%
	CommCare Parents hypothetical					
	CommCare 19-20 hypothetical					
	CommCare <133 FPL hypothetical					
	Essential 19-20 hypothetical					
	Misc (MH BPHC)					
	SHIP Continuous Eligibility	$ 3,507,840	$ 3,662,185	$ 3,823,321	$ 3,991,547	4.4%
	PCPR (Primary Care Payment Reform)	$ -				
	Medical Homes					
	Pediatric Asthma	$ -	$ -	$ -	$ -	
	Early Intervention Specialty Services	$ -	$ -	$ -	$ -	
	Provisional Eligibility	$ 628,597	$ 655,627	$ 683,819	$ 713,223	4.3%
	Pilot ACO shared savings	$ 44,000,000				
	End-of-Month Coverage	$ 14,061,108	$ 14,061,108	$ 14,061,108	$ 14,061,108	
	1915(c) adjustment					
	Total Projected Expenditures (non-SNCP)	**$ 8,021,061,935**	**$ 8,064,093,002**	**$ 8,385,794,576**	**$ 8,720,486,390**	

	Schedule C Total
	Exclude Sch. C SNCP expenditures
	Exclude Sch. C CC Hypo expenditures
	Exclude Essential 19-20 Hypo expend.
	BPHC
	Subtotal: Non-SNCP non-Hypo Sch. C
	Completion (claims run out)
	Actual / Estimated P4P
	CarePlus payments to plans
	Total expenditures not yet reported on Schedule C
	Total Schedule C with Adjustments
	Total from above (line 25)
	Tie out

SUMMARY of Fiscal Impact for 1115 Demonstration Amendment Request

Amendment	Fiscal Impact	SFY18	SFY19	SFY20	Impact to Member Months or PMPMs		SFY18	SFY19	SFY20
Eliminate NEMT from Care Plus except for SUD									
	Fiscal Impact	**$ 2,500,000**	**$ 5,000,000**	**$ 5,000,000**	**PMPM Impact**				
	MEG Reduction				(WOW Cap)	PMPM Reduction			
	New Adult	$ 2,500,000	$ 5,000,000	$ 5,000,000		New Adult	$ 0.56	$ 1.13	$ 1.15
Eliminate provisional eligibility for adults based on self-attested income									
	Fiscal Impact	**$ 31,403,919**							
	MEG Reduction								
	Base, Families	$ 12,091,067	$ -	$ -					
	Base, Disabled	$ 2,878,073	$ -	$ -					
	New Adult	$ 13,492,273	$ -	$ -					
	Reduce PE line	$ 2,942,506	$ -	$ -					
		$ 31,403,919	**$ -**	**$ -**					
Non-disabled adults >100% FPL to Connector									
	Fiscal Impact	**$0**	**$ 239,500,000**	**$ 479,000,000**	**Member Impact**				
	MEG Reduction				(WOW Cap)	MM Reduction		**840,000**	**1,680,000**
	Base Families	$ -	$ 127,803,496	$ 255,606,993		Base Families	$ -	645,918	1,291,835
	New Adult	$ -	$ 111,696,504	$ 223,393,007		New Adult	$ -	194,082	388,165
Non-disabled parents <100% FPL Standard to CarePlus									
	Fiscal Impact	**$0**	**$ 2,500,000**	**$ 5,000,000**	**PMPM Impact**				
	MEG Reduction				(WOW Cap)	PMPM Reduction			
	Base Families	$ -	$ 2,500,000	$ 5,000,000		Base Families	$ -	$ 0.26	$ 0.54
Eliminate Limited for Connector Eligibles									
	Fiscal Impact	**$0**	**$ 5,000,000**	**$ 5,000,000**	**Member Impact**				
	MEG Reduction				(WOW Cap)	MM Reduction		**189,906**	**379,812**
	Base Families	$ -	$ 5,000,000	$ 5,000,000		Base Families	-	189,906	379,812
Narrower network PCC Plan									
	Fiscal Impact	**$0**	**$ 2,500,000**	**$ 5,000,000**					
	MEG Reduction								
	1902 (r) (2) Childre	$ -	$ 33,980	$ 69,646					
	1902 (r) (2) Disable	$ -	$ 15,340	$ 31,442					
	Base Disabled (incl	$ -	$ 777,696	$ 1,600,317					
	Base Families	$ -	$ 767,193	$ 1,458,290					
	E - HIV/FA	$ -	$ 2,326	$ 4,778					
	BCCTP	$ -	$ 1,604	$ 3,436					
	CommonHealth (hy	$ -	$ 31,347	$ 67,855					
	CommonHealth Me	$ -	$ 120	$ 245					
	TANF/EAEDC	$ -	$ 144,530	$ 300,246					
	New Adult	$ -	$ 725,864	$ 1,463,746					
IMD Exclusion Waiver									
	Fiscal Impact	**$ 13,821,891**			**Member Impact**				
	Add to MEGs				(WOW Cap)	Add to MMs	**25,336**		
	1902 (r) (2) Disable	$ 949,130				1902 (r) (2) Disa	4,453		
	Base Disabled (incl	$ 7,713,893				Base Disabled (i	9,553		
	Base Families	$ 504,806				Base Families	2,000		
	New Adult	$ 4,654,062				New Adult	9,330		

These impact analyses were conducted by examining data in the state's MMIS and HIX information systems for fiscal years 2016 and 2017, and developing estimates for cost,savings, and utilization for each initiative.

Base PMPM

WOW Base PMPMs are trended from existing WOW PMPM using the President's Budget trend rate

1115 Demonstration Renewal (December 2011) trend rate

	SFY 2012	SFY 2013	SFY 2014	
Base Families	5.3%	5.3%	5.3%	Adults + Children trend
Base Disabled/MCB	6.0%	6.0%	6.0%	Blind/Disabled trend
1902 (r) 2 Children	4.9%	4.9%	4.9%	Children trend
1902 (r) 2 Disabled	6.0%	6.0%	6.0%	Blind/Disabled trend
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	Adults trend

Note: these trends reflect a 2011-2013 aggregate trend (per CMS direction)

Base PMPMs without adjustments

	SFY 2011	SFY 2012	4th Extension SFY 2013	SFY 2014
Base Families	$ 533.73	$ 562.02	$ 591.81	$ 623.17
Base Disabled/MCB	$1,155.55	$1,224.88	$1,298.38	$1,376.28
1902 (r) 2 Children	$ 436.22	$ 457.59	$ 480.02	$ 503.54
1902 (r) 2 Disabled	$ 904.76	$ 959.04	$1,016.59	$1,077.58
1902 (r) 2 BCCTP	$3,489.72	$3,674.67	$3,869.43	$4,074.51

Hypothetical Trends

CommCare & Essential	5.3%	5.3%	5.3%	Adults trend
CommonHealth	6.0%	6.0%	6.0%	Blind/Disabled trend

President's trend:

1115 Demonstration 2016 Renewal trend rate

	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
Base Families	5.2%	5.2%	5.2%	3.8%	3.8%	3.8%	3.8%	3.8%	Adults + Children trend	PB is 4.8, using state trend
Base Disabled/MCB	4.8%	4.8%	4.8%	4.0%	4.0%	4.0%	4.0%	4.0%	Blind/Disabled trend	PB is 4.4, using state trend
1902 (r) 2 Children	4.6%	4.6%	4.6%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Children trend	Using state trend
1902 (r) 2 Disabled	4.8%	4.8%	4.8%	3.6%	3.6%	3.6%	3.6%	3.6%	Blind/Disabled trend	Using state trend
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Adults trend	Using state trend
Hypothetical Trends										
CommCare & Essential	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	Current Adults trend	This program no longer exists
CommonHealth	4.8%	4.8%	4.8%	4.4%	4.4%	4.4%	4.4%	4.4%	Blind/Disabled trend	Updated to use PB

Base PMPMs WITH WAIVER CHANGES 2017

						PMPMs QE33117			
					5th Extension	$ 781.72	$ 811.42		
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Base Families	$ 623.17	$ 655.57	$ 689.66	$ 725.53	$ 753.10	$ 781.46	$ 810.88	$ 841.69	$ 873.67
Base Disabled/MCB	$1,376.28	$1,442.34	$1,511.57	$1,584.13	$1,647.49	$1,713.39	$1,781.93	$ 1,853.21	$ 1,927.34
1902 (r) 2 Children	$ 503.54	$ 526.70	$ 550.93	$ 576.27	$ 597.02	$ 618.51	$ 640.78	$ 663.85	$ 687.75
1902 (r) 2 Disabled	$1,077.58	$1,129.30	$1,183.51	$1,240.32	$1,284.97	$1,331.23	$1,379.15	$ 1,428.80	$ 1,480.24
1902 (r) 2 BCCTP	$4,074.51	$4,290.46	$4,517.85	$4,757.30	$4,928.56	$5,105.99	$5,289.81	$ 5,480.24	$ 5,677.53

LTSS PMPM

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Base Families					7.16	8.50	10.09	11.98	14.22
Base Disabled/MCB					232.52	267.44	307.60	353.79	406.92
1902 (r) 2 Children					10.25	12.13	14.36	17.00	20.12
1902 (r) 2 Disabled					8.36	8.36	8.36	8.36	8.36
1902 (r) 2 BCCTP					28.22	31.12	34.31	37.83	41.71

TOTAL PMPM: Medical + LTSS PMPM

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Base Families	$ 623.17	$ 655.57	$ 689.66	$ 725.53	$ 760.26	$ 789.96	$ 820.97	$ 853.67	$ 887.89
Base Disabled/MCB	$1,376.28	$1,442.34	$1,511.57	$1,584.13	$1,880.01	$1,980.83	$2,089.53	$ 2,207.00	$ 2,334.26
1902 (r) 2 Children	$ 503.54	$ 526.70	$ 550.93	$ 576.27	$ 607.27	$ 630.64	$ 655.14	$ 680.85	$ 707.87
1902 (r) 2 Disabled	$1,077.58	$1,129.30	$1,183.51	$1,240.32	$1,293.33	$1,339.59	$1,387.51	$ 1,437.16	$ 1,488.60
1902 (r) 2 BCCTP	$4,074.51	$4,290.46	$4,517.85	$4,757.30	$4,956.78	$5,137.11	$5,324.12	$ 5,518.07	$ 5,719.24

Notes:
(1) LTSS PMPMs, as calculated on the LTSS projection tab, are added to the base PMPM begininng in 2018. The total PMPM is used on the WOW Cap tab.

ACA PMPM

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		CommCare 19+20
SFY 2009	$	374.33
SFY 2010	$	392.71
SFY 2011	$	338.05
SFY 2012	$	399.63
SFY 2013	$	420.81
SFY 2014	$	443.11

Actual / Projected PMPM		
		CommCare <133 (k)(2)
SFY 2009		N/A
SFY 2010	$	397.48
SFY 2011	$	393.82
SFY 2012	$	407.89
SFY 2013	$	429.51
SFY 2014	$	452.28

Actual / Projected PMPM	
	Essential 19+20
SFY 2009	$292.13
SFY 2010	$311.52
SFY 2011	$271.48
SFY 2012	$297.58
SFY 2013	$313.35
SFY 2014	$329.96

Note: The hypothetical populations to the left are some of the populations that will make up the new "VIII Group" in 2014. The new VIII Group also will include other populations, such as our current Basic and Essential 21-64 year old populations. The Essential population, for example, will make up about one-third of the total VIII Group. Essential members are significantly higher cost (approx. $1,000 PMPM). This will increase the average cost for the overall VIII Group compared to the historical costs for the hypothetical populations shown here. In addition, the benefits and cost sharing for the new VIII

		= (AVG Enrollment / Total Enrollment)	PMPM
CarePlus Direct Coverage RC IX From MassHealth	MassHealth Essential (0 - 100%)	33.97%	445
	MassHealth HIV (0 - 138%)	0.00%	445
	Insurance Partnership (0- 138%)	0.34%	445
From CommCare	CommCare (0 - 100%)	21.89%	445
	CommCare Adults (101 - 138%)	9.04%	445
From HSN	HSN (0 - 100%)	3.34%	445
	HSN (101 - 138%)	0.86%	445
From MSP	MSP - Premium Assistance (0 - 100%)	0.02%	445
	MSP - Direct Coverage (0 - 100%)	0.21%	445
	MSP - Premium Assistance (101 - 138%)	0.05%	445
	MSP - Direct Coverage (101 - 138%)	0.29%	445
New MassHealth Enrollees	New Adult Enrollees - Childless (0 - 100%)	3.17%	445

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	New Adult Enrollees - Childless (101 - 138%)	2.19%	445
CarePlus Direct Coverage RC X	MassHealth Basic 21-64 Yr Olds	4.98%	1075
CarePlus Premium Assistance	Insurance Partnership (0- 138%)	0.34%	349
	HSN (0 - 100%)	5.01%	383
	HSN (101 - 138%)	1.30%	350
	New Adult Enrollees - Childless (0 - 100%)	3.17%	350
	New Adult Enrollees - Childless (101 - 138%)	2.19%	350
Standard/Benchmark 1	MassHealth HIV (0 - 138%)	0.32%	1410
	MassHealth Basic 19-20 Yr Olds	0.04%	322
	MassHealth Essential 19-20 Yr Olds	2.03%	322
	CommCare (0 - 100%) 19-20 Yr Olds	1.32%	322
	CommCare Adults (101 - 138%) 19-20 Yr Olds	0.23%	322
	HSN (0 - 100%)	0.51%	322
	HSN (101 - 138%)	0.06%	322
	MSP - Premium Assistance (0 - 100%)	0.00%	322
	MSP - Direct Coverage (101 - 138%)	0.01%	322
	MSP - Premium Assistance (101 - 138%)	0.00%	322
	MSP - Direct Coverage (101 - 138%)	0.01%	322
	New Adult Enrollees - Parents (0 - 138%)	2.61%	350
	New Adult Enrollees - Childless (0 - 100%) 19-20	0.38%	322
	New Adult Enrollees - Childless (101 - 138%) 19-20	0.11%	322
ACA Expansion Population	**Weighted Average PMPM**	**461.23**	

Base PMPMs WITH WAIVER CHANGES 2017						PMPMs QE33117				
			5th Extension			$561.68	$585.83	$611.02		
	SFY 2014		**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**
New Adults		$461.23	$485.67	$511.42	$538.52	$561.12	$584.70	$609.87	$636.10	$663.45
	Trend Rate		5.3%	5.3%	5.3%	4.3%	4.3%	4.3%	4.3%	4.3%
	LTSS					5.73	6.32	6.97	7.69	8.48
	Total PMPM		$485.67	$511.42	$538.52	$566.85	$591.02	$616.84	$643.79	$671.93

Notes
(1) LTSS PMPM costs, as calculated on the LTSS projection tab, are added to the base PMPM beginning in SFY2018. This total PMPM is used on the WOW cap tab.

