



*The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place
Boston, MA 02108*



DEVAL L. PATRICK
Governor

JOHN W. POLANOWICZ
Secretary

KRISTIN L. THORN
Acting Medicaid Director

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave, S.W., Room 314G
Washington D.C., 20201

September 30, 2013

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

Dear Administrator Tavenner:

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 extend the Massachusetts Section 1115 Demonstration Project (11-W-00030/1).

Since 1997, the Demonstration has enabled Massachusetts to implement new and innovative programs to provide high quality care for its residents. The Demonstration has since proven to be integral to the goals of health care reform for nearly two decades.

Massachusetts led the nation with Chapter 58 of the Acts of 2006, through which the state set itself on the path to providing access to affordable health care for all residents of the Commonwealth. Within a few years, the state demonstrated its ability to achieve near universal health care coverage. We are proud that Massachusetts' overall rate of insurance remains at 97 percent – the highest of any state in the nation – despite the challenges of the recent recession. MassHealth played a critical role in this process through expansions of the Medicaid program and the creation of the Safety Net Care Pool, which supported access to health insurance for many of the uninsured through the Commonwealth Care program and provided valuable support to safety net providers. These providers have been essential partners in making the expansion of health coverage successful by helping people enroll in the new health insurance programs and caring for thousands of the newly insured.

After the initial achievements of the 2006 legislation, the Commonwealth put the second phase of health reform into action. Chapter 224 of the Acts of 2012 serves as the next step in true reform of the health care system by enacting cost containment measures, promoting improvements in quality and health outcomes, and increasing transparency in the health care marketplace. The legislation sets ambitious goals for Massachusetts and

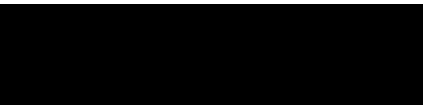
MassHealth. A major provision requires MassHealth to continue to shift away from the traditional fee-for-service model towards alternative payment methodologies. This requirement presents an opportunity for MassHealth to bolster the sustainability of the Medicaid program and the broader health system by maintaining high-quality care, testing innovative models of care delivery, and reining in the rate of cost growth.

At the same time, Massachusetts is in the final stages of preparing to implement major elements of the national health care reform law, known as the Affordable Care Act (ACA). The ACA will further expand access to health insurance; strengthen consumer protections; and support innovation, efficiency, and long-term affordability in the health care system. Putting the ACA into action continues to be a major undertaking, with significant efforts underway across state government and throughout the health care sector.

As we tackle these challenges, it is an opportune time to renew the 1115 Demonstration. In the enclosed request we propose to extend the Demonstration for a five-year term. In order to show continued improvements, the state seeks time and stability to make longer-term investments in order to realize the full potential of the initiatives supported by the Demonstration. Massachusetts continues to pursue the goals of maintaining near-universal health care coverage; redirecting spending from uncompensated care to insurance coverage; enacting delivery system reforms that promote patient-centered care and improved health outcomes; and advancing alternative payment methodologies to plans and providers that reward quality and reduce costs. These goals are challenging, but we believe they are achievable and will yield meaningful results for the residents of the Commonwealth.

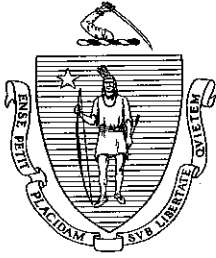
The state appreciates the support that CMS has provided for the Demonstration since 1997, and we look forward to discussing the proposed extension request with you and your staff in more detail. The achievements of these innovative programs would not have been possible without the guidance and support of CMS. The Commonwealth continues to value its partnership with CMS in our united efforts to transform the health care system and to improve the lives of Massachusetts residents.

Sincerely,

A large black rectangular redaction box covers the signature area.

John Polanowicz
Secretary, Executive Office of Health and Human Services

cc: Cindy Mann
Rich McGreal
Julie McCarthy
Juliana Sharp
Erica Colbert



OFFICE OF THE GOVERNOR
COMMONWEALTH OF MASSACHUSETTS
STATE HOUSE • BOSTON, MA 02133
(617) 725-4000

DEVAL L. PATRICK
GOVERNOR

January 27, 2014

Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington D.C., 20201

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

Dear Secretary Sebelius:

In my capacity as Governor of the Commonwealth of Massachusetts, I am re-submitting to the Centers for Medicare and Medicaid Services (CMS) a request to extend the Massachusetts Section 1115 Demonstration Project (11-W-00030/1). Based on the feedback provided, we have made the appropriate adjustments to our renewal request. The specific elements we have included are:

- A thorough summary of the Commonwealth's public noticing process, which complies with 42 C.F.R. §431.412(c)(2)(vii) and 42 C.F.R. §431.408(a)(3);
- Additional detail regarding new and continued waiver authorities the Commonwealth is requesting, and;
- An appendix which describes our research hypotheses for each proposed waiver initiative.

Kathleen Sebelius, Secretary
January 27, 2014
Page Two

I look forward to working with you in the coming months as we aim to strengthen and transform the health care system while we serve the residents of Massachusetts.

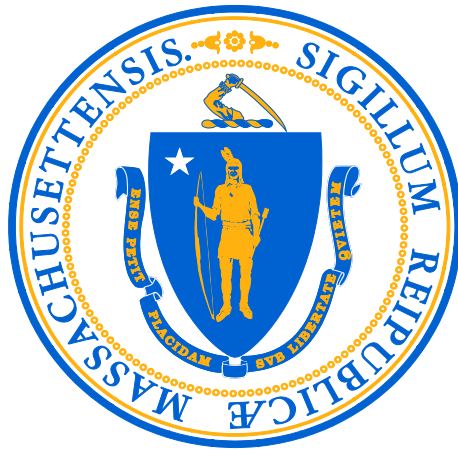
Sincerely,



cc: John Polanowicz, Massachusetts Secretary of Health and Human Services
Kristin Thorn, Massachusetts Medicaid Director
Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services
Cindy Mann, Deputy Administrator/Director, Centers for Medicaid and CHIP Services
Dianne T. Gerrits, Director, Division of State Demonstration and Waivers
Richard McGreal, Associate Regional Administrator, Centers for Medicare and Medicaid Services

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

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



September 30, 2013

Updated January 28, 2014

Table of Contents

- Executive Summary..... 1
- Section 1 MassHealth’s Role in Massachusetts’ Evolving Health Care System 5
- Section 2 Massachusetts’ Successes 8
 - Coverage..... 8
 - Reducing Barriers to Coverage 10
 - Managed Care..... 11
 - Redirecting Uncompensated Care Spending 11
 - Continued Support for Reform 12
 - Demonstration Evaluation..... 13
 - Monitoring Quality and Access to Care 14
- Section 3 Moving Massachusetts’ Health Care Reform into the ACA Framework 15
- Section 4 Chapter 224: Improving Quality & Containing Costs in the Massachusetts Health Care System..... 18
 - Cost Growth Targets..... 19
 - Alternative Payment Methodologies..... 19
 - Delivery System Transformation 20
 - Resources for Community-based Public Health and Health Care Delivery System..... 21
 - Transparency and Health Information Technology 21
 - Moving Health Reform Forward 22
- Section 5 Requested Changes to the Demonstration 22
 - A Five-Year Renewal Period and the One Care Integrated Care Model 23
 - Advancing Alternative Payment Models 24
 - Pediatric Asthma Pilot Program..... 27
 - Safety Net Care Pool..... 29
 - Express Lane Renewal..... 39
 - Medicare Cost Sharing Assistance 40
 - Early Intervention / Applied Behavioral Analysis for Autism..... 41
- Section 6 Public Notice and Comment Process 41
- Section 7 Budget Neutrality 45
 - Budget Neutrality Methodology..... 45
 - Budget Neutrality Impact 46
- Section 8 Conclusion 47

Appendices:

Appendix A: List of Frequently Used Abbreviations

Appendix B: Interim Evaluation of the Demonstration

Appendix C: Requested Safety Net Care Pool Funding

Appendix D: Budget Neutrality Worksheets

Appendix E: Public Notice Materials

Appendix F: Summary of Proposed Demonstration Changes

Executive Summary

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

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

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

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

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

Moving the Demonstration into the Affordable Care Act Framework. With the implementation of the federal Affordable Care Act (ACA), some MassHealth programs will continue, some will end, and others will be introduced. With the recent Waiver amendment, approved on September 30, 2013, the

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

Demonstration's goals and objectives now fully align with the ACA. Eligibility for subsidized coverage will be simplified and Massachusetts' coverage structure will align more closely with the national vision for insurance affordability programs. Implementation of the ACA will also expand the availability of subsidized coverage to new groups in Massachusetts.

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

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

Requested Changes to the Demonstration

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

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

Advancing Alternative Payment Models

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

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

2. Pursuing a future Accountable Care Organization initiative

The authority to engage in shared savings and shared risk payment arrangements with providers will establish the foundation for the Commonwealth to fully implement alternative payment arrangements, such as a future Accountable Care Organization (ACO) model to be implemented across MassHealth's managed care programs. With the Primary Care Payment Reform Initiative as its foundation, MassHealth's future ACO model would: shifting the contracting entity from a Primary Care Clinician (PCC) to an ACO; adjusting the payment model to encourage providers to take on higher levels of risk; and modifying quality metrics and delivery model requirements to extend beyond a medical home to a "medical neighborhood."

Pediatric Asthma Pilot Program

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

Safety Net Care Pool

The Commonwealth requests the following authorities for the SNCP:

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

Express Lane Renewal

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

Medicare Cost Sharing Assistance

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

Early Intervention / Applied Behavioral Analysis for Autism

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

Budget Neutrality

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

Public Notice and Comment Period

The public process that the Commonwealth implemented prior to submitting this Request conforms with the transparency and public notice requirements outlined in 42 CFR § 431.400 et seq., and the requirements of Standard Terms and Conditions 14, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements as outlined in the Massachusetts' approved state plan. The Commonwealth remains committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

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

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

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

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

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

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

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

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

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

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

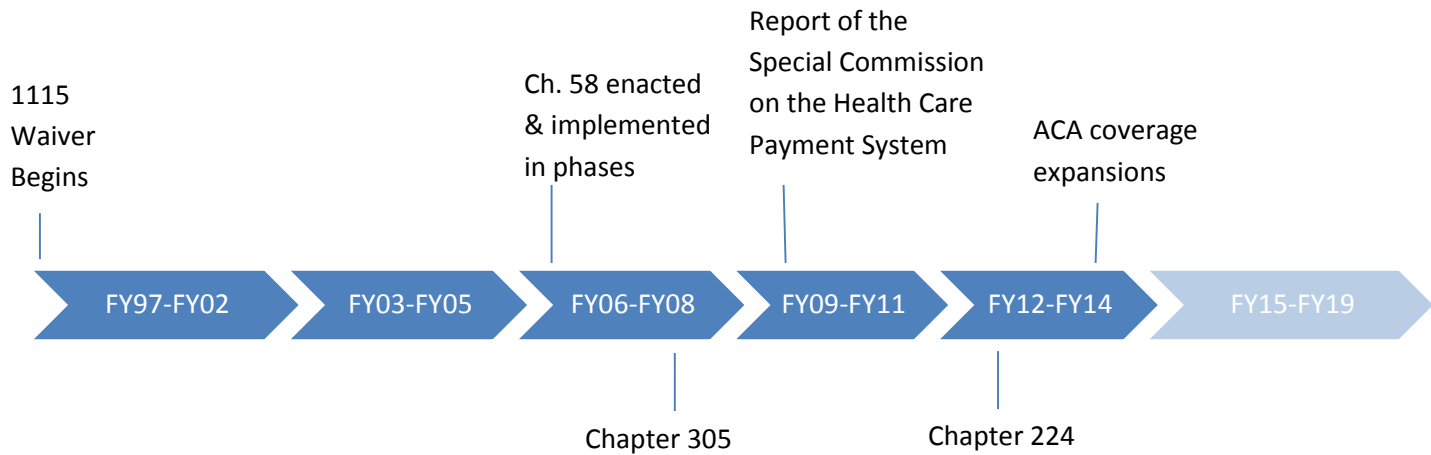
³ Massachusetts Health Care Quality and Cost Council. "Roadmap to Cost Containment: Massachusetts Health Care Quality and Cost Council Final Report." October 2009. <http://archives.lib.state.ma.us/handle/2452/46756>, accessed August 9, 2013.