CommonHealth

1/8/2016

Trended baseline CommonHealth costs

Base year: SFY 2006

Approved trend rates: 7.0% through SFY 2008, 7.61% through SFY 2011

Using 1115 Demonstration trends for disabled for 2012-2014, 6.0%

4.80% Updated Trend Rate for SFY 15-21

4.40% Updated Trend Rate for SFY 17-22

	SFY 2006
Total spending	$ 61,168,938
Part D spending	$ 8,730,110
Net spending	$ 52,438,828
Member months	137,818
PMPM	$ 380.49

This calculation is based on the same data used for the adjustment from the 2006 amendment

Trend through SFY 2022

	Member Months (not incl. 65+)	Trended PMPM (not incl. 65+)	Trended spending (not incl. 65+)	Member Months (65+)	Trended PMPM (65+)	Trended spending (65+)	LTSS PMPM	LTSS spending (PMPM x MM)	**Total trended spending**	From WW Expenditures **Actual / projected spending**	Used for WOW Cap **Lesser of Actuals or Trended**
SFY 2006	137,818	$ 380.49	$ 52,438,828						**$ 52,438,828**	$ 52,438,828	**$ 52,438,828**
SFY 2007	147,218	$ 407.13	$ 59,936,748						**$ 59,936,748**	$ 61,576,778	**$ 59,936,748**
SFY 2008	157,887	$ 435.63	$ 68,779,809						**$ 68,779,809**	$ 61,721,922	**$ 61,721,922**
SFY 2009	164,603	$ 465.51	$ 76,624,474						**$ 76,624,474**	$ 87,276,901	**$ 76,624,474**
SFY 2010	185,138	$ 497.44	$ 92,095,935						**$ 92,095,935**	$ 72,745,738	**$ 72,745,738**
SFY 2011	201,460	$ 531.57	$ 107,089,890						**$ 107,089,890**	$ 78,960,022	**$ 78,960,022**
SFY 2012	214,279	$ 563.46	$ 120,737,583						**$ 120,737,583**	$ 79,202,469	**$ 79,202,469**
SFY 2013	216,304	$ 609.43	$ 131,821,823						**$ 131,821,823**	$ 83,910,244	**$ 83,910,244**
SFY 2014	223,704	$ 643.37	$ 143,923,930						**$ 143,923,930**	$ 87,280,637	**$ 87,280,637**
SFY 2015	229,545	$ 674.25	$ 154,770,582	28,072	$ 348.30	$ 9,777,406			**$ 164,547,988**	$ 171,038,287	**$ 164,547,988**
SFY 2016	236,432	$ 706.61	$ 167,065,908	28,072	$ 365.02	$ 10,246,841			**$ 177,312,749**	$ 116,136,585	**$ 116,136,585**
SFY 2017	243,525	$ 737.70	$ 179,649,342	28,072	$ 381.08	$ 10,697,678			**$ 190,347,019**	$ 150,582,753	**$ 150,582,753**
SFY 2018	250,831	$ 770.16	$ 193,180,723	28,072	$ 397.85	$ 11,168,445			**$ 204,349,168**	$ 203,955,104	**$ 203,955,104**
SFY 2019	258,356	$ 804.05	$ 207,731,151	28,072	$ 415.36	$ 11,659,986			**$ 219,391,137**	$ 218,803,518	**$ 218,803,518**
SFY 2020	266,107	$ 839.43	$ 223,377,730	28,072	$ 433.64	$ 12,173,142	$ 23.86	$ 6,349,313	**$ 241,900,185**	$ 241,096,883	**$ 241,096,883**
SFY 2021	274,090	$ 876.36	$ 240,202,356	28,072	$ 452.72	$ 12,708,756	$ 24.08	$ 6,600,087	**$ 259,511,199**	$ 258,469,241	**$ 258,469,241**
SFY 2022	282,313	$ 914.92	$ 258,294,672	28,072	$ 472.64	$ 13,267,950	$ 24.30	$ 6,860,206	**$ 278,422,828**	$ 277,115,433	**$ 277,115,433**

SFY15 CH working adults 65+ values (2/22/16)

Member months	28,072	
PMPM	$ 348.30	
spending	$ 9,777,406	$ 348.297

<65 MM trend rate

1.03
1.03
1.03
1.03 rate to use

16 37291
17 42324

SFY17 CH working adults 65+ values (11/16/16)

Member months	42,124
PMPM	$ 366.32
Spending	$ 15,430,892

4.40% Updated Trend Rate for SFY 17-22

Medicare Cost Sharing for CommonHealth Population between 133-135% FPL

133-135% FPL	Medicare Cost Sharing - CommonHealth Population		
	Member Months	PMPM	Total Projected Expenditures
SFY 2015	3,216	$104.90	$337,358
SFY 2016	3,264	$106.45	$347,479
SFY 2017	3,313	$108.02	$357,904
SFY 2018	3,363	$109.62	$368,641
SFY 2019	3,413	$111.24	$379,700
SFY 2020	3,465	$112.88	$391,091
SFY 2021	3,517	$114.55	$402,824
SFY 2022	3,569	$116.24	$414,908

EAEDC and TANF PMPM Projection

	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Member Months	1,142,947	907,555	771,229	792,823	815,022	837,843	861,303	885,419
Amount Paid	$378,111,525.30	$311,069,054.66	$260,948,537.69	$270,864,582.12	$281,157,436.24	$295,215,308	$309,976,073	$325,474,877
PMPM	$330.82	$342.76	$338.35	$341.65	$344.97	$352.35	$359.89	$367.59

Member Months Trend
2.8%

1115 Demonstration 2014 Renewal (June 2014) trend rate				1115 Demonstration 2017 Renewal trend rate					
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
Base Families	5.2%	5.2%	5.2%	3.8%	3.8%	3.8%	3.8%	3.8%	Adults + Children tren	Updated
Base Disabled/MCB	4.8%	4.8%	4.8%	4.0%	4.0%	4.0%	4.0%	4.0%	Blind/Disabled trend	Updated
1902 (r) 2 Children	4.6%	4.6%	4.6%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Children trend	Updated
1902 (r) 2 Disabled	4.8%	4.8%	4.8%	3.6%	3.6%	3.6%	3.6%	3.6%	Blind/Disabled trend	Updated
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Adults trend	Updated
Hypothetical Trends										
CommCare & Essential	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	Current Adults trend	no longer exists
CommonHealth	4.8%	4.8%	4.8%	4.4%	4.4%	4.4%	4.4%	4.4%	Blind/Disabled trend	Updated

Projected DSH allotment

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FFY	Allot W/O ARRA (Federal share)	Allot W/ ARRA (Federal share)	CMS Corrections *	*11/1/16 MassHealth Edits*	Allotment w/ ARRA (Total Computable)	*11/1/16 MassHealth Edits*	Source	CMS Corrections	Source
2008	287,285,600				574,571,200	***574,571,200***	Federal Register		Federal Register
2009	299,926,166	307,424,320	307,424,320	***307,424,320***	614,848,640	***614,848,640***	Federal Register		Federal Register
2010	299,926,166	315,109,928	315,109,928	***315,109,928***	630,219,856	***630,219,856***	Federal Register		Federal Register
2011	305,324,837		305,024,911	***305,024,911***	610,649,674	***610,049,822***	Federal Register	610,049,822	Federal Register
2012	314,685,733		312,955,559	***312,955,559***	629,371,466	***625,911,118***	CMS	625,911,118	Federal Register
2013	320,507,419		320,466,492	***320,466,492***	641,014,838.12	***640,932,984***	Projected using CPI-U estima	640,932,984	Federal Register
2014	325,273,489		325,273,489	***325,593,956***	650,546,978.00	***651,187,912***	Federal Register	650,546,978	Federal Register
2015	331,778,959		330,477,865	***330,477,865***	663,557,917.56	***660,955,730***	Projected using CPI-U estimate		
2016	273,717,641		337,419,933	***331,469,299***	547,435,281.99	***662,938,598***	Federal Register		
2017	225,817,054		343,662,202	***334,452,523***	451,634,107.64	***668,905,046***	Federal Register (Prelim)		
2018	186,299,069		350,019,952	***275,923,331***	372,598,138.80	***551,846,663***	Projected using estimated MA DSH reduction percentage		
2019	153,696,732		356,495,322	***227,636,748***	307,393,464.51	***455,273,497***	Projected using estimated MA DSH reduction percentage		
2020	126,799,804		356,495,322	***187,800,317***	253,599,608.22	***375,600,635***	Projected using estimated MA DSH reduction percentage		
2021	104,609,838		356,495,322	***154,935,262***	209,219,676.78	***309,870,524***	Projected using estimated MA DSH reduction percentage		
2022	86,303,117		356,495,322	***127,821,591***	172,606,233.35	***255,643,182***	Projected using estimated MA DSH reduction percentage		

Shift to SFY **(3/4 same SFY; 1/4 next SFY)**

SFY 2009	$	604,779,280
SFY 2010	$	626,377,052
SFY 2011	$	615,542,220
SFY 2012	$	624,691,018
SFY 2013	$	638,103,995
SFY 2014	***$***	***648,624,180***
SFY 2015	***$***	***658,513,776***
SFY 2016	***$***	***662,442,881***
SFY 2017	***$***	***667,413,434***
SFY 2018	***$***	***581,111,259***
SFY 2019	***$***	***479,416,788***
SFY 2020	***$***	***395,518,850***
SFY 2021	***$***	***326,303,052***
SFY 2022	***$***	***269,200,018***

Projected decline begins Oct 1, 2017

Assumptions
CMS' "Corrections" based on guidance effective March 31, 2014
Calculation in reg 42 C.F.R. § 447.294 (effective Nov. 18, 2013, still current)
Updated guidance on reductions was issued April 16, 2015- effective date shifted to FY18, same methdology
Uses actual Federal Register figures for FY16, projected FY17

2014 3-year renewal DSH allotment $ 1,874,073,054

5-year renewal DSH allotment SFY 18-22 **$ 3,375,000,000** Held flat at $675M/year

Change in SNCP

Base	$	4,600,000,000
Old DSH	$	1,723,713,600
New DSH	$	1,874,073,054
Change	$	150,359,454
New SNCP (SFY 2009 to 2011)	$	4,750,359,454

used for SNCP cap and provider subcap

Sources:

FY 2009 Revised Preliminary Allotment U/ARRA
FY 2010 Preliminary Allotment
FY 2014 Final- Federal Register (2016)
FY 2016 Final- Federal Register (2016)

2016: https://www.gpo.gov/fdsys/pkg/FR-2016-10-26/pdf/2016-25813.pdf
2014: https://federalregister.gov/a/2014-04032

2010: http://edocket.access.gpo.gov/2010/pdf/2010-8502.pdf
p. 21314 Federal Register / Vol. 75, No. 78 / Friday, April 23, 2010 / Notices

DSH Allotment prior to FY18 reduction methodology changes
DSH Allotment grows based on CPI-U - Consumer Price Index for all Urban Consumers.

FFY 2014	1.1 to 1.2	1.15%	Core PCE inflation projection	
Longer term	2.0	2.00%	PCE inflation projection	
		Monetary Policy Report to the Congress (February 11, 2014)		
		http://www.federalreserve.gov/monetarypolicy/mpr_20140211_part3.htm		
FFY 2010	0.8 to 1.0	0.90%	Core PCE inflation projection	
Longer term	1.7 to 2.0	1.85%	PCE inflation projection	
		Monetary Policy Report to the Congress (July 21, 2010)		
		http://www.federalreserve.gov/monetarypolicy/mpr_20100721_part4.htm		

DSH Allotment FY18 and after, with reduction applied

Estimated MA reduction % 17.5% Assumes same percentage reduction is applied year-over-year, beginning FY 2018

http://www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04032.pdf

#	Payment Type	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per SFY					Total SFY 2018-2022	Applicable footnotes
					SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
	System Transformation Incentive Based Pools										
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC XX	$425.00	$425.00	$400.00	$325.00	$225.00	$1,800.00	(1)
2	Public Hospital Transformation and Incentive Initiatives (PHTII)	n/a		Cambridge Health Alliance	$309.00	$243.00	$100.00	$100.00	$100.00	$852.00	(2)
	System Transformation Incentive Based Pools Subtotal				***$734.00***	***$668.00***	***$500.00***	***$425.00***	***$325.00***	***$2,652.00***	
	Disproportionate Share Hospital (DSH) Pool										
3	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	$20.00	$20.00	$20.00	$20.00	$20.00	$100.00	2
		DSH									
4	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101CMR 613.00, 614.00	All acute hospitals and CHCs	$287.00	$287.00	$288.00	$288.00	$290.00	$1,440.00	(3)
5	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	(4)
6	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$51.00	$52.00	$52.00	$52.00	$52.00	$259.00	5
7	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$137.00	$139.00	$139.00	$139.00	$139.00	$693.00	5
8	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	$180.00	$177.00	$176.00	$176.00	$174.00	$883.00	
	Disproportionate Share Hospital (DSH) Pool Subtotal:				***$675.00***	***$675.00***	***$675.00***	***$675.00***	***$675.00***	***$3,375.00***	
	Uncompensated Care (UCC) Pool										
9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals	$0.00	$10.00	$10.00	$10.00	$10.00	$40.00	3

10	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$65.00	$15.00	$15.00	$15.00	$15.00	$125.00	5
11	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	$147.00	$75.00	$75.00	$75.00	$75.00	$447.00	5
				Uncompensated Care (UCC) Pool Subtotal:	***$212.00***	***$100.00***	***$100.00***	***$100.00***	***$100.00***	***$612.00***	
	ConnectorCare Subsidies										
12	DSHP – Health Connector Subsidies	n/a		n/a	$250.00	$250.00	$250.00	$250.00	$250.00	$1,250.00	6
				DSHP – Health Connector Subtotal	***$250.00***	***$250.00***	***$250.00***	***$250.00***	***$250.00***	***$1,250.00***	
	Total				**$1,871.00**	**$1,693.00**	**$1,525.00**	**$1,450.00**	**$1,350.00**	**$7,889.00**	

*Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration projec

SNCP expenditures for dates of service in SFY 2012-2014 (projected and rounded)

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Expenditures for dates of service in SFY 2015-2018 (projected and ro

		Federal Share	caps		SFY 2012	SFY 2013	SFY 2014	3-year total 12-14	SFY2015	SFY2016	2-year total 15-16	SFY2017	3 year total (15-17)
1	Public Service Hospital Safety Net Care Payment	State appropriation	Provider	Boston Medical Center	$ 332.0	$ 332.0	$ 332.0	**$ 996.0**	$ 52.0	$ 52.0	**$ 104.0**	$ 52.0	**$ 156.0**
				Cambridge Health Alliance					$ 88.0	$ 88.0	**$ 176.0**	$ 88.0	**$ 264.0**
2	Health Safety Net Trust Fund Safety Net Care Payment	State appropriation, payer surcharge	Provider	All acute hospitals	$ 77.7	$ 159.4	$ 156.3	**$ 393.4**	$ 156.3	$ 156.3	**$ 312.5**	$ 156.3	**$ 468.8**
3	Institutions for Mental Disease (IMD)	State appropriation	Provider	Psychiatric Inpatient Hospitals Community-based detoxification centers	$ 9.9	$ 22.0	$ 24.0	**$ 55.8**	$ 24.0	$ 27.1	**$ 51.0**	$ 27.1	**$ 78.1**
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	CPE	Provider	Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Mass. Hospital	$ 40.0	$ 43.0	$ 45.0	**$ 128.0**	$ 45.0	$ 45.0	**$ 90.0**	$ 45.0	**$ 135.0**
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	CPE	Provider	Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Lindemann Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester State Hospital	$ 70.0	$ 74.0	$ 77.0	**$ 221.0**	$ 77.0	$ 96.4	**$ 173.4**	$ 96.4	**$ 269.8**
6	Delivery System Transformation Incentives	State appropriation, IGT	DSTI	Cambridge Health Alliance Boston Medical Center Holyoke Medical Center Lawrence General Hospital Mercy Medical Center Signature Healthcare Brockton Hospital Steward Carney Hospital	$ 209.3	$ 209.4	$ 209.3	**$ 628.0**	$ 215.2	$ 230.2	**$ 445.4**	$ 230.2	**$ 675.60**
7	Public Hospital Incentive Initiative	State appropriation, IGT	n/a	Cambridge Health Alliance					$ 220.0	$ 220.0	**$ 440.0**	$ 220.0	**$ 660.0**
8	Designated State Health Programs (DSHP)	State appropriation	DSHP	n/a	$ 340.9	$ 310.0	$ 130.0	**$ 780.9**	$ 385.0	$ 257.0	**$ 642.0**	$ 129.0	**$ 771.0**
9	DSHP - Connector Care subsidies	State appropriation	n/a	n/a	n/a	n/a	$ -	**$ -**	$ 41.8	$ 75.2	**$ 117.0**	$ 78.3	**$ 195.3**
10	DSHP - Commonwealth Care Transition	State appropriation	Overall SNCP	n/a	n/a	n/a	$ 139.5	**$ 139.5**	$ 175.4		**$ 175.4**		**$ 175.4**
11	DSHP - Temporary Coverage (AA Population)	State appropriation	Overall SNCP				$ 194.3	**$ 194.3**	$ 560.2		**$ 560.2**		**$ 560.2**
	Commonwealth Care	State appropriation	n/a	n/a	$ 305.1	$ 303.1	$ 152.5	**$ 760.7**			**$ -**		**$ -**
12	Infrastructure and Capacity-building	State appropriation	Infra.	Eligible providers	$ 3.0	$ 14.5	$ 26.0	**$ 43.5**	$ 20.0	$ 20.0	**$ 40.0**	$ 20.0	**$ 60.0**
					$ 1,387.8	**$ 1,467.4**	**$ 1,485.9**	**$ 4,341.1**	$ 2,059.8	**$ 1,267.1**	**$ 3,327.0**	**$ 1,142.2**	**$ 4,469.2**

Expenditure Limits (STC ¶46)			
	SNCP Aggregate Cap (approved)		$ 4,400.0
	(over)/under		$ 58.9
Subcaps	***Subcap***	***Expend.***	***(over)/under***
Infrastructure Subcap (5% of SNCP cap)	*$ 220.0*	*$ 43.5*	*$ 176.5*
Provider Subcap	*$ 1,874.1*	*$ 1,794.2*	*$ 79.9*
DSHP Subcap	*$ 800.0*	*$ 780.9*	*$ 19*

The following notes, referenced by line number, are incorporated by reference into chart A

(1) The provider-specific Public Service Hospital Safety Net Care payments approved by CMS are reflected in the table above. The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment.

(2) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding.

(3) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD category: inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification centers.

(4-5) Expenditures for lines #4-5 are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis.
Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth.

(6) Terms and Conditions governing Delivery System Transformation Incentives are detailed in Attachment F. A list of eligible hospitals and initial funding allotments are contained in Attachment I.

(7) Public Hospital Incentive Initiative: payments for reporting measures, compensating CHA for their progress towards delivery system transformation and sustainability.

(8) DSHP programs are listed separately in Attachment E. Authority for DSHP applies only to expenditures for dates of service through December 31, 2013.

(9) DSHP - Connector Care subsidies. Updated 7/14/14 to reflect actuals.

(10) DSHP Commonwealth Care Transition - Orderly Closeout. Updated 7/14/14 to reflect actuals.

(11) DSHP - Temporary Coverage. Updated 7/14/14 to reflect actuals.

(12) Infrastructure and Capacity-Building (ICB) funds support Commonwealth-defined health systems improvement projects, and are approved by CMS on an aggregate basis,

SNCP expenditures for dates of service in SFY 2012-2014 (projected and rounded) DRAFT - for policy discussion only **SNCP expenditures for dates of service in SFY 2015-2019 (projected and roun**

#	Type	Source of Non-Federal Share	Applic. caps	Eligible providers	Total SNCP expenditure per SFY 12-14 SFY 2012	SFY 2013	SFY 2014	3-year total 12-14	Total SNCP expenditure per SFY 15-19 SFY2015	SFY2016	SFY2017	SFY2018	SFY2019
1	Public Service Hospital Safety Net Care Payment	State appropriation	Provider	Boston Medical Center	$ 332.0	$ 332.0	$ 332.0	**$ 996.0**	$ 52.0	$ 52.0	$ 52.0		
				Cambridge Health Alliance					$ 88.0	$ 88.0	$ 88.0		
2	Health Safety Net Trust Fund Safety Net Care Payment	State appropriation, payer surcharge	Provider	All acute hospitals	$ 77.7	$ 159.4	$ 156.3	**$ 393.4**	$ 169.0	$ 169.0	$ 156.3		
3	Institutions for Mental Disease (IMD)	State appropriation	Provider	Psychiatric Inpatient Hospitals Community-based detoxification centers	$ 9.9	$ 22.0	$ 24.0	**$ 55.8**	$ 24.0	$ 30.0	$ 31.0		
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	CPE	Provider	Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Mass. Hospital	$ 40.0	$ 43.0	$ 45.0	**$ 128.0**	$ 45.0	$ 41.0	$ 41.0		
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	CPE	Provider	Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Lindemann Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester State Hospital	$ 70.0	$ 74.0	$ 77.0	**$ 221.0**	$ 97.9	$ 108.8	$ 100.0		
6	Delivery System Transformation Incentives	State appropriation, IGT	DSTI	Cambridge Health Alliance Boston Medical Center Holyoke Medical Center Lawrence General Hospital Mercy Medical Center Signature Healthcare Brockton Hospital Steward Carney Hospital	$ 209.3	$ 209.4	$ 209.3	**$ 628.0**	$ 209.3	$ 215.2	$ 215.2		
7	Public Hospital Incentive Initiative	State appropriation, IGT	n/a	Cambridge Health Alliance					$ 220.0	$ 220.0	$ 220.0		
8	Designated State Health Programs (DSHP)	State appropriation	DSHP	n/a	$ 340.9	$ 310.0	$ 130.0	**$ 780.9**	$ 334.0	$ 257.0	$ 129.0		
9	DSHP - Connector Care premium subsidies	State appropriation	DSHP	n/a	n/a	n/a	$ -	**$ -**	$ 41.8	$ 75.2	$ 147.0	$ 106.0	$ 111.0
10	DSHP- Connector Care cost sharing subsidies	State appropriation	n/a	n/a	n/a	n/a	n/a		n/a	n/a	$ 87.3	$ 91.9	$ 96.7
11	DSHP - Commonwealth Care Transition	State appropriation	Overall SNCP	n/a	n/a	n/a	$ 139.5	**$ 139.5**	$ 175.4				
12	DSHP - Temporary Coverage (AA Population)	State appropriation	Overall SNCP				$ 194.3	**$ 194.3**	$ 560.2				
13	Commonwealth Care	State appropriation	n/a	n/a	$ 305.1	$ 303.1	$ 152.5	**$ 760.7**					
14	Infrastructure and Capacity-building	State appropriation	Infra.	Eligible providers	$ 3.0	$ 14.5	$ 26.0	**$ 43.5**	$ 20.0	$ -	$ 26.0		
								$ 4,341.1	$ 2,036.6	$ 1,256.2	$ 1,292.8		

Expenditure Limits (STC ¶46)		
SNCP Aggregate Cap (approved)		$ 4,400.0
(over)/under		$ 58.9
Subcaps	***Subcap***	***Expend.***	***(over)/under***
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DSHP Subcap	*$ 800.0*	*$ 780.9*	*$ 19*

The following notes, referenced by line number, are incorporated by reference into chart A

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(12) Infrastructure and Capacity-Building (ICB) funds support Commonwealth-defined health systems improvement projects, and are approved by CMS on an aggregate basis,

ıded)	
	5-year total 15-19
$	156.0
$	264.0
$	494.30
$	84.97
$	127.00
$	306.70
$	639.73
$	660.00
$	720.00
$	481.00
$	275.90
$	175.40
$	560.20
$	-
$	46.00
$	4,991

Hypothetical Population Analysis

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STC 73(a)(iii): Starting in SFY 2009, actual expenditures for the CommCare-19+20 and CommCare Parents [parents and caretaker relatives who would be eligible for base EGs, except for income] EGs will be included in the expenditure limit for the Commonwealth.