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

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

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

Figure 1



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

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

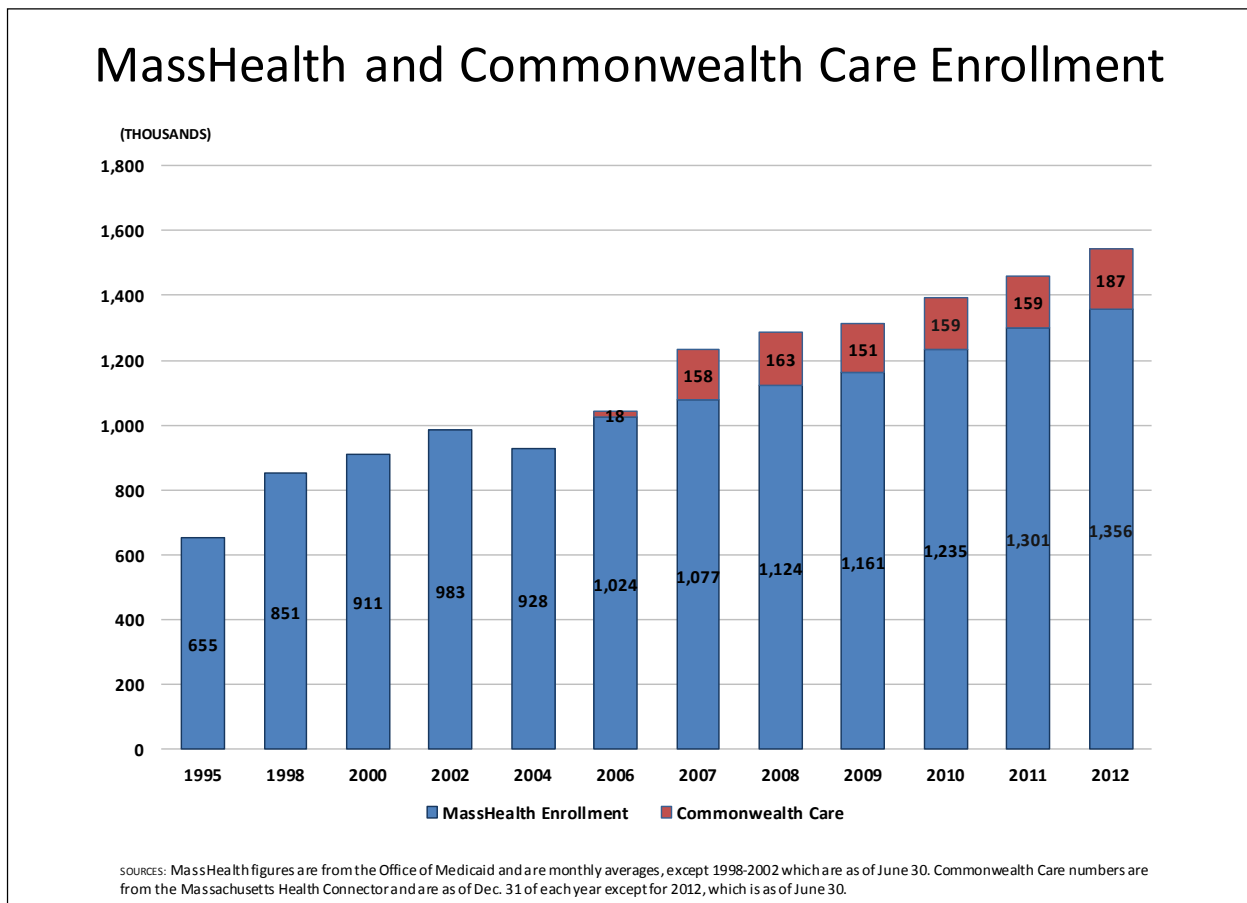
Section 2 Massachusetts' Successes

Coverage

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

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

Figure 2



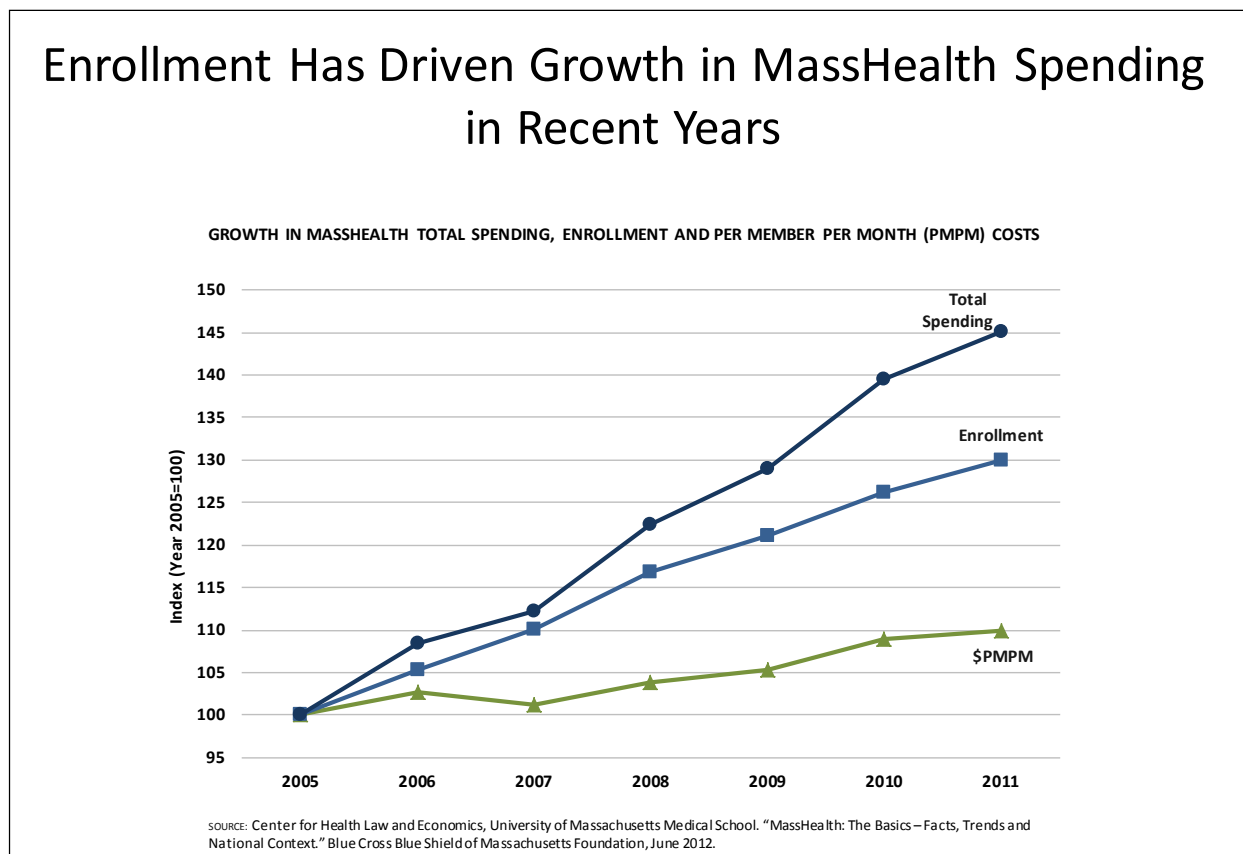
Some of the MassHealth enrollment increase in the last several years is a reflection of Medicaid's traditional safety net role, as recession-driven unemployment led to a reduction in coverage through employer-sponsored insurance across the state (though the number of employers offering coverage did not decline, remaining higher than the national average). The annual Massachusetts Health Insurance Survey shows the overall uninsured rate declining to 1.9 percent of the population in 2010, rising slightly to 3.1 percent in 2011, though this uptick is not statistically significant. In 2011, the most recent year for which data are available, 1.2 percent of children and 3.7 percent of non-elderly adults were without insurance.⁶ To compare with national statistics, the Current Population Survey measured the Massachusetts uninsured rate at 3.8 percent in 2011-12, the lowest rate by far of any state and a fraction of the national rate of 15.6 percent.⁷ Whatever the source, Massachusetts has clearly made significant gains in its goal of greatly expanding insurance coverage.

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

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

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

Figure 3



Reducing Barriers to Coverage

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

- *Administrative review* – automatic eligibility renewal, based on a match with current program data, for members whose circumstances are unlikely to change from year to year (such as elders living in nursing facilities). Members meet the criteria if they have Social Security as their sole source of income and also have Medicare coverage.
- *Express lane renewal* – renewal process completed through a data match with the Supplemental Nutrition Assistance Program (SNAP) for families enrolled in that program. Children in SNAP are eligible for this process by authority of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA); Massachusetts included the parents and caretaker relatives of those children as part of the latest Demonstration extension.

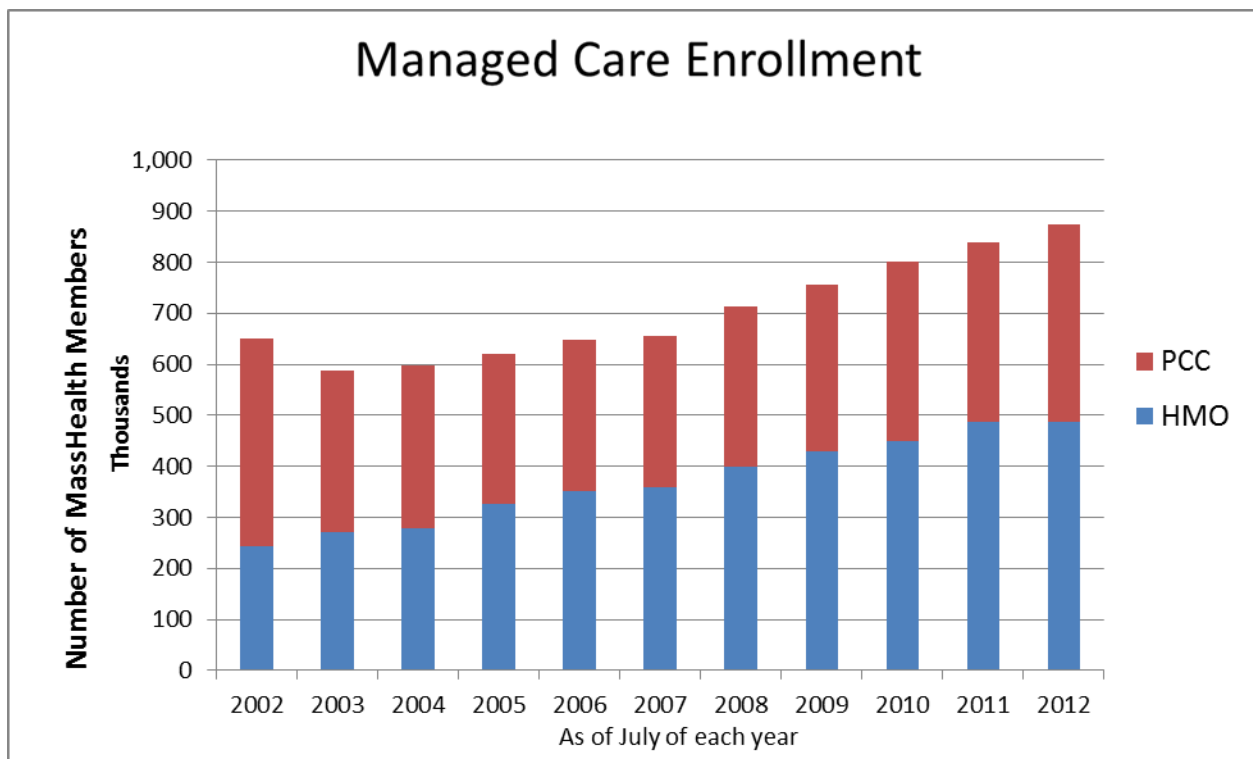
⁸ Robert Seifert and Amanda Littell-Clark, “Enrollment Volatility in MassHealth: A Progress Report.” Massachusetts Medicaid Policy Institute, April 2013. <http://bluecrossmafoundation.org/publication/enrollment-volatility-masshealth-progress-report>, accessed August 9, 2013.