Starting April 1, 2010, actual expenditures for the CommCare-133 EG [<=133% FPL] will be included in the expenditure limit for the Commonwealth.

The amount of actual expenditures to be included will be the lower of the trended baseline costs, or actual per member per most cost experience for these groups in SFYs 2009-2011.

19 + 20 year olds

Member Months

	CommCare 19+20
SFY 2009	117,343
SFY 2010	108,929
SFY 2011	91,938
SFY 2012	70,986
SFY 2013	0
SFY 2014	0

Actual PMPM

	CommCare 19+20
SFY 2009	$ 374.33
SFY 2010	$ 391.76
SFY 2011	$ 419.21
SFY 2012	$ 399.63
SFY 2013	#DIV/0!
SFY 2014	#DIV/0!

Actual total expenditures
Used for WW Expenditures

SFY 2009	$ 43,925,128
SFY 2010	$ 42,673,532
SFY 2011	$ 38,541,369
SFY 2012	$ 28,367,948
SFY 2013	$ -
SFY 2014	$ -
	$ 153,507,977

Trended PMPM

	CommCare 19+20	
SFY 2009	$ 374.33	
SFY 2010	$ 400.35	7.0%
SFY 2011	$ 428.17	7.0%
SFY 2012	$ 447.13	5.3%
SFY 2013	$ 470.83	5.3%
SFY 2014	$ 495.78	5.3%

Trended baseline costs

SFY 2009	$ 43,925,128
SFY 2010	$ 43,609,471
SFY 2011	$ 39,365,262
SFY 2012	$ 31,739,970
SFY 2013	$ 34,425,009
SFY 2014	$ 37,336,720

Lesser of Actuals or Trended
Used for WOW Cap

SFY 2009	$ 43,925,128
SFY 2010	$ 42,673,532
SFY 2011	$ 38,541,369
SFY 2012	$ 28,367,948
SFY 2013	$ -
SFY 2014	$ -

CommCare Parents

Member Months

	CommCare Parents
SFY 2009	86,941
SFY 2010	101,210
SFY 2011	113,240
SFY 2012	116,834
SFY 2013	0
SFY 2014	0

Actual PMPM

	CommCare Parents
SFY 2009	$ 374.33
SFY 2010	$ 372.27
SFY 2011	$ 401.67
SFY 2012	$ 375.02
SFY 2013	#DIV/0!
SFY 2014	#DIV/0!

Trended PMPM

	CommCare Parents	
SFY 2009	$ 374.33	
SFY 2010	$ 400.35	7.0%
SFY 2011	$ 428.17	7.0%
SFY 2012	$ 498.35	5.3%
SFY 2013	$ 524.77	5.3%
SFY 2014	$ 552.58	5.3%

Actual total expenditures Used for WW Expenditures		
SFY 2009	$	32,544,698
SFY 2010	$	37,677,624
SFY 2011	$	45,484,664
SFY 2012	$	43,815,208
SFY 2013		42,057,862
SFY 2014		31,002,402
	$	232,582,459

Trended baseline costs		
SFY 2009	$	32,544,698
SFY 2010	$	40,519,364
SFY 2011	$	48,486,027
SFY 2012	$	58,224,347
SFY 2013	$	63,150,442
SFY 2014	$	68,491,989

Lesser of Actuals or Trended Used for WOW Cap		
SFY 2009	$	32,544,698
SFY 2010	$	37,677,624
SFY 2011	$	45,484,664
SFY 2012	$	43,815,208
SFY 2013	$	42,057,862
SFY 2014	$	31,002,402

CommCare < 133% FPL (1902(k)(2))

Member Months	CommCare <133 (k)(2)
SFY 2009	N/A
SFY 2010	244,835
SFY 2011	949,547
SFY 2012	949,810
SFY 2013	0
SFY 2014	0

Actual PMPM	CommCare <133 (k)(2)	
SFY 2009		N/A
SFY 2010	$	396.60
SFY 2011	$	426.13
SFY 2012	$	407.89
SFY 2013		#DIV/0!
SFY 2014		#DIV/0!

Actual total expenditures Used for WW Expenditures		
SFY 2009		N/A
SFY 2010	$	97,101,247
SFY 2011	$	404,633,007
SFY 2012	$	387,422,325
SFY 2013	$	-
SFY 2014	$	-
	$	889,156,579

Trended PMPM	CommCare <133 (k)(2)		
SFY 2009		N/A	
SFY 2010	$	397.48	
SFY 2011	$	425.11	7.0%
SFY 2012	$	498.36	5.3%
SFY 2013	$	524.77	5.3%
SFY 2014	$	552.58	5.3%

Trended baseline costs		
SFY 2009		N/A
SFY 2010	$	97,317,635
SFY 2011	$	403,658,851
SFY 2012	$	473,347,312
SFY 2013	$	513,384,748
SFY 2014	$	556,809,132

Lesser of Actuals or Trended Used for WOW Cap		
SFY 2009		N/A
SFY 2010	$	97,101,247
SFY 2011	$	403,658,851
SFY 2012	$	387,422,325
SFY 2013	$	-
SFY 2014	$	-

Essential 19+20 Hypothetical Population

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1) STC 73(a)(iii): Starting in SFY 2009, actual expenditures for the Essential-19+20 EG (19 and 20-year old members enrolled in Essential) will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline costs, or actual per member per most cost experience for these groups in SFYs 2009-2014.

2) Expenditures for Essential 19+20 in SFY 2013 and SFY 2014 Q1&Q2 were estimated by multiplying total Essential expenditures by the ratio of Essential 19+20 member months to total Essential member months.

Member Months	Essential 19+20	all Essential	% 19+20
SFY 2009	57,938		
SFY 2010	81,721		
SFY 2011	91,598		
SFY 2012	89,796		
SFY 2013	86,079	1,350,686	6.37%
SFY 2014	40,743		

Actual PMPM	Essential 19+20
SFY 2009	$292.13
SFY 2010	$311.52
SFY 2011	$266.61
SFY 2012	$294.89
SFY 2013	$317.02
SFY 2014	$339.52

Actual total expenditures Used for WW Expenditures		
SFY 2009	$	16,925,270
SFY 2010	$	25,457,917
SFY 2011	$	24,420,584
SFY 2012	$	26,479,824
SFY 2013	$	27,288,877
SFY 2014	$	13,832,815
	$	134,405,287

Trended PMPM	Essential	
SFY 2009	$ 292.13	
SFY 2010	$ 312.43	7.0%
SFY 2011	$ 334.14	7.0%
SFY 2012	$ 378.31	5.3%
SFY 2013	$ 398.36	5.3%
SFY 2014	$ 419.47	5.3%

Trended baseline costs		
SFY 2009	$	16,925,270
SFY 2010	$	25,532,098
SFY 2011	$	30,033,750
SFY 2012	$	33,267,008
SFY 2013	$	36,081,065
SFY 2014	$	39,133,162

Lesser of Actuals or Trended Used for WOW Cap		
SFY 2009	$	16,925,270
SFY 2010	$	25,457,917
SFY 2011	$	24,420,584
SFY 2012	$	26,479,824
SFY 2013	$	27,288,877
SFY 2014	$	13,832,815

Duals with No Resource Test

					<<<ACTUAL	PROJECTED>>>					
	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18	SFY19	SFY20	SFY21	SFY22
did not update expenditures			Expenditures			Expenditures					
BD - Base, Disabled	$871,998,229	$856,213,663	$922,846,853	$948,886,213	$1,022,276,868	$1,101,343,850	$1,177,468,737	$1,258,855,376	$1,345,867,460	$1,438,893,818	$1,538,350,159
BF - Base, Families	$221,019,182	$223,426,156	$200,806,041	$227,751,279	$246,302,987	$266,365,843	$284,229,402	$303,290,963	$323,630,868	$345,334,848	$368,494,385
RD - 1902(R)2, Disabled	$28,930,331	$29,746,821	$30,053,235	$21,955,954	$23,654,115	$25,483,619	$27,140,258	$28,904,592	$30,783,622	$32,784,804	$34,916,078
TOTAL	**$1,121,947,742**	**$1,109,386,640**	**$1,153,706,129**	**$1,198,593,446**	**$1,292,233,970**	**$1,393,193,312**	**$1,488,838,397**	**$1,591,050,931**	**$1,700,281,949**	**$1,817,013,470**	**$1,941,760,622**
updated member months Jan 2015			Member Months			Member Months					
BD - Base, Disabled	2,684,832	2,275,925	2,258,952	2,216,308	2,278,365	2,342,159	2,407,739	2,475,156	2,544,461	2,615,705	2,688,945
BF - Base, Families	1,982,742	2,017,239	1,783,831	1,923,190	1,977,039	2,032,396	2,089,303	2,147,804	2,207,942	2,269,765	2,333,318
RD - 1902(R)2, Disabled	173,273	19,327	18,885	13,165	13,534	13,913	14,302	14,703	15,114	15,538	15,973
TOTAL	**4,840,848**	**4,312,490**	**4,061,669**	**4,175,395**	**4,292,306**	**4,412,491**	**4,536,041**	**4,663,050**	**4,793,615**	**4,927,836**	**5,065,816**
			PMPM			PMPM					
BD - Base, Disabled	$324.79	$376.20	$408.53	$428.14	$448.69	$470.23	$489.03	$508.60	$528.94	$550.10	$572.10
BF - Base, Families	$111.47	$110.76	$112.57	$118.42	$124.58	$131.06	$136.04	$141.21	$146.58	$152.15	$157.93
RD - 1902(R)2, Disabled	$166.96	$1,539.13	$1,591.34	$1,667.72	$1,747.77	$1,831.67	$1,897.61	$1,965.92	$2,036.70	$2,110.02	$2,185.98
TOTAL	**$231.74**	**$223.16**	**$243.59**	**$287.06**	**$301.06**	**$315.74**	**$328.22**	**$341.20**	**$354.70**	**$368.72**	**$383.31**

TRENDS

Member Month Trend
2.80%

1115 Demonstration 2014 Renewal (June 2014) trend rate				1115 Demonstration 2017 Renewal trend rate					
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	
Base Families	5.2%	5.2%	5.2%	3.8%	3.8%	3.8%	3.8%	3.8%	Adults + Children trend
Base Disabled/MCB	4.8%	4.8%	4.8%	4.0%	4.0%	4.0%	4.0%	4.0%	Blind/Disabled trend
1902 (r) 2 Children	4.6%	4.6%	4.6%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Children trend
1902 (r) 2 Disabled	4.8%	4.8%	4.8%	3.6%	3.6%	3.6%	3.6%	3.6%	Blind/Disabled trend
1902 (r) 2 BCCTP	5.3%	5.3%	5.3%	3.6%	3.6%	3.6%	3.6%	3.6%	Current Adults trend
Hypothetical Trends									
CommCare & Essential	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	Current Adults trend
CommonHealth	4.8%	4.8%	4.8%	4.4%	4.4%	4.4%	4.4%	4.4%	Blind/Disabled trend

ConnectorCare Subsidies

	Total Member Months	Total Subsidies Expenditures	Total Subsidies PMPM
SFY 2017	1,907,631	$ 142,892,276	$ 74.91
SFY 2018	2,088,729	$ 335,847,746	$ 160.79
SFY 2019	2,239,117	$ 367,243,301	$ 164.01
SFY 2020	2,400,334	$ 402,346,546	$ 167.62
SFY 2021	2,573,158	$ 441,595,344	$ 171.62
SFY 2022	2,758,425	$ 485,479,268	$ 176.00

Enrollment Growth SFY18-22
7.2%

AA Temporary Coverage

AA Temporary Coverage					
	Member Months	**PMPM**			**Total Projected Expenditures**
SFY 2014	1,081,404	$ 179.67			$ 194,299,113
SFY 2015	2,909,960	$ 192.50			$ 560,167,209

SFY2015 projection through February 2015

CommCare Transition

CommCare Transition					
	Member Months	**PMPM**			**Total Projected Expenditures**
SFY 2014	605,636	$ 230.37			$ 139,518,148
SFY 2015	807,515	$ 217.16			$ 175,360,611

SFY2015 projection through February 2015

MA SUD PMPM Back-Up

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11/4/2016

Service Type	Total Spend SFY17	Per User Per Month
Residential Rehab Services		
Adult	$ 31,511,896	$ 387.88
Youth	$ 913,598	$ 387.88
Adolescent	$ 1,036,893	$ 387.88
Family	$ 1,018,836	$ 387.88
Transitional Support Services	$ 20,686,061	$ 387.88
Total	**$ 55,167,284**	**$ 387.88**