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

Managed Care

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

Figure 4

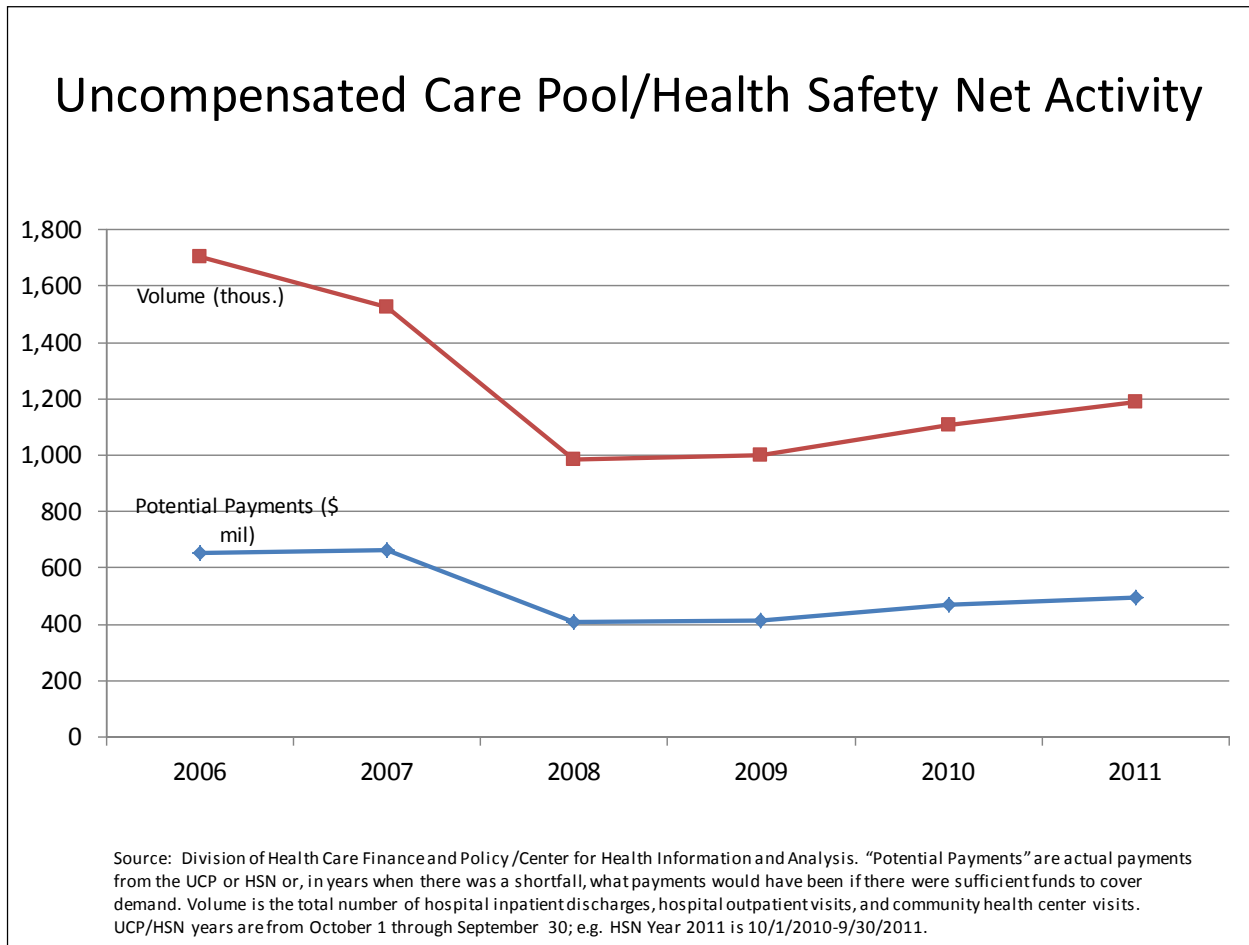


Redirecting Uncompensated Care Spending

A goal of the Demonstration since 2006 has been to redirect spending for care delivered to uninsured people to spending for coverage for those people. To a great extent that goal was achieved by the

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

Figure 5



Continued Support for Reform

The Demonstration is a centerpiece of the state's health care reform, and public support for reform continues to be high. About two-thirds of non-elderly adults in Massachusetts supported reform when it began in 2006, and that statistic has not significantly changed since then. Members of minority groups

tend to be slightly more supportive, but there is no significant difference in support between those with incomes above and below 300 percent of the Federal Poverty Level (FPL). Most employers believe health care reform has been good for Massachusetts. Among physicians, three-quarters believe the Massachusetts reform law should continue, eight in ten believe it has helped the previously uninsured, and nearly nine in ten believe that it improved or did not affect the quality of care.⁹

Demonstration Evaluation

In the evaluation of the Demonstration for the current renewal period, the goals on which the Demonstration is being evaluated are articulated to reflect MassHealth's current policy priorities:

1. Maintain near universal coverage for all citizens of the Commonwealth;
2. Continue the redirection of spending from uncompensated care to insurance coverage;
3. Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and
4. Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

Interim evaluation results (Appendix B) show progress toward the goals. Successful maintenance of near universal coverage is demonstrated by increased Commonwealth Care enrollment, coupled with stable estimates of the uninsured and implementation of the retention efforts described above. The redirection of uncompensated care spending stalled somewhat, as HSN payments have not continued their decline. However, the number of HSN users has grown, and therefore *per-capita* uncompensated care spending has declined.¹⁰ The increase in the number of people utilizing services paid for by the HSN is likely associated with recession-related trends such as loss of coverage, increases in overall health care costs, and declines in median household income.

The Delivery System Transformation Initiatives (DSTI) and Patient Centered Medical Home Initiative (PCMHI) exemplify progress in delivery system transformation and preparation for alternative payment models. The hospitals participating in the DSTI program met 95 percent of their metrics, demonstrating successful implementation of delivery system reforms. PCMHI proved to be useful for practice participants, as all showed increased adoption of medical home competencies. For the next renewal period, Massachusetts will maintain its evaluation framework for the elements of the Demonstration for which it seeks continuing authority. In addition, we will integrate the evaluation of new elements of the Demonstration into this existing framework. Appendix F contains a summary of proposed changes to the Demonstration with a preliminary evaluation hypothesis for each.

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

¹⁰ TE Anderson et al., "MassHealth Section 1115(a) Demonstration Waiver 2011-2014 Interim Evaluation Report." Center for Health Policy and Research, University of Massachusetts Medical School. Draft June 8, 2013.

Monitoring Quality and Access to Care

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

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

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

HEDIS. The 2012 HEDIS evaluation focused on two domains: “staying healthy” and “living with illness.” Overall, MassHealth MCOs performed well compared with national averages. They performed best in the “staying healthy” domain (childhood immunization status, immunization for adolescents, well child visits for infants and young children, adolescent well-care visits, and chlamydia screening in women), with all plans’ measures equal to or significantly higher than the national Medicaid 75th percentile for the measures. Results were more mixed in the “living with illness” domain (comprehensive diabetes care, antidepressant medication management, and follow-up after hospitalization for mental illness). In general, plans did well on the measures for diabetes care and follow-up after hospitalization for mental illness (though one plan scored below benchmarks on the latter measures). In contrast, three plans scored below benchmarks on the antidepressant medication management measure.

Patient Experience Survey. The Massachusetts Aligned Patient Experience Survey (MA-PES) assesses seven domains of care. For adults, the areas of best performance were in the domains of provider-patient communication and office staff; areas for improvement were in the domains of access, behavioral health and self-management support. For pediatric care, areas of best performance were communication, access and office staff; areas for improvement included child development, provider advice on child safety, and self-management support.

External Quality Review. For Fiscal Year 2012 MassHealth’s external quality review organization (EQRO) undertook two separate assessments relevant to the Demonstration:

Managed Care Organization (MCO) Comparative Report: For this report, the EQRO reviewed two performance improvement projects – one selected by MassHealth and the other by each of the five MassHealth MCOs – and validated three HEDIS measures. The EQRO found that MCOs demonstrate the principles of continuous quality improvement and overall strong analytic and data capabilities, that strong performance on HEDIS measures demonstrate a commitment to providing quality care and services, and that they continue to invest in strong information systems that support the production of performance improvement indicators and HEDIS measures. The report also identifies key challenges and opportunities. It found that the MCOs should continue to focus on improvement in their substance abuse aftercare effectiveness activities. According to the report, the MCOs have opportunities to develop targeted improvement strategies to improve their performance on behavioral health HEDIS measures, and to continue to pursue the collection of accurate race, ethnicity and language data to support disparities initiatives and performance improvement.

Massachusetts Behavioral Health Partnership (MBHP). The EQRO found that MBHP demonstrated increases in the percentage of members who initiated aftercare and engaged in community-based services, a goal of its increasing aftercare performance improvement project. It also found that MBHP exceeds national Medicaid 90th percentile of performance on the Follow-up Care for Children Prescribed ADHD Medication HEDIS measures, and that its use of PCC plan data have improved multiple facets of member care. The EQRO identified key challenges and opportunities, including better focusing interventions on the receipt of clinically delivered aftercare services, developing more aggressive, person-centered interventions for its performance improvement projects, and partnering with the PCC Plan to develop a system-wide clinical performance improvement strategy.

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

Over the 17 years of the Demonstration thus far, eligibility has been expanded to encompass populations that have grown in numbers and diversity. MassHealth members qualify for coverage by virtue of a combination of age, income, family status, pregnancy, disability status, specific disease, and employment status. Over time, MassHealth has developed a number of programs within the Demonstration to serve these diverse groups, using targeted eligibility criteria and benefit packages for different populations. With the implementation of the ACA, some of these programs will continue, some will end, and others will be introduced. (Changes to Demonstration programs as of January 1, 2014 were described in detail as part of the Waiver amendment approved on September 30, 2013.) With the recent amendment, the Demonstration's goals and objectives now align with the ACA. All MassHealth members who were eligible prior to ACA implementation will remain eligible, though some will be in different programs offering similar or richer benefits and affordability levels.