Updated 5/31/2017

Service Type	Total Spend SFY17	Per User Per Month
Residential Rehab Services		
Adult	$ 13,137,743	$ 387.88
Youth	$ 380,892	$ 387.88
Adolescent	$ 432,295	$ 387.88
Family	$ 424,767	$ 387.88
Transitional Support Services	$ 8,624,304	$ 387.88
Total	**$ 23,000,000**	**$ 387.88**

SHIP PMPM

Continuous Eligibility spending only

Based on estimated premium contribution and enrollment

	SFY17	SFY18&19	Notes
	7,800	20,000	Total SHIP members with MH Premium Assistance: July to July
Estimated PMPM $ 300	5,200	13,333	Members with alternate redetermination period (66%)
	1,248	**3,200**	Members who would have otherwise closed (24%)

Month	Alt. Redet. Multiplier	SFY17	**Cost SFY17**	SFY18&19	**Cost SFY18**	**Cost SFY19**	
Jan	6	208	$ 374,400	533	$ 960,000	$ 960,000	
Feb	5	208	$ 312,000	533	$ 800,000	$ 800,000	
March	4	208	$ 249,600	533	$ 640,000	$ 640,000	
April	3	208	$ 187,200	533	$ 480,000	$ 480,000	
May	2	208	$ 124,800	533	$ 320,000	$ 320,000	
June	1	208	$ 62,400	533	$ 160,000	$ 160,000	
			$ 1,310,400		**$ 3,360,000**	**$ 3,360,000**	**Annual Cost for Continuous Eligibility**

ACO Shared Savings

Member Months	PMPM	Total Spend SFY19
1,200,000	$ 36.67	$ 44,000,000

Draft Evaluation Plan for the Massachusetts 1115 Demonstration Waiver

Introduction

Since its launch in 1997, the MassHealth 1115 Demonstration Waiver ("waiver") has served as a vehicle for expanding coverage, encouraging better coordination and cost containment through managed care, and supporting safety net providers. On November 4, 2016, the Centers for Medicare and Medicaid Services (CMS) approved the sixth extension of the waiver for the period July 1, 2017 through June 30, 2022. This extension seeks to transform the delivery of care for most MassHealth members and to change how that care is paid for, with the goals of improving quality and establishing greater control over spending. The waiver also addresses the epidemic of opioid drug use in Massachusetts. The waiver extension seeks to advance ~~five~~six 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
- 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 ~~MassHealth covered services~~ coverage for non-disabled adults with commercial plans, ~~health insurance (where appropriate) and~~ refinement of provisional eligibility, adoption of widely used commercial tools for prescription drugs, and changes to cost sharing requirements for higher income members.

The waiver draft evaluation design contained in this document is meant to meet the requirements of the independent evaluation described in the MassHealth Medicaid Section 1115 Demonstration Special Terms and Conditions (STC), Section XI: Evaluation. This evaluation design addresses the research questions and hypotheses suggested by CMS as well as additional areas of importance to the MassHealth waiver implementation.

The evaluation will explore the research questions and hypotheses related to the overarching aims of the demonstration, as well as those linked to specific goals. Although this document refers to key elements of the DSRIP funding (e.g. Community Partners and Flexible Services), a separate independent evaluation design (see

hypothesis 2d below) will allow for component analysis of the initiatives funded by the DSRIP and will be submitted under separate cover per the STC.

Evaluation Budget: A high-level draft budget has been prepared and is attached.

Demonstration Evaluation Aim:
As stated in STC 84(b), the overarching aim of the independent evaluation is to "evaluate whether the preponderance of the evidence about the costs and effectiveness of the demonstration when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes."

The primary mechanism by which MassHealth intends to advance Goals 1 and 2 is by promoting the formation of Accountable Care Organizations (ACOs) and Community Partners (CPs) to organize the delivery of care for MassHealth members under the age of 65 without other insurance coverage. ACO and CP development will receive additional support from the Delivery System Reform Incentive Program (DSRIP).

Evaluation Research Questions and Hypotheses

Overarching Evaluation Question
Did the payment and delivery system reforms facilitated by the waiver lead to decreases in the total cost of care (TCOC) while maintaining or improving quality?

- Hypothesis A: Waiver-enabled payment and delivery system reforms will result in reductions in the total cost of care (TCOC) for MassHealth's managed care population.
- Hypothesis B: Waiver-enabled payment and delivery system reforms will maintain or improve clinical quality.
- Hypothesis C: Waiver-enabled payment and delivery system reforms will maintain or improve members' experiences with care.

As a general principle, throughout the evaluation and design, total costs under the demonstration to estimates of what costs would have been without the demonstration, accounting for changes in provider rates, health care utilization, and administrative activities will be compared. Comparisons of changes in access and quality within managed care populations will rely on standard metrics as summarized in the attached measures table and compared to the non-managed care population where appropriate and possible.

Waiver 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.

Research Question 1
Did the waiver's payment and delivery system reforms promote systems of integrated and coordinated care?

- Hypothesis 1a: The waiver's support will result in new partnerships and collaborations between ACOs and community partners offering behavioral health and long-term services and supports.
- Hypothesis 1b: The waiver's support will increase acceptance of TCOC risk-based payments among MassHealth providers.
- Hypothesis 1c: The waiver's support will lead to stronger aggregate provider networks in the ACO and MCO programs relative to the Primary Care Clinician (PCC) plan in relation to types and breadth of providers, as well as quality and outcomes of services.
- Hypothesis 1d: The waiver's support will increase the use of Electronic Health Records (EHRs) and other infrastructure capabilities designed to improve interconnectivity among providers.

Evaluation Approach for Goal 1

Study Design:
Hypothesis 1a:

- The requirements for contracting between managed care entities and community partners as a result of the waiver and the number and nature of contracts executed will be identified.
- The volume, nature, and providers of non-medical services used by ACOs will be examined.

Hypothesis 1b:

- The level of acceptance of TCOC payments will be determined by examining the total outlay of Medicaid funds going to entities in the form of risk-based payments versus fee-for-service comparing changes over time starting with pre-waiver baselines.

Hypothesis 1c:

- Network adequacy using specific Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses, in addition to Managed Care Organizations' (ACO models and MCOs) reported compliance with MassHealth network adequacy standards regarding types and breadth of providers, will be measured.
- Trends in social, behavioral and LTSS service use, by type and in total, for all managed care enrollees and within patient groups (such as those with quadriplegia) with needs for such services will be tracked.
- Quality and outcomes will be examined by measuring: the fraction of relevant population groups with any of the above services; among people with any such service use, its "volume" (e.g., numbers of visits/encounters, and the estimated cost of all services); among those who used services, looking for reductions in avoidable hospitalizations.

Hypothesis 1d:

- The number of provider organizations within the ACOs and CPs that have adopted EHRs will be tracked.
- The number of provider organizations within the ACOs and CPs that are connected to the Mass HIway will be tracked.

Data Needed for Evaluation: Documents that define the new contractual requirements for managed care entities, community partners, and service providers as a result of the waiver; documentation regarding the parties to, timing, scope, and nature of contracts actually executed; transactional data (bills or encounter records) relating to the volume, cost, nature of and providers of non-medical services used by ACOs; and data from the Massachsuetts eHealth Institute (MeHI) that reports EHR adoption and HIway connection rates among providers operating throughout the Commonwealth.

Study Populations: All potential partners to new contracting arrangements providing services to MassHealth members under the age of 65.

Access, Service Delivery Improvement, Health Outcomes, Satisfaction, and Cost Measures: The only questions considered here relate to the nature and amount of delivery system reorganization into integrated risk-bearing networks.

Data Analysis Plans: Simple descriptive statistics will be used to examine year-over-year changes in delivery system integration during the waiver period. Reporting will capture numbers of distinct providers, and the total volume cost of specified services delivered under accountable care contracts.

Waiver Goal 2: Improve integration of physical, behavioral and long-term services.

Research Question 2
Has the waiver promoted integrated care systems that demonstrate improved care quality and member experience?

- Hypothesis 2a: The waiver support for integration of physical, behavioral and long-term services will result in improved coordination across silos of care (e.g., physical health, behavioral health, LTSS, and social supports) as well as quality and outcomes of care.
- Hypothesis 2b: The waiver will lead to improved experience of care, especially through member engagement in primary care and/or closer coordination among providers.
- Hypothesis 2c: Accountability provisions under the waiver initiative will result in reductions in the growth of avoidable inpatient utilization.
- Hypothesis 2d: DSRIP funding for developing Community Partners and Flexible Services will contribute to increased integration of care systems and improved member experience.

Evaluation Approach for Goal 2

Study Design:
Hypothesis 2a:

- Encounter data will be used to examine trends in the receipt of behavioral health, LTSS and social support services for members of ACOs overall, and within groups of patients especially likely to need each of these kinds of services.

Hypothesis 2b:

- Trends in CAHPS survey responses will be examined with regard to patient experience related to the timing, nature, and scope of services received. Data will be examined overall, and within groups of patients especially those likely to need specific kinds of services.

Hypothesis 2c:

- Trends in care quality including potentially avoidable admisisons and other quality and outcome measures from the ACO measure slate will be examined.

Hypothesis 2d:

- Data from DSRIP-funded programs will be reviewed to assess contributions to the overall success of the waiver, and to achieving specific performance measures and outcomes as described in the DSRIP protocol Appendix E. In addition, return on investment (ROI) analyses will be performed to assist the state in determining which investments might be continued after the waiver period. Note that a detailed evaluation design for the DSRIP program will be submitted for review to CMS by June 30, 2018 consistent with the STC.

Most questions will be examined longitudinally for MassHealth members overall, looking at year-over-year changes for enrollee groups (principally PCC plan vs. managed care), and separately within policy relevant subgroups, such as, people with behavioral health and those with LTSS needs. Changes in trends for measures and outcomes will be considered prior to, and following, programmatic changes enabled by the waiver. Trends in utilization and costs will be examined (risk-adjusted) for the managed care sector as a whole, and in comparison to the PCC plan.

The qualitative arm of the evaluation will entail case studies of select ACOs throughout the demonstration period to understand implementation and to pinpoint the conditions associated with higher and lower performing ACOs and CPs. Replication logic will be used to identify organizational conditions associated with specific operational outcomes such as successful vs. problematic implementation; improved care quality vs. static or declining care quality; and reduced care costs vs. flat or increasing care costs.

Data Needed for Evaluation: Both qualitative and quantitative data will be collected to evaluate Goal 2. The core quantitative data for examining the impact on the populations participating in managed care will be derived from required reporting from organizations providing these services. Data for measuring overall trends for comparing costs and

service use between managed and non-managed care populations (overall and within utilization categories) will be derived from state's MMIS and data warehouse systems in two kinds of files: utilization records (claims/encounter data) and person-level files (descriptions of member characteristics, eligibility for special programs, etc.).

Qualitative data related to implementation and member experience will be derived from key informant interviews and patient surveys. This information will be used to conduct "internal validity analyses" in which changes in the organization, cost and use of services will be linked to the time frames during which, and the populations for which, reforms were actually implemented. Qualitative data from key informant interviews will be used to understand the facilitators and barriers to successful implementation, which can inform how best to revise and modify implementation during the demonstration period and inform future replication efforts.

Study Population: The total study population for examining these hypotheses will be MassHealth members under the age of 65 with a special emphasis on those participating in managed care. Many questions will be examined within the subpopulations that would reasonably be expected to be affected by particular programs – such as the impact of integrated systems of care on members who have unmet needs for behavioral health care and/or long-term care services.

For the qualitative phase, the study population will consist of select ACO sites and within those sites, a purposeful sample of key informants representing a cross-section of administrative, clinical and support staff involved in implementing organizational change under the demonstration. To understand the initial implementation, baseline site visits will identify a sample of ACOs representing the range of adopted models. In subsequent site visits, findings will be used from the quantitative arm of the evaluation to identify and study ACO sites that perform relatively well or underperform with respect to key outcomes of interest, such as care cost and care quality.

Access, Service Delivery Improvement, Health Outcomes, Satisfaction, and Cost Measures: To measure the impact of payment reforms, measures that MassHealth will require from its accountable care entities will be relied upon (see measure table, Attachment A). MassHealth will strive to ensure that these new data will be collected at the person-level, and standardized across the entire sector without which neither comparisons with the PCC plan, nor with the pre-waiver period, will be possible.

Data Analysis Plans: Describing member characteristics, cost and utilization (and bivariate relationships among these) for the MassHealth population overall and by program (PCC vs. various managed care models) will be a first approach, as well as changes in these features and relationships over time. Difference-in-difference analyses will be the primary strategy for testing hypotheses relating to the effects of specific interventions and the effects of the combined reforms. Prior to modeling, examining distributions of key variables, to inform how to construct analytic variables (e.g., an expectation to "top-code" very expensive cases; noting that, choosing an appropriate top-coding threshold requires examining the entire cost distribution, eliminating data

errors, and distinguishing predictable high costs – such as those incurred by people who require a $300,000/year drug – from random, insurable events, such as, costs incurred by a third-degree burn victim). Informed by qualitative research, a "stepped-wedge" design will be used to take advantage of the "natural experiment" provided by the phase-in of delivery innovations.