The shift to the ACA environment will simplify eligibility for subsidized coverage in the Commonwealth and align Massachusetts' coverage structure more closely to the nationwide vision for insurance affordability programs outlined in the ACA. At the same time, implementation of the ACA will expand

the availability of subsidized coverage to new groups, such as people earning between 300 percent and 400 percent FPL.

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

Table 1. Demonstration Program Populations

Pre-2014	As of January 1, 2014
<p>MassHealth Standard</p> <p>Children up to age 19 ≤150% FPL Children receiving Title IV-E adoption assistance Parents ≤133% FPL Pregnant women ≤200% FPL Adults w disabilities (age 19-64) ≤133% FPL Individuals in need of treatment for breast or cervical cancer ≤250% HCBS Waiver group ≤300% SSI and <\$2,000 assets Former foster care youth up to age 21</p>	<p>MassHealth Standard/Alternative Benefit Plan (ABP 1)</p> <p>Children up to age 19 ≤150% FPL Children receiving Title IV-E adoption assistance Parents ≤133% FPL Pregnant women ≤200% FPL Adults w disabilities (age 19-64) ≤133% FPL Individuals in need of treatment for breast or cervical cancer ≤250% HCBS Waiver group ≤300% SSI and <\$2,000 assets Former foster care youth up to age 21 PLUS 19-20 year olds ≤150% FPL Individuals with HIV ≤133% FPL Individuals receiving services through the Department of Mental Health ≤133% FPL Former foster care youth up to age 26</p>
<p>MassHealth CommonHealth</p> <p>Adults and children with disabilities who are not eligible for MassHealth Standard based on income</p>	<p>MassHealth CommonHealth</p> <p>UNCHANGED</p>
<p>MassHealth Family Assistance</p> <p>Individuals with HIV ≤200% FPL Children 150.1-200% FPL</p>	<p>MassHealth Family Assistance</p> <p>Individuals with HIV 133.1-200% FPL (≤133% <i>in Standard</i>) Children 150.1-200% FPL</p>
	<p>MassHealth CarePlus</p> <p>Individuals ≤133% FPL previously eligible for MassHealth Essential, MassHealth Basic Medical Security Plan, Insurance Partnership, Commonwealth Care, or receiving services paid for by the Health Safety Net Newly eligible individuals ≤133% FPL</p>
<p>MassHealth Insurance Partnership</p> <p>Employees of small employers receiving premium assistance, ≤300% FPL</p>	<p>DISCONTINUED</p> <p>Members move to MassHealth CarePlus or QHP + State Wrap (ConnectorCare)</p>
<p>MassHealth Basic</p> <p>Childless adults ≤100% FPL who are long-term unemployed and receiving mental health services or Emergency Aid to Elders, Disabled and Children</p>	<p>DISCONTINUED</p> <p>Members move to MassHealth Standard or MassHealth CarePlus</p>

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

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

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

- Establishes a statewide health care cost growth target;
- Requires state programs, including MassHealth, to lead by example in moving toward alternative payment models;
- Allows for anticipated changes in the health care delivery system, including the adoption of ACO and PCMH models;

- Commits significant resources to investing in community-based public health initiatives and the health care delivery system; and
- Increases transparency through enhanced reporting and the use of health information technology (HIT).

Chapter 224 requires MassHealth, along with other payers and providers, to play a significant role in meeting the Commonwealth's goals of cost containment and improved health care quality. Below is a summary of the major provisions of Chapter 224, describing MassHealth's role in advancing the sweeping health care system changes envisioned in the law.¹¹

Cost Growth Targets

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

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

Alternative Payment Methodologies

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

Chapter 224 calls on MassHealth to swiftly transition its members to APMs, by requiring that 25 percent of members participate in APMs by July 1, 2013, 50 percent by July 1, 2014 and 80 percent by July 1,

¹¹ For a full description of Chapter 224's requirements and its implications for MassHealth, see A. Gosline and E. Rodman, "Summary of Chapter 224 of the Acts of 2012," available at: <http://bluecrossmafoundation.org/publication/summary-chapter-224-acts-2012>, and R. Seifert and R. Gershon, "Chapter 224 of the Acts of 2012: Implications for MassHealth." Blue Cross Blue Shield of Massachusetts Foundation, September 2012, available at: <http://bluecrossmafoundation.org/publication/chapter-224-acts-2012-implications-masshealth>.

2015. In addition, the law requires other public payers such as the Group Insurance Commission – as well as private payers – to implement APMs and reduce the use of fee-for-service payments.

In part to meet the requirements of Chapter 224, MassHealth has developed the Primary Care Payment Reform Initiative (PCPRI), an alternative payment model that allows primary care providers to assume accountability for the cost and quality of care through a risk-adjusted, per member, per month payment, a quality incentive payment and a shared savings / risk payment. Working in partnership with its contracted MCOs and other managed care entities (MCEs), PCPRI will be implemented across MassHealth’s managed care programs including the PCC Plan and the MCOs. MassHealth plans to build on PCPRI to initiate an alternative payment program for ACOs and health systems to assume accountability for total medical expenses, as outlined in Section 5 below. Payment and delivery system transformation will be implemented across MassHealth’s managed care programs, including the PCC Plan and the MCO program, and will:

- Focus on integration of behavioral health care with primary care;
- Include a strong role for primary care, building on the Patient Centered Medical Home Initiative;
- Focus on improving quality and access and aligning quality measures for use program-wide;
- Provide access to enhanced care coordination and care management services either performed at the provider level, MCO/MCE level, or a combination of both.

MassHealth also continues to develop an alternative payment program focused on high-risk pediatric patients with asthma, with the goals of achieving better care coordination and higher quality care at total lower costs by preventing unnecessary hospital admissions and emergency room utilization.

Delivery System Transformation

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

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

providers, to serve members with chronic behavioral health conditions, integrating behavioral health and primary care.

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

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

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

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

Transparency and Health Information Technology

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

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

Moving Health Reform Forward

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

Section 5 Requested Changes to the Demonstration

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

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

The Commonwealth requests to continue all authorities approved in the current Demonstration, including new authorities approved as part of the recent Demonstration amendment. In particular, among other new authorities, the amendment included time-limited authority to establish automatic MassHealth eligibility for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children; we request to continue this authority for the renewal period. These authorities serve to establish continuity and stability for the Commonwealth as we pursue further reforms to transform the health care landscape.

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

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

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

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

- Both demonstration projects include the target population of persons with disabilities who are under the age of 65.
- The 1115 Demonstration provides the eligibility rules that ultimately determine who is a non-elderly “dual eligible individual,” as it contains the rules defining MassHealth Standard and CommonHealth eligibility. Any changes to the income methodology, spend-down, resource, or cost-sharing provisions of the 1115 Demonstration would directly affect the ability of individuals to become enrolled or stay enrolled in One Care. This would de-stabilize services for the Duals Demonstration enrollees and adversely affect our ability to accurately evaluate the Duals Demonstration.

- The Duals Demonstration provides the managed care authority needed to offer the full gamut of Medicare and Medicaid services within the capitation for the One Care plans. The 1115 Demonstration cannot authorize the inclusion of Medicare services, nor does it currently include Medicaid long-term services and supports, as those services are not currently included in the budget neutrality construct of the 1115 Demonstration.

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

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

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

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

Advancing Alternative Payment Models

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

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

Historically, the payment and delivery systems in Massachusetts, as in the rest of the country, have been grounded in a traditional fee-for-service (FFS) structure that does not inherently promote efficiency, quality or coordination of care. MassHealth, particularly in light of the recent passage of comprehensive health care cost containment legislation, Chapter 224 of the Acts of 2012, is fully committed to transforming its payment and delivery systems. The Primary Care Payment Reform Initiative (PCPRI) is MassHealth's flagship alternative payment model. Based largely on the successes and findings of the Massachusetts Patient Centered Medical Home Initiative (MA-PCMHI), MassHealth has developed PCPRI as a broader, scalable model for alternative payment methodologies and medical home transformation in the Commonwealth.

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

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

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

Like MA-PCMHI, the PCPRI is based on a vision for primary care providers to take accountability for the cost and quality of care through a patient-centered medical home that includes care coordination and care management, enhanced access to primary care, coordination with community and public health resources, integration with behavioral health, and population health management. PCPRI differs from MA-PCMHI in its payment model and delivery system requirements and, while the PCPRI involves both

the PCC Plan and the MCOs, PCPRI will not include patients within the primary care practices who are not covered by MassHealth.