For some questions that relate specifically to populations with extremely low turnover, differences in person-level trajectories for long-term stayers who remain in a program that is not affected by waiver-based changes will be examined, versus those who switch programs (e.g., from PCC to managed care) versus those who do not change programs, but their programs undergo waiver-encouraged changes.

Data analysis and interpretation will be "risk-adjusted" where appropriate – that is, examining outcomes and changes in outcomes after accounting for differences in, and changes in, relevant patient characteristics – except in settings where there is controversy about whether risk adjustment is appropriate, in which case the approach will be to conduct and present both raw and risk adjusted analyses.

For the qualitative arm of the evaluation, content coding and analysis to determine major themes present in the interviews will be used both within and across study ACO sites. Coded and sorted data will then serve as the basis of creating site-specific reports and data matrices, both of which will facilitate cross-ACO comparisons. Through this process, how the program was implemented at study sites will be assessed, including, similarities and differences across sites that vary on performance, and how the program was implemented overall.

Waiver Goal 3: Maintain near-universal coverage.

Research Question 3
What is the impact of the waiver's investments in improved enrollment and redetermination processes and insurance subsidies on insurance rates?

Hypothesis 3: The waiver's investments in improved enrollment procedures and insurance subsidies will be associated with the continued maintenance of near-universal coverage in Massachusetts.

Evaluation Approach for Goal 3

Study Design and Outcome Measures:
Hypothesis 3:

- Describing trends in the distributions of existing measures to track five population-level measures: 1) Among Massachusetts residents under the age of 65, number (and fraction) of uninsured; 2) Volume and cost of uncompensated care and supplemental payments to hospitals; 3) Number of individuals accessing the Health Safety Net; 4) Number of individuals who take up Qualified Health Plan coverage with assistance from the Commonwealth Health Insurance

Connector Authority (Health Connector) subsidy program; and 5) Number of individuals who are waiver-eligible but have employer-sponsored coverage.

Background: The waiver invests in several improvements to facilitate and sustain enrollment in insurance coverage, including: streamlined redetermination procedures for select MassHealth members; developing comprehensive enrollment materials and trainings to support consumer choice; providing subsidies to low income people to purchase health insurance; and improved eligibility system and website/consumer functionality. The overall approach for addressing the research question and hypothesis under Goal 3 will be a descriptive analysis of existing population-level measures examining changes in state-wide insurance rates and related metrics.

Data Needed for Evaluation: Secondary data sources will be exclusively relied upon for the population-level measures: data sets and operational statistics from the Massachusetts Center for Health Information and Analysis, MassHealth, and the Health Connector. The datasets will include: the Massachusetts Health Insurance Survey, Health Safety Net claims enrollment data, and the Health Connector subsidy program data.

Study Population: With the exception of the measure related to the statewide coverage rate, 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 near-universal coverage is maintained. Where feasible and useful, select population-level measures will be compared to national trends.

Data Analysis: Summary statistics for each PLM at three time points over the waiver period, baseline, mid-point and end-point will be provided. The analytic approach for each measure will vary by data source and measures. While the data will be reported on an annual basis, some data sources contain monthly capture of various activities (e.g., the number of demonstration eligible accessing employer sponsored insurance), while other data are only available on an annual basis. Data will be presented in tables and graphs in order to display trends over time for each population-level measure.

Timeline: Summary statistics for each population-level measure at three time points over the demonstration period will be provided: baseline, mid-point and end-point.

Former Foster Care Youth from Other States

Continuing to provide coverage to former foster care youth who aged out of foster care under the responsibility of another state (and were enrolled in Medicaid in the state in which they live) supports Goal #3. This coverage is a means of increasing and strengthening overall coverage of former foster care youth and improving health outcomes for these youth. The waiver goals that will be tested are as follows:

1. Ensure access to Medicaid services for former foster care individuals between the ages of 18 and 26, who previously resided in another state (the "target population").
2. Improve or maintatin health outcomes for the target population.

Evaluation Questions and Hypotheses

Demonstration Goal 1: Expand access to Medicaid for former foster care youth who were in foster care and Medicaid in another state and are now applying for Medicaid in the state in which they live.					
Evaluation Component	**Evaluation Question**	**Evaluation Hypotheses**	**Measure [Reported for each Demonstration Year]**	**Recommended Data Source**	**Analytic Approach**
Process	Does the demonstration provide continuous health insurance coverage?	Beneficiaries will be continuously enrolled for 12 months.	Number of beneficiaries continuously enrolled/ total number of enrollees	Medicaid claims and enrollment data	Descriptive statistics (frequency and percentages specified annually over 5-year Waiver period)
	How did beneficiaries utilize health services?	Beneficiaries will access health services.	Number of beneficiaries who had an ambulatory care visit/ Total number of beneficiaries	Medicaid claims	Descriptive statistics (frequency and percentages specified annually over 5-year Waiver period)
			Number of beneficiaries who had an emergency department visit/ Total number of beneficiaries		
			Number of beneficiaries who had an inpatient visit/ Total number of beneficiaries		
			Number of beneficiaries who had a behavioral health encounter /Total number of beneficiaries		
Demonstration Goal 2: Improve or maintain health outcomes for the target population.					
Outcomes/ Impact	What do health outcomes look like for beneficiaries?	Beneficiaries will have positive health outcomes [as defined by NQF measures]	Number of beneficiaries with appropriate follow-up care for hospitalizations (physical and/or mental illness) / Total number of beneficiaries with hospitalizations	Medicaid claims	Descriptive statistics (frequency and percentages specified annually over 5-year Waiver period)

Methodology

a. Evaluation design: The evaluation design will utilize a post-only assessment. The timeframe for the post-only period will begin when the demonstration begins, and ends when the demonstration ends (i.e. July 1, 2018 to June 30, 2022).

b. Data Collection and Sources: For the evaluation we will rely on data collected retrospectively through administrative data, including Massachusetts Medicaid (MassHealth) claims and enrollment files. We propose to time the data collection and analysis around the due dates for the overall Waiver's interim and summative evaluation reports (June 30, 2021 and December 31, 2022 respectively). This translates into one data request in July 2020, capturing administrative claims for the period July 2017 to December 2019; and a second data request July 2021, refreshing the claims data with data for the period January 2020 to December 2021. Claims and enrollment data are cleaned and validated by MassHealth prior to making the files available for evaluators. The only limitation of the data is the anticipated 6-month time-lag for MassHealth claims, which means we will not be able to include the last 6 months of the Waiver period in our analysis.

c. Data Analysis Strategy: We will use descriptive statistics for the analysis. We will specify and present all measures on an annual basis.

- Quantitative Methods: For all evaluation questions, we will employ descriptive statistics including frequency and percentages for dichotomous outcomes and means/standard deviations and medicans/ranges for continuous outcomes.

Waiver Goal 4: Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals

Research Question 4:
What is the impact of safety net funding investments on safety-net provider hospital performance and financial sustainability?

- Hypothesis 4a: Increasing the portion of funding for safety-net hospitals under the Public Health Transformation and Incentive Initiative (PHTII) and Disproportionate Share Hospital (DSH) pool will result in improved care quality at these sites.
- Hypothesis 4b: Supplemental payments to hospitals funded through the DSH pool will help to address their underlying financial needs so they can continue to serve Medicaid and uninsured residents.

Evaluation Approach for Goal 4

Study Design:
Hypothesis 4a:

- Identify trends in quality measures at Cambridge Health Alliance and safety net payment eligible hospitals to examine if funding changes have improved overall quality outcomes.

Hypothesis 4b:

- Track uncompensated care and supplemental payments at safetynet hospitals to assess uncompensated care costs before and after supplemental payments.

The approach will be to monitor and track hospital performance (CHA and the safety-net hospitals) and the degree to which each meets performance targets (and thus receives the at-risk portion of the PHTII and safety net payments during the waiver period). The following outcome measures will be used: 1) ACO performance measures defined for DSRIP (CHA and safety-net hospitals) 2) ACO participation and "strengthened outcome improvement measurement slate" for on-going PHTII initiatives related to behavioral health integration (CHA only). Additionally, supplemental payments to safey-net hospitals will be tracked (i.e., Safety Net Provider Payments). The outcome measure will be each hospital's remaining uncompensated care costs post-supplemental payments.

Background: Under the waiver, two existing programs will continue, but with modifications. These are the Public Health Transformation and Incentive Initiative (PHTII) and the Disproportionate Share Hospital (DSH) pool. PHTII provides funds to CHA, the Commonwealth's only non-state, non-federal public acute hospital to support delivery system transformation. In the new waiver, an increasing portion of PHTII funding will be at-risk based on two activities: 1) Participation in an ACO model and demonstrated success on corresponding ACO performance measures (specifically the same performance goals established under DSRIP) 2) Continuation and strengthening of initiatives approved through PHTII in the prior demonstration period, including but not limited to initiatives focused on behavioral health integration and demonstrated success on corresponding performance measures.

DSH provides funding to support payments for uncompensated care provided to Medicaid and low-income, uninsured individuals. Under the waiver, a new component of the DSH pool is Safety Net Provider Payments, intended to provide ongoing financial support to the state's safety-net hospitals. These hospitals serve a disproportionately high proportion of Medicaid and uninsured patients, and have budget shortfalls related to providing a lot of care that is uncompensated. An increasing portion of these payments will be at risk, and hospitals will be required to meet the same performance goals established for DSRIP in order continue to receive these payments.

Data Needed for Evaluation: Data sources include: 1) PHTII and hospital safety-net Reports for Payment that hospitals under these programs will be required to submit, detailing key accomplishments in the reporting period towards the associated metrics, and outcome and improvement measures 2) state cost reports 3) data provided by MassHealth on supplemental payments to safety-net hospitals.

Study Population: The study population will be patients served by CHA and the 14 safety-net hospitals eligible for safety net payments. CHA has among the highest concentration of patients participating in MassHealth programs of any acute hospital in

the Commonwealth. The study population will also include a purposeful sample of key informants at select hospitals.

Data Analysis: A data set will be created to capture and track hospital performance measures annually throughout the demonstration period. These data will support high-level analysis of the degree to which hospitals participating in PHTII and hospitals eligible for safety net payments meet performance goals related to care quality and cost, and to ACO participation.

Waiver Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services.

Research Question 5:
What is the impact of expanding MassHealth coverage to include residential services and recovery support services on care quality and outcomes for members with substance use disorders (SUD)?

- Hypothesis 5a: Expanding coverage to include residential services and recovery support services will result in improved care quality and outcomes for patients with SUD.
- Hypothesis 5b: Expanding coverage to include residential services and recovery support services will result in reduced care costs for patients with SUD.
- Hypothesis 5c: Expanding coverage to include residential services and recovery support services will result in reduced Opioid drug overdoses.

Evaluation Approach for Goal 5

Study Design:
Hypothesis 5a:
- Trends in care quality and outcomes for patients with SUD will be examined, including who is, and who is not receiving needed services.

Hypothesis 5b:
- Trends will be examined in total costs of care for patients with SUD.

Hypothesis 5c:
- Trends in numbers of opioid overdoses will be examined.

Substance use disorder (SUD) services are offered by the Department of Public Health's Bureau of Substance Abuse Services (BSAS) and by MassHealth. Before the demonstration's approval, MassHealth services were limited to outpatient counseling, methadone treatment, short-term detoxification services, and short-term residential services. To improve state-wide capacity and respond to the opioid crisis, the demonstration will expand SUD treatment in the Commonwealth by adding Medicaid coverage for 24-hour community-based rehabilitation though high-intensity Residential Services, transitional support services (including recovery coaches and navigators), and Residential Rehabilitation. With the exception of recovery coaching services (which are limited to MassHealth members in an MCO or ACO), all MassHealth members except

those in MassHealth Limited are eligible for expanded substance use disorder services as part of the waiver. A primary aim of these new services is to divert SUD patients from inpatient mental health and substance use disorders services to community-based environments.

Data Needed for Evaluation: Data for this evaluation will include: 1) MassHealth enrollment and claims/encounter data for all MassHealth members under the age of 65 and the Department of Public Health's Chapter 55 data.

Outcome Measures: Outcome measures will include cost and utilization, quality and patient outcomes. Costs and utilization will be examined, including TCOC and within categories, such as, inpatient, residential rehabilitation, coaching, etc. Care quality measures will include initiation and engagement in SUD treatment; medication assistance treatment (MA) use; avoidable ED use and inpatient hospitalizations. Care outcomes will include rates of long-term recovery and both fatal and non-fatal overdoses, as well as a subset of National Outcome Measures, to look for decreases in criminal justice involvement and increases in stable housing.

Study Population: MassHealth members with substance use disorders (alcohol or other drugs).