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

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

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

To support providers in managing care and costs, MassHealth anticipates providing timely data for care coordination and cost management, and offering targeted technical assistance to providers. MassHealth is still evaluating the results from MA-PCMHI, and will continue to use those insights in the development of PCPRI and other alternative payment models. The Commonwealth looks forward to working with CMS to determine if any new waivers or expenditure authorities are needed to allow the Commonwealth to set shared savings/risk targets, make shared savings/risk payments, as well as recoup payments to providers over the course of the waiver period.

2) Pursuing a Future ACO Initiative

The authority to engage in shared savings and shared risk –based payment arrangements with providers will establish the foundation for the Commonwealth to fully implement the PCPRI. This will also allow MassHealth to expand the use of alternative payment arrangements, including a future accountable care organization (ACO) model which would be implemented across both the MCO and PCC programs. A global payment model would build on Primary Care Payment Reform, maintaining the emphasis on medical home transformation and behavioral health integration.

MassHealth is in the early stages of determining what shape an ACO model may take, but we have outlined the basic principles of what would constitute such an arrangement, including:

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

In anticipation of this transformation, MassHealth is committed to a robust and responsive stakeholder process to obtain input and develop a model which best serves our unique population. We will rely on the experience and expertise of consumers and providers across the spectrum of care to collaborate with us, and we plan to work closely with our contracted MCOs and MCEs, advocates and other state and federal partners on the path to developing and implementing this new initiative. The Commonwealth looks forward to working with CMS in developing and implementing its ACO model, including determining if any new waiver or expenditure authorities are required.

Pediatric Asthma Pilot Program

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

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

Commonwealth estimates that at least 200 MassHealth members will qualify for and be enrolled in the pilot program.

The pilot program will be implemented in two phases, with each phase expected to last from one to two years. Phase 1 will begin once the Commonwealth receives CMS approval and PCC Plan provider contracts for the selected practice sites are amended. During Phase 1, participating PCCs will receive a per member, per month bundled payment that will pay for asthma mitigation services not currently paid for by the PCC Plan for high-risk asthma patients, including home visits and care coordination services provided by qualified community health workers, along with supplies and services to mitigate the effects of environmental asthma triggers.

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

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

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

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

Safety Net Care Pool

The years 2005 and 2006 were a watershed period for MassHealth. As state leaders were determining the best path to ensure universal access to health insurance—deliberations that culminated in the enactment of Chapter 58 in 2006—negotiations over renewal of the Demonstration between the Commonwealth and CMS led to creation of the Safety Net Care Pool (SNCP). The SNCP reflects the ongoing state-federal partnership by providing critical funding for the Commonwealth Care program, the Designated State Health Programs, the HSN, hospital expenditures by the Department of Public Health and the Department of Mental Health, and other supplemental payments to safety net providers. Through these expenditures, safety net providers are supported in their efforts to provide health care for the newly insured and uninsured low-income residents.

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

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

The Commonwealth requests the following authorities for the SNCP:

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

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

1) Provider Sub-Cap

Massachusetts proposes to eliminate the Provider Sub-Cap that has served as an upper limit on certain payments to providers under the Safety Net Care Pool. The amount of the annual Provider Sub-Cap has been determined by the Commonwealth's annual Disproportionate Share Hospital (DSH) payment allotment.

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

The Commonwealth's proposal to maintain the Safety Net Care Pool without any restriction based on the state's DSH allotment is consistent with policies that CMS has approved in other states. For example, California and Texas both have Uncompensated Care Pools whose limits are not tied DSH funding. The budget neutrality savings that Massachusetts has accrued under the Demonstration are more than sufficient to support continued provider payments through the Safety Net Care Pool. The Commonwealth requests a change the Safety Net Care Pool expenditure limits to make this proposed change.

2) Designated State Health Programs

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

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

- i) Massachusetts requests expenditure authority for health programs previously authorized as DSHP, such as programs administered by the Massachusetts Department of Public Health, the

Department of Mental Health, the Department of Corrections, the Department of Elder Affairs, and the Executive Office of Health and Human Services.

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

- ii) Massachusetts requests expenditure authority for state-supported subsidies for individuals with incomes up to 300 percent of the Federal Poverty Level (FPL) who enroll in insurance through the Health Connector marketplace. These state subsidies will supplement federal premium tax credits and cost sharing reductions that will also be available for qualified plans purchased through the Health Connector. The combination of federal and state subsidies will make subsidized coverage for this population as affordable for them as it is today under Commonwealth Care. The state subsidies will include a premium assistance component, as indicated in MassHealth's June 14, 2013 Amendment request, and a cost sharing reduction component.

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

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

expenditures. This is important to provide surety during the transition period to the ACA environment.

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

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

3) Delivery System Transformation Initiatives

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

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

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

Semi-annual and annual progress reports for state fiscal years 2012 and 2013 demonstrate that providers receiving DSTI funding have taken critical steps toward system transformation. Examples of

the work that each hospital has undertaken during the current demonstration period so far are highlighted below. Some examples include:

Boston Medical Center's Re-Engineered Discharge Process (Project RED). Boston Medical Center's (BMC's) Project RED aims to decrease preventable hospital readmissions and returns to the emergency department by educating patients about their hospital and post-hospital care and ensuring a smooth discharge transition. In the second year of the initiative, Project RED was expanded into the daily workflow of a dedicated inpatient unit, allowing BMC to better integrate the program and create staffing efficiencies. An initial internal analysis demonstrated that the readmission rate for patients enrolled in the Project RED program at BMC declined 27 percent, while the readmission rate for adult medical Medicaid patients not enrolled in the program declined 15 percent. With continued DSTI support, BMC will take lessons learned from Project RED and develop an approach for reducing readmissions more broadly across the hospital, while continuing to meet the unique needs of the low-income population.

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

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

Lawrence General Hospital's Physician Hospital Organization (PHO) Initiative. Lawrence General Hospital (LGH) used DSTI funds to bring its disparate, independent physician group practices, solo practitioners, and the independent local health center together under an umbrella entity, the Physician Hospital Organization (PHO). More than 320 physicians joined the PHO and for the first time are working together on clinical integration, engaging in dialogue about referral patterns, preventing "leakage" to higher cost providers, contracts, payment systems and technology initiatives. LGH intends to continue

this project to invest in referral systems and data analytics, steps that will enhance the PHO's capacity to enter into contracts with health plans as an entity, and accept alternatives to fee-for-service payments.

Mercy Medical Center's Aligning Systems to Improve Health Outcomes & and Quality. Mercy Medical Center (Mercy) is designing and implementing an innovative, patient-centered, care coordination and management system called Care Logistics™. This system integrates hospital system workflows to reduce the time to place patients in available beds, treat patients and discharge them safely to the appropriate level of care. Mercy completed a comprehensive assessment of its current care management processes, based on interviews of 261 hospital staff from 39 departments. The hospital is developing a new care coordination model that reconfigures eleven major hospital departments linked by "spokes" into a cohesive "Care Coordination Center" hub. These changes are fostering greater team work, improved patient flow, and enhanced quality. In the next renewal period, Mercy will continue to develop and refine this new organizational structure.

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

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

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

integration and care management, as well as to advance payment models that align incentives more effectively at the provider level.

Massachusetts DSTI initiatives are on track in making essential foundational progress, revealing great promise, early results, and learning from initial activities. Yet DSTI initiatives are ongoing, and there is significant value in continuing DSTI to yield further advances. Learning from current DSTI initiatives has provided meaningful insights about spreading transformation and additional areas of focus for future DSTI activities. Unlike other states that have received initial approval for five-year hospital incentive programs, Massachusetts' DSTI program was initially approved for three years, due to the length of the Demonstration renewal term. While the three-year period offers an opportunity to show important initial progress in the DSTI initiatives, more time is needed to solidify this early success and to realize greater results.

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

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

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

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

4) Supplemental Payments for Cambridge Health Alliance

Improving health and health care for Demonstration populations is contingent on the contributions of the Commonwealth's largest and most concentrated Medicaid safety net systems. As Massachusetts' successful coverage expansions are transitioned to other states through the ACA and the

Commonwealth initiates state-led payment reform and cost containment, providers like Cambridge Health Alliance (CHA) will play a prominent role in advancing promising delivery system transformation and emerging public payer alternative payment models that better align health outcomes with the payment system. The Commonwealth proposes continued support for CHA, Massachusetts' only public acute hospital system and an essential partner in serving Medicaid and uninsured populations. This funding will support CHA's unique and critical role in the Medicaid delivery system, its robust model of care for particularly vulnerable patient populations, and its ongoing transformation.

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

CHA is distinguished from other Massachusetts providers by the following:

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

¹² Comparative payer mix data is based on FY 2011 Gross Patient Service Revenue from Massachusetts' Hospital Statement of Costs, Revenues, and Statistics (DHCFP-403). Medicaid and low-income public payer populations include Medicaid fee-for-service, Medicaid managed care, residually uninsured and Commonwealth Care.

¹³ Ibid.

¹⁴ Based on FY 2011 encounters from Massachusetts' Hospital Statement of Costs, Revenues and Statistics (DHCFP-403).

¹⁵ Ibid.

¹⁶ Cambridge Health Alliance Internal Statistics, SFY 2012.

¹⁷ Ibid.

¹⁸ Ibid.

- CHA, through its fully integrated and owned primary care sites and health centers, is an ongoing force in improving primary care access for underserved patients, growing primary care panel patients by 40% during the period spanning Massachusetts' health reform;¹⁹ and
- CHA's community teaching programs are oriented to training future generations of physicians and clinicians in critical shortage professions such as primary care and behavioral health in new PCMH and medical and behavioral health integration models of care.

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

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

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

¹⁹ Ibid.

CHA continues to be an essential provider in Massachusetts' safety net health care system for Medicaid, uninsured and low-income individuals. The Commonwealth and the federal government have long recognized, through approved Demonstration renewals, the need to provide special recognition of the unique public safety net requirements CHA faces and the challenges of financing of those requirements. CHA's payments support the overall Massachusetts Medicaid health care financing structure.

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

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

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

5) Infrastructure and Capacity Building Grants

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

The ICB grants are distributed through a competitive procurement process. Acute hospitals and CHCs are eligible to apply, and additional criteria may target funding. For example, specific funding was allocated toward critical access hospitals in the past to encourage their participation. In future years, the Commonwealth intends to target grant funds to providers based on their Medicaid payer mix and commercial payer mix, and we may also consider targeting based on the relative prices hospitals receive

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

Currently, providers have the opportunity to apply for projects that fall into five major categories: (i) developing a fully integrated delivery system; (ii) ability to move towards value-based purchasing and alternative payment methodologies; (iii) health outcomes and quality; (iv) outreach and enrollment; and (v) enhancing business strategy and operations capacity. These categories allow providers to make systemic transformations, which would be unattainable without support from MassHealth. In future years, MassHealth aims to leverage grant funds to provide additional encouragement to providers to build partnerships across the care delivery spectrum. MassHealth aims to support care coordination with post-acute, home health and other providers that play important roles in supporting high quality, integrated care for vulnerable populations.

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

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

Express Lane Renewal

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

MassHealth has utilized the Express Lane renewal process for a large number of members.²⁰ The agency selected approximately 55,546 children and 36,992 adults (36,451 families) for the Express Lane renewal process between October 2012 and June 2013. It is expected that an additional 10,709 children and 7,188 adults (7,053 families) will be selected by the end of the first full year the process has operated, in September 2013. The Commonwealth estimates that at that point approximately 40 percent of children and 34 percent of adult MassHealth members with incomes less than or equal to 150 percent FPL will have been selected for the Express Lane renewal process.

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

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

The Commonwealth is also seeking authority to expand the Express Lane renewal process to adults receiving Medicaid benefits with MassHealth-verified income at or below 133 percent FPL and SNAP-verified income at or below 163 percent FPL.

The Commonwealth expects nearly 200,000 members to go through the Express Lane Eligibility renewal process, or nearly 125,000 households. These totals include families that already are eligible for Express Lane renewals and adults who would be eligible with this expanded authority. The Commonwealth requests to continue its waiver authorities under Section 1902(a)(10)(A), Section 1902(a)(10)(C)(i)-(iii), and Section 1902(a) (17), and we look forward to working with CMS to determine if any new waiver or expenditure authorities are needed to enable the continuation and expansion of Express Lane Renewals, as outlined above.

Medicare Cost Sharing Assistance

For MassHealth Standard disabled or caretaker/parent elderly members at or under 133 percent FPL who are eligible for Medicare, the Commonwealth requests authority to pay the cost of monthly Medicare Part A and Part B premiums and the cost of deductibles and coinsurance under Part A and Part B. Coverage shall begin on the first day of the month following the date of the eligibility determination.

²⁰ The data provided in this section does not include a small subset of adults and children receiving state-funded only benefits as well as households containing adults receiving traditional Medicaid benefits.

For CommonHealth members with gross income above 133 percent FPL and less than 135 percent FPL, the Commonwealth will pay the cost of monthly Medicare Part B premiums under the Qualified Individual Program except that the Commonwealth will not extend payment if the Commonwealth estimates that the amount of assistance provided to members during the calendar year exceeds the allocation under Section 1933 of the Social Security Act. Coverage may begin up to three months before the date of application. The Commonwealth requests authority to provide this Medicare cost sharing assistance to the Demonstration eligible members described without applying an asset test, consistent with the eligibility methodology implemented in this Demonstration. The Commonwealth looks forward to working with CMS to determine whether any new waiver or expenditure authorities are needed to enable this request.

Early Intervention / Applied Behavioral Analysis for Autism

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

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

Section 6 Public Notice and Comment Process

The public process used prior to submitting this Request conforms with the transparency and public notice requirements outlined in 42 CFR § 431.400 et seq., and the requirements of STC 14, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements as outlined in the

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

State's approved State plan. The Commonwealth remains committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

The Commonwealth released the Request for a thirty day public comment period starting on August 20, 2013 by posting the Request, a table of Safety Net Care Pool funding requests, the Budget Neutrality worksheets, and a Summary of the Request (including notice of the public hearing and the instructions for submitting comments) on the MassHealth Demonstration website (<http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html>). The announcement and links to documents were included in email updates distributed broadly to over 600 stakeholders, representing advocates, organizations and individuals who are deeply engaged with the Commonwealth. Notice of the Request and the public comment period were also provided through announcements in the *Boston Globe*, the *Worcester Telegram and Gazette*, and the *Springfield Republican*.

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

The Tribal consultation requirements were met through providing a summary of the Request on a conference call with Tribal leaders or their designees and additional Tribal health contacts on July 31, 2013. The Commonwealth provided a summary of the call via email, and made available the official renewal request Summary. When the documents were posted online, the Commonwealth followed up with tribal representatives with a reminder of the posting, including links to the documents and instructions for providing comment. No comments or questions from tribal representatives were submitted.

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

These two public stakeholder meetings, in geographically distinct areas of the state, afforded the public throughout the Commonwealth the opportunity to provide comment, in accordance with 42 CFR 431.408. Boston is located in eastern Massachusetts, and nearly 70 percent of Massachusetts residents live in the greater Boston Area. Worcester is located in the geographic center of Massachusetts and is the second largest city in the Commonwealth. As the seventh smallest state, Massachusetts is small enough to allow residents to travel to geographically distinct locations within the in a relatively short period of time. Boston is located approximately an hour and a half by car from eastern part of Massachusetts, and similarly, Worcester is located approximately an hour and a half by car from western part of the Commonwealth.

Questions and comments were solicited from the audience at the stakeholder meetings. In addition, the Commonwealth received 16 comment letters from health care organizations including several safety net hospitals, a coalition of consumer advocates and providers, a health insurance carrier, a trade

association that represents health plans, a hospital association and a labor union. Overall, the comments were overwhelmingly supportive of the Request, with suggestions or concerns as noted below.

Multiple respondents expressed strong support for the Commonwealth's Delivery System Transformation Initiatives and Infrastructure and Capacity Building grants, regarding them as important vehicles for effecting delivery system reform and supporting safety net providers that are disadvantaged with respect to the resources otherwise available to undertake transformative efforts to improve services and quality. Many respondents also made positive comments about the Commonwealth's request for a five-year renewal, which they felt would facilitate long-term planning and provide greater stability for the Demonstration. Respondents strongly approved of the expansion of Express Lane Eligibility where the opportunity to reduce churn for Medicaid members was a goal worth pursuing. Plans to develop alternative payment models, including the Primary Care Payment Reform initiative and especially an ACO model, were met with much enthusiasm. Many respondents were eager to collaborate in developing an ACO initiative with MassHealth in order to improve care for patients while delivering cost-savings to the Commonwealth. In addition, respondents expressed support for the state supplements to federal premium tax credits and cost-sharing reductions for incomes up to 300% FPL and for Medicare cost-sharing which would keep health care affordable for many enrollees. Respondents were also supportive of the elimination of the Safety Net Care Pool provider sub-cap and the expansion of Designated State Health Programs in order to advance the Commonwealth's health care reform efforts.