Data Analysis Plans: Broadly, the same analytic strategies described for the Goal 2 aims will be applied. There will be an examination of changes in the total size of the population with identified SUD, and its characteristics, and trends in the tracked measures, both with and without risk adjustment.

Waiver 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~~MassHealth covered services with commercial health insurance (where appropriate), and~~ refinement of provisional eligibility, adoption of widely-used commercial tools for prescription drugs, and changes to cost sharing requirements for higher income members.

Research Question 6:
What is the impact of the waiver's alignment of coverage for non-disabled adults with commercial plans~~MassHealth covered services with commercial health insurance, and~~ refinement of provisional eligibility,the use of widely used commercial tools for prescription drugs, and changes to cost sharing requirements for higher income members?

- Hypothesis 6A: The ~~waiver's changes to align MassHealth covered services with commercial health insurance (where appropriate)~~ alignment of coverage for non-disabled adults with commercial plans, adoption of widely-used commercial tools for prescription drugs and the waiver of federal cost sharing limits of 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 refinement of provisional eligibility will result in increased program integrity as it would eliminate provisional Medicaid coverage for individuals who are not financially eligible.

- Hypothesis 6C: 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.

Evaluation approach for Goal 6

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 change in the percentage of individuals who receive provisional eligibility but are later disenrolled due to unverified income during the waiver period (after the proposals are implemented) will be compared to the trends in these percentages prior to the waiver period.

In order to evaluate Hypothesis 6C, the evaluator will compare the 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.

Summary of data needed for the waiver evaluation: Data needed for evaluating specific hypotheses are linked to the waiver goals, research questions, hypotheses and evaluation plans as described above. In summary, the evaluation plan will require:

- Medicaid enrollment, encounters and claims data for the entire under 65 population for a minimum of two years prior to the start of the demonstration through 2022.
- Cost data related to managed care payments and related cost reports
- Exact specifications of the algorithms used to calculate the standardized ACO measure slate and a person-level data file indicating who is eligible for each measure and the outcome on that measure for that person, and similar data for the CPs.
- Data from patient surveys.
- Access to the exact requirements for network adequacy specified in contracts between MH and the managed care entities.
- The PHTII and safety-net hospital data used to calculate eligibility for these facilities' at-risk payments.
- State cost reports, and supplemental payments to safety-net hospitals.
- MeHI data on EHR adoption and HIway connection rates.
- Access to ACO and CP sites to conduct key informant interviews.

Assurances needed to obtain data: Data for this evaluation will be based on existing data sources where available. However, most of the needed information is Medicaid program-related administrative, clinical, management, and program-specific data that will need to be provided to the independent evaluator. It is anticipated that the Independent Evaluator will function as a Business Associate of the Executive Office of Health and Human Services and thus be provided with the necessary data to complete the activities outlined in the evaluation plan. As such, the Business Associate will comply with all the requirements of the HIPAA Rules applicable to a Business Associate as well as specific requirements included in data use agreements.

Timeline: (see Attachment B: MassHealth 1115 Waiver Evaluation Timeline Linked to Key Milestones and DSRIP Program)

As specified in the STC, a draft Interim Evaluation Report will be submitted to CMS one year prior to this renewal period ending June 30. 2022. A preliminary draft of the Summative Evaluation Report (SER) for the demonstration period starting July 1, 2017 through June 30, 2022 will be submitted 180 days before the end of the demonstration, and a final SER will be submitted for CMS review within 500 calendar days of the end of the demonstration period. The DSRIP evaluation design will be submitted to CMS by

June 30, 2018 and the DSRIP Interim Report by June 30, 2020 consistent with STC and DSRIP protocol.

Massachusetts agrees to post the final approved Evaluation Design, Interim Evaluation Report and Summative Evaluation report on the Commonwealth's website within 30 days of approval by CMS.

Process to Select Evaluator:

MassHealth intends to select the University of Massachusetts Medical School (UMMS) as its independent evaluator for the overall 1115 waiver. MassHealth is explicitly authorized to enter into Interdepartmental Services Agreements (ISAs) with UMMS for the purpose of obtaining, among other things, consulting services related to quality assurance and program evaluation and development for the MassHealth program. See e.g. Chapter 133 of the Acts of 2016, line item 4000-0321.

Furthermore, no competitive procurement is required for ISAs. ISAs are explicitly exempt from Massachusetts state procurement regulations that otherwise require competitive procurements. Instead, ISAs are governed by 815 CMR 6.00, which requires state agencies to use good business practices to determine whether entering into an ISA provides the best value to the Commonwealth. No competitive procurement is required for the state agency to reach the conclusion that another state agency provides best value.

We may consider a procurement for the DSRIP evaluator.

Attachments:

- Attachment A: Proposed Measure Tables (updated 9-8-17)
- Attachment B: MassHealth 1115 Waiver Evaluation Timeline Linked to Key Milestones and DSRIP Program

Attachment A: Proposed Measure Tables

ACO Measure Slate

Anticipated ACO Quality Measure Slate

#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
	Prevention & Wellness											
1	Well child visits in first 15 months of life	The percentage of ACO attributed members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	H	NCQA – Health Plan	1392	NCQA Quality Compass	Yearly	R	P	P	P	P
2	Well child visits 3-6 yrs	The percentage of ACO attributed members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	H	NCQA – Health Plan	1516	NCQA Quality Compass	Yearly	R	P	P	P	P
3	Adolescent well-care visit	The percentage of ACO attributed members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	H	NCQA – Health Plan	N/A	NCQA Quality Compass	Yearly	R	P	P	P	P
4	Weight Assessment / Nutrition Counseling and Physical Activity for Children/Adolescents	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: -BMI Percentile Documentation -Counseling for Nutrition -Counseling for Physical Activity.	H	NCQA - Health Plan	24	NCQA Quality Compass	Yearly	R	P	P	P	P
5	Prenatal Care	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these ACO attributed members, the measure assesses the following facets of prenatal and postpartum care. -Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as an ACO attributed woman in the first trimester, on the attribution start date or within 42 days of ACO attribution. -Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
6	Postpartum Care		H	NCQA – Health Plan	1517	NCQA Quality Compass	Yearly	R	P	P	P	P
7	Oral Evaluation, Dental Services	Percentage of ACO attributed members under age 21 who received a comprehensive or periodic oral evaluation as a dental service within the measurement year.	C	American Dental Association on behalf of the Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
8	Tobacco Use: Screening and Cessation Intervention	The percentage of ACO attributed members, ages 18 – 64, who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	H	American Medical Association on behalf of the Physician Consortium for Performance Improvement® - Medical Specialty Society	28	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

9	Adult BMI Assessment	The percentage of ACO attributed members 18-64 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	H	NCQA – Health Plan	23	NCQA Quality Compass	Yearly	R	P	P	P	P
10	Immunization for Adolescents	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	H	NCQA – Health Plan	1407	NCQA Quality Compass	Yearly	R	P	P	P	P
	Chronic Disease Management											
11	Controlling High Blood Pressure	The percentage of ACO attributed members 18-64 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: -ACO attributed members 18–59 years of age whose BP was <140/90 mm Hg -ACO attributed members 60–64 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg -ACO attributed members 60–64 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg	H	NCQA – Health Plan	18	NCQA Quality Compass	Yearly	R	P	P	P	P
12	COPD or Asthma Admission Rate in Older Adults	Risk-adjusted ratio of observed to expected hospital admissions with principal diagnosis code for COPD or asthma, for adults ages 40-64, during the measurement period.	C	AHRQ	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
13	Asthma Medication Ratio	The percentage of ACO attributed members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA – Health Plan	1800	NCQA Quality Compass	Yearly	R	P	P	P	P
14	Comprehensive Diabetes Care: A1c Poor Control	The percentage of ACO attributed members 18–64 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	H	NCQA – Health Plan	59	NCQA Quality Compass	Yearly	R	P	P	P	P
15	Diabetes Short-Term Complications Admission Rate	Risk-adjusted ratio of observed to expected admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma), for adults ages 18-64, during the measurement period.	C	AHRQ	272	EOHHS benchmarks derived from baseline data	Yearly	R	P	P	P	P

	Behavioral Health / Substance Abuse											
16	Developmental Screening for behavioral health needs: Under Age 21	The percentage of well child visits among MH ACO attributed members ages 0-20 that included a screening for behavioral health needs using an age appropriate EOHHS approved developmental screen.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
17	Screening for clinical depression and documentation of follow-up plan: Age 12+	The Percentage of patients aged 12 - 64 years of age screened for clinical depression at least once using an age appropriate standardized depression screening tool on the date of an eligible encounter AND if positive, a follow-up plan is documented on the date of the positive screen.	H	CMS	418	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
18	Depression Remission Measure Set	The percentage of members 12-64 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. -Follow-Up PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score. -Depression Remission. The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score. -Depression Response. The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.	H	Minnesota Community Measurement (also adapted by CMS and NCQA)	710	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
19	Initiation and Engagement of AOD Treatment (Initiation)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. -Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	C	NCQA – Health Plan	4	NCQA Quality Compass	Yearly	R	P	P	P	P
20	Initiation and Engagement of AOD Treatment (Engagement)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. -Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	C	NCQA – Health Plan	4	NCQA Quality Compass	Yearly	R	P	P	P	P
21	Follow-Up After Hospitalization for Mental Illness (7-day)	The percentage of discharges for members 6-64 years of age who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: -The percentage of discharges for which the member received follow-up within 30 days of discharge. -The percentage of discharges for which the member received follow-up within 7 days of discharge.	C	NCQA – Health Plan	576	NCQA Quality Compass	Yearly	R	P	P	P	P

22	Follow-up care for children prescribed ADHD medication - Initiation Phase	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. -Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.	C	NCQA – Health Plan	108	NCQA Quality Compass	Yearly	R	P	P	P	P
23	Follow-up care for children prescribed ADHD medication - Continuation Phase	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. -Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	C	NCQA – Health Plan	108	NCQA Quality Compass	Yearly	R	P	P	P	P
24	Opioid Addiction Counseling	The percentage of ACO attributed members, ages 18-64, with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction within the 12 month reporting period.	C	AMA	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
	Long Term Services and Supports											
25	Assessment for LTSS	The percentage of MH ACO attributed members, ages 3-64, who were assigned to a LTSS CP on or between October 3 of the year prior to the measurement year and October 2 of the measurement year with documentation of an approved EOHHS Comprehensive Assessment within 90 days of assignment.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P

	Integration											
26	Utilization of Behavioral Health Community Partner Care Coordination Services	The Percentage of MH ACO attributed members, 18-64, who were assigned to a BH CP on or between October 3rd of the year prior to the measurement year and October 2nd of the measurement year, who had at least one BH CP support within 90 days of the assignment date.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
27	Utilization of Outpatient BH Services	The percentage of MH ACO-attributed members, ages 4-64, at risk for SMI/SED and/or SUD that utilized outpatient BH services during the measurement period.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
28	Hospital Admissions for SMI/SUD Population	Rate of hospital admissions for treatment of selected mental illness or substance abuse disorder among ACO attributed members, 4-64 years of age, at risk for SMI/SED and/or SUD.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
29	Emergency Department Utilization for SMI/SUD Population	Risk-adjusted ratio of observed to expected ED visits during the measurement period, for ACO attributed members, 4-64 years of age, at risk for SMI/SED and/or SUD for treatment of a selected mental illness or substance use disorder (as identified by primary diagnosis).	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
30	Follow-Up After Emergency Department Visit for Mental Illness	The percentage of emergency department (ED) visits for members 6 - 64 years of age with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: -The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. -The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.	C	NCQA – Health Plan	2605	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
31	Utilization of LTSS Community Partners	The Percentage of MH ACO attributed members, 3-64, who were assigned to a LTSS CP on or between October 3rd of the year prior to the measurement year and October 2nd of the measurement year, and who received at least 1 LTSS CP support service within 90 days of the assignment date.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
32	All Cause Readmission among LTSS CP eligible	Risk-adjusted ratio of observed to expected ACO attributed LTSS CP eligible members ages 4 - 64 who were hospitalized and subsequently readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P

32	All Cause Readmission among LTSS CP eligible	Risk-adjusted ratio of observed to expected ACO attributed LTSS CP eligible members ages 4 - 64 who were hospitalized and subsequently readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
33	Social Service Screening	The percentage of ACO attributed members, age 0- 64, who were screened for health-related social needs in the measurement year.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
34	Utilization of Flexible Services	Percentage of MH ACO attributed members, 0-64, who received a flexible services support referral from their care team on or between October 3rd of the year prior to the measurement year and October 2nd of the measurement year that received flexible services support within 90 days of the referral.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
35	Care Plan Collaboration Across PC, BH, LTSS, and SS, Providers		H		N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
36	Community Tenure	For members, ages 3-64, assigned to either a BH CP or an LTSS CP, the percentage of eligible days that these members are residing in their home or in a community setting without utilizing acute or post-acute inpatient services.	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
	Avoidable Utilization											
37	Potentially Preventable Admissions	A risk-adjusted ratio of actual to expected rates of potentially preventable admissions or hospitalizations for conditions identified as ambulatory care sensitive (ACS). The actual-to-expected PPVA rate is the Actual Rate/Expected Rate.	C	3M	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	P	P	P	P
38	All Condition Readmission	Risk-adjusted ratio of observed to expected ACO attributed members up to age 65 who were hospitalized and subsequently readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	CMS*	1789*	EOHHS benchmarks derived from baseline data	Yearly	R	P	P	P	P
39	Potentially Preventable Emergency Department Visits	A risk-adjusted ratio of actual to expected rates of potentially preventable Emergency Department Visits for conditions identified as ambulatory care sensitive (ACS). The actual-to-expected PPV rate is the Actual Rate/Expected Rate.	C	3M	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	R	R
Member Experience			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P

* CMS specifications as documented in NQF #1789 will be utilized with changes to the age range (up to age 64 rather than 65 and above) and the insured population (Medicaid rather than Medicare)

BH CP Quality Measure Slate. ***Measures will be calculated for BH CP Engaged Enrollees, unless otherwise specified***

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Prenatal Care	Timeliness of Prenatal Care: The percentage of deliveries of live births to CP Engaged Enrollees between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of assignment to the BH CP.	C	NCQA	1517	NCQA Quality Compass	Yearly	R	R	P	P	P
2	Annual primary care visit	Percent of CP Engaged Enrollee who had an annual primary care visit in the last 15 months	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
II. Chronic Disease Management												
3	COPD or Asthma Admission Rate in Older Adults	All discharges with a principal diagnosis code for COPD or asthma in adults ages 40 years and older, for CP Engaged Enrollees with COPD or asthma, with risk-adjusted comparison of observed discharges to expected discharges for each ACO.	C	CMS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
4	Asthma Medication Ratio	The percentage of CP Engaged Enrollees who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	C	NCQA	1800	NCQA Quality Compass	Yearly	R	R	P	P	P
5	Diabetes Short-Term Complications Admission Rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 CP Engaged Enrollee months ages 18 to 64. Excludes obstetric admissions and transfers from other institutions.	C	CMS	272	NCQA Quality Compass	Yearly	R	R	R	P	P
III. Behavioral Health / Substance Use Disorder												
6	Initiation and Engagement of AOD Treatment (Initiation)	The percentage of CP Engaged Enrollees with a new episode of AOD who received the following: Initiation of AOD Treatment	C	NCQA	4	NCQA Quality Compass	Yearly	R	R	P	P	P
7	Initiation and Engagement of AOD Treatment (Engagement)	The percentage of CP Engaged Enrollees with a new episode of AOD who received the following: Engagement of AOD Treatment	C	NCQA	4	NCQA Quality Compass	Yearly	R	R	P	P	P
8	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for CP Engaged Enrollees who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576	NCQA Quality Compass	Yearly	R	R	P	P	P
9	Follow-up After Hospitalization for Mental Illness (3-day) by BH CP	Percentage of discharges for CP Engaged Enrollees who were hospitalized for treatment of selected mental illness diagnoses and who had a face-to-face encounter with a BH CP within 3 days of discharge	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
IV. Member Experience												
A. Access			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Participation in Care Planning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Quality and Appropriateness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
E. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
F. Social Connectedness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
G. Self Determination			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
H. Functioning			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
Self Reported Outcomes			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
J. General Satisfaction			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
V. Integration												
11	Social Service Screening	Percentage of CP Engaged Enrollees who were screened for social service needs	H	EOHHS	N/A		Yearly	R	R	R	P	P
12	Utilization of Flexible Services	Percentage of CP Engaged Enrollees recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	R	P	P
13	Utilization of Outpatient BH Services	Percentage of CP Engaged Enrollees that have utilized outpatient BH services during the measurement period	C	EOHHS	N/A		Yearly	R	R	R	P	P
VI. Avoidable Utilization												
14	All Condition Readmission	Risk-adjusted ratio of observed to expected CP Engaged Enrollees who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
15	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for CP Engaged Enrollees ages 18 to 64 per 1,000 member months.	C	3M	N/A		Yearly	R	R	R	P	P
VII. Engagement												
16	BH Comprehensive Assessment /Care Plan in 90 Days	Percentage of CP Assigned Enrollees with documentation of a comprehensive assessment and approval of a care plan by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to BH CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
17	Rate of Care Plan Completion	Percentage of CP Assigned Enrollees who had a completed care plan during the measurement period	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P

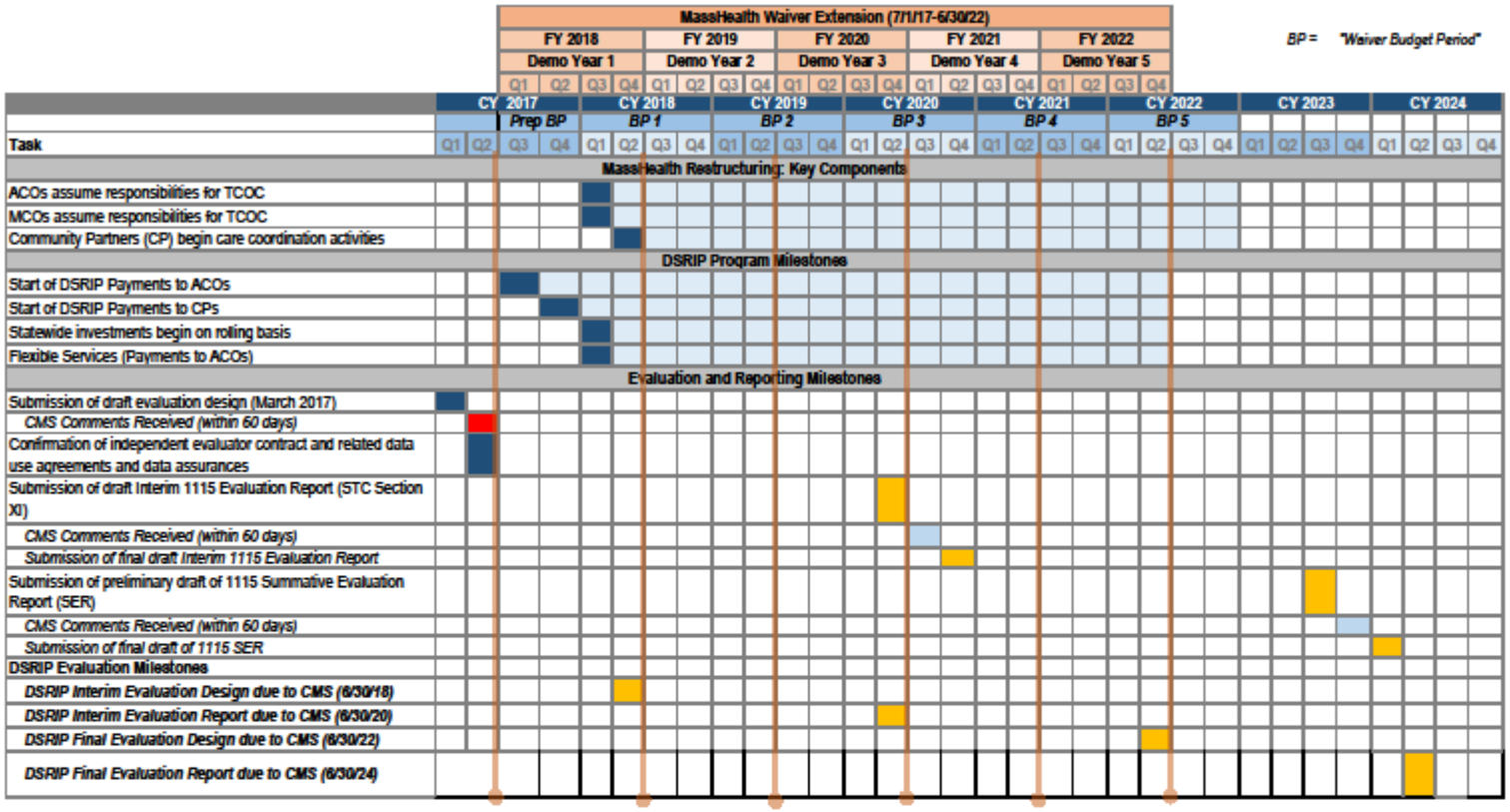
LTSS CP Quality Measure Slate. ***Measures will be calculated for LTSS CP Engaged Enrollees, unless otherwise specified***

#	Measure	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Well child visits 3-6 yrs	Percentage of CP Engaged Enrollees 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	C	NCQA	1516	NCQA Quality Compass	Yearly	R	R	P	P	P
2	Adolescent well-care visit	Percentage of CP Engaged Enrollees 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A	NCQA Quality Compass	Yearly	R	R	P	P	P
3	Oral Evaluation, Dental Services	Percentage of CP Engaged Enrollees under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
II. Member Experience												
A. Service Delivery			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
B. Health and Wellness			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
C. Choice and Control/Consumer Voice			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
D. Effectiveness/Quality of Care			Survey	TBD	N/A	TBD	Yearly	R	R	P	P	P
III. Integration												
5	Utilization of Flexible Services	Percentage of CP Engaged Enrollees recommended by their care team to receive flexible services support that received flexible services support	H	EOHHS	N/A		Yearly	R	R	R	P	P
6	Social Service Screening	Percentage of CP Engaged Enrollees who were screened for social service needs	H	EOHHS	N/A		Yearly	R	R	R	P	P
7	Annual primary care visit	Percent of CP Engaged Enrollees who had an annual primary care visit in the last 15 months	C	EOHHS	N/A		Yearly	R	R	R	P	P
IV. Avoidable Utilization												
8	All Cause Readmission	Risk-adjusted ratio of observed to expected CP Engaged Enrollees who were hospitalized and who were subsequently hospitalized and readmitted to a hospital within 30 days following discharge from the hospital for the index admission.	C	NQF	1789	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
9	Potentially Preventable ED Visits	Risk-adjusted ratio of observed to expected emergency department visits for CP Engaged Enrollees ages 18 to 64 per 1,000 member months.	C	3M	N/A		Yearly	R	R	R	P	P
V. Engagement												
10	LTSS Care Plan in 90 days	Percentage of CP Assigned Enrollees with documentation of a LTSS care plan that is approved by primary care clinician or designee and member (or legal authorized representative, as appropriate) within 90 days of assignment to LTSS CP.	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P
11	Rate of Care Plan Completion	Percentage of CP Assigned Enrollees who had a completed care plan during the measurement period	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	R	P	P

CSA Quality Measure Slate

#	Measures	Description	Claims/Encounters Only (C) Or Chart Review (H)	Measure Steward	NQF #	Benchmarking Source	Reporting Frequency	Pay-for-Performance Phase In R = Reporting, P = Pay-for-Performance,				
								PY1 (CY2018)	PY2 (CY2019)	PY3 (CY2020)	PY4 (CY2021)	PY5 (CY2022)
I. Prevention & Wellness												
1	Well child visits 3-6 yrs	Percentage of CSA members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement period.	C	NCQA	1516	NCQA Quality Compass	Yearly	R	R	P	P	P
2	Adolescent well-care visit	Percentage of CSA members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics and gynecology (OB/GYN) practitioner during the measurement period.	C	NCQA	N/A	NCQA Quality Compass	Yearly	R	R	P	P	P
3	Oral Evaluation, Dental Services	Percentage of CSA members under age 21 years who received a comprehensive or periodic oral evaluation as a dental service within the measurement period.	C	Dental Quality Alliance	2517	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
II. Behavioral Health												
4	Follow-Up After Hospitalization for Mental Illness (7-day)	Percentage of discharges for CSA members ages 6 to 64 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.	C	NCQA	576	NCQA Quality Compass	Yearly	R	R	P	P	P
III. Member Experience: Wraparound Fidelity Index Short Form (WFI-EZ) - Caregiver Form												
A. Your Experiences around Wraparound			Form	TBD	N/A			R	R	P	P	P
B. Satisfaction			Form	TBD	N/A			R	R	P	P	P
C. Outcomes			Form	TBD	N/A			R	R	P	P	P
IV. Avoidable Utilization												
6	Hospital Admissions for SMI/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI and/or SUD who were hospitalized for treatment of selected mental illness diagnoses or substance use disorder (regardless of primary or secondary diagnosis)	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
7	Emergency Department Utilization for SMI/SUD Population	Risk-adjusted percentage of CSA members with a diagnosis of SMI and/or SUD who utilized the emergency department for a selected mental illness or substance use disorder that is either the primary or secondary diagnosis	C	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P
V. Engagement												
8	CSA Comprehensive Care Plan in 90 Days	Percentage of CSA members with documentation of a care plan and approval of care plan by primary care clinician or designee and member or legal authorized representative as appropriate . Expected attainment = 70% or above	H	EOHHS	N/A	EOHHS benchmarks derived from baseline data	Yearly	R	R	P	P	P

Attachment B: MassHealth 1115 Waiver Evaluation Timeline Linked to Key Milestones and DSRIP Program



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