Some respondents encouraged the Commonwealth to proceed carefully in developing new alternative payment models. They urged the Commonwealth to seek broad stakeholder input and cautioned that models that work for the private sector may need to be modified for the Medicaid population. One respondent suggested that the Commonwealth's planning can benefit from prior work by Medicaid managed care organizations. In designing an ACO model, respondents recommended that the Commonwealth allow for flexibility to encourage both large and small health care providers to participate. Respondents also urged the Commonwealth to consider the level of overall reimbursement in an ACO model, including for behavioral health providers, and to carefully time the implementation of any new models relative to other programs. One respondent expressed concerns regarding implementation of both the Primary Care Payment Reform initiative and an ACO model, but the same respondent offered enthusiasm for and interest in being involved with the development of alternative payment models and an ACO model that includes managed care organizations. Another respondent urged the Commonwealth specifically to request authority to include Medicare beneficiaries in ACO models.

The Commonwealth agrees that creating alternative payment models will require significant planning and development, and the submitted comments provide us with important points to consider as we move toward implementation. As noted in the Request, we are committed to engaging with providers, consumers, advocates, managed care providers and other stakeholders and will ensure that the development of an ACO model will involve a robust and responsive stakeholder process. In the

upcoming months, we look forward to working with our partners across the state to advance this initiative and ensure that this model best serves our unique and diverse members.

A few respondents supported the idea of broadening the eligibility criteria for the Infrastructure and Capacity Building (ICB) grants to incorporate more providers, including hospitals that serve low-income populations outside Boston, or to incentivize hospitals to work with other provider types such as those who provide long-term services and supports, such as home health providers. One respondent recommended prioritizing ICB funding for providers with commercial relative prices within 10% of the state median, suggesting that this indicates a lack of market strength to be able to rely on commercial revenues to support infrastructure investments. The Commonwealth recognizes that cooperation among providers is vitally important and understands the impact of hospitals' varying commercial payment rates. In response to these comments, we have broadened our proposal to consider relative commercial payer price, along with payer mix, in the targeting of ICB funds. We will also use ICB funding opportunities to encourage and support collaboration among hospitals, community health centers and other providers, including community-based behavioral health and long-term service providers, to ensure that patients benefit from well-coordinated care provided in the appropriate setting.

An additional issue was raised related to the retroactive eligibility period for members. Two respondents urged the Commonwealth to adopt 90-day retroactive eligibility rather than the current policy of ten days. The Commonwealth appreciates the concerns expressed by the commenters but does not recommend amending its retroactive eligibility policy. Massachusetts has achieved and maintained near-universal health care coverage for the last several years and has significantly reduced the number of uninsured, particularly among low-income residents. With implementation of the Affordable Care Act, there will be even fewer barriers to obtaining and maintaining coverage. Various programs and processes will be in place to ensure that individuals will not be without health insurance for extended periods of time, such as the Single Streamlined Application, Navigators and Certified Application Counselors, hospital determined presumptive eligibility and the opportunity to apply by telephone, paper, online or in person. In addition, MassHealth's ten-day retroactive eligibility policy has reduced the administrative burden for members, who without this policy would be required to submit evidence of incurred medical expenses in order to qualify for retroactive coverage. In light of all of these considerations, the Commonwealth does not believe it is necessary to change its ten-day retroactive eligibility policy at this time.

Several suggestions were raised by single respondents but are worth noting. One respondent sought assurance that upon expansion of the OneCare model from dual eligibles to non-dual eligible disabled members, new providers will have the opportunity to contract with the Commonwealth. The Commonwealth would like to clarify that it intends to explore expansion of the integrated care model that incorporates all services for disabled members, including long term services and supports; this change would not necessarily be restricted to current OneCare health plans.

Another respondent encouraged the Commonwealth to expand its partnerships with managed care contractors and to re-open its procurement process for managed care programs more frequently. The

Commonwealth recognizes that the health care marketplace is particularly dynamic at this time and will take these shifts into account in the development of our purchasing strategies.

In addition, one respondent qualified its support for the five-year waiver renewal term by urging the Commonwealth to reexamine this request pending initial discussions with our federal partners. A respondent sought to ensure that the cost limit protocol that is being developed not harm the Commonwealth's safety net and community hospitals. Another respondent urged the Commonwealth to pursue a Basic Health Program for individuals with incomes at or below 200 percent of the FPL. This commenter also urged MassHealth to simplify its coverage types, and if possible to provide coverage through a single program, MassHealth Standard, for all members. It was also suggested that MassHealth should consider making the Express Lane Eligibility process bi-directional so that MassHealth members could easily be identified and enrolled in SNAP benefits.

The Commonwealth appreciates each of these comments and will take them into consideration as we move forward with further policy development.

Section 7 Budget Neutrality

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

Budget Neutrality Methodology

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

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

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

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

Budget Neutrality Impact

As noted above, the changes proposed in this renewal request continue to meet budget neutrality requirements during the extension period. The attached budget neutrality demonstration shows that projected expenditures under the life of the waiver from SFY2009 through the end of the Demonstration renewal request will be approximately \$33.6 billion less than projected expenditures in the absence of the Demonstration.

Moreover, as detailed in the Commonwealth's quarterly budget neutrality reports, the cushion has grown since our 2008 Demonstration renewal term. This is the result of program efficiencies that have maintained cost growth below anticipated trends. Realized and anticipated savings that continue to be reflected in the current projection include creating consistency among providers in hospital rates, limiting current-year inflation in provider and MCO rates, enhancing compliance activities and utilization management, and other significant savings projects in the Governor's SFY 2014 budget, such as investments in health care access and quality and implementation of the health care cost containment law. The current budget neutrality statement reflects these successful ongoing efforts to implement cost containment initiatives across the MassHealth program in the current economic context.

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

Section 8 Conclusion

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

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

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

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

Appendix A. List of Frequently Used Abbreviations

ACA	Affordable Care Act
ACO	Accountable Care Organization
APM	Alternative Payment Methodology
CHA	Cambridge Health Alliance
Chapter 224	Chapter 224 of the Acts of 2012
CHIA	Center for Health Information and Analysis
CHIPRA	Children’s Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare and Medicaid Services
CPCP	Comprehensive Primary Care Payment
Demonstration	MassHealth 1115 Demonstration
DSH	Disproportionate Share Hospital
DSHP	Designated State Health Program
DSTI	Delivery System Transformation Initiative
EHR	Electronic Health Record
EQRO	External Quality Review Organization
FPL	Federal Poverty Level
HIE	Health Information Exchange
HIT	Health Information Technology
HPC	Health Policy Commission
HSN	Health Safety Net
ICB	Infrastructure and Capacity Building
MA-PCMHI	Massachusetts Patient-Centered Medical Home Initiative

MCO	Managed Care Organization
NCQA	National Committee for Quality Assurance
One Care	One Care: MassHealth plus Medicare
PCC	Primary Care Clinician
PCC Plan	Primary Care Clinician Plan
PCMH	Patient-Centered Medical Home
PCPRI	Primary Care Payment Reform Initiative
PMPM	Per Member, Per Month
QHP	Qualified Health Plan
SNAP	Supplemental Nutrition Assistance Program
SNCP	Safety Net Care Pool
STC	Special Terms and Conditions of the 1115 Demonstration Waiver

September 26, 2013



MassHealth Section 1115(a) Demonstration Waiver 2011-2014 Interim Evaluation Report

Prepared by:

Teresa E. Anderson, PhD
Georgianna Willis, PhD
Debi Lang, MS
Kathy Muhr, MEd
Heather E. Posner, MSPH

In cooperation with:

Massachusetts Executive Office of Health
and Human Services

Acknowledgements

The University of Massachusetts Medical School (UMMS) Center for Health Policy and Research wishes to thank staff in the Executive Office of Health and Human Services Office of Medicaid, and the Center for Health Information and Analysis, as well as its colleagues in the UMMS Center for Health Care Financing, for their expertise and support.

Table of Contents

Acknowledgements.....	iii
Executive Summary	vii
1 Introduction.....	1
2 Background	2
2.1 The Economic Context.....	2
2.2 The 1115 Waiver and Massachusetts Health Reform.....	3
3 Interim Evaluation Findings of the MassHealth 1115 Demonstration.....	5
3.1 Delivery System Transformation Initiatives (DSTI).....	5
3.1.1 DSTI Background.....	5
3.1.2 DSTI Evaluation Methods.....	6
3.1.3 DSTI Interim Findings.....	6
3.2 Express Lane Eligibility Program (ELE).....	7
3.2.1 ELE Methods.....	7
3.2.2 ELE Interim Findings	8
3.3 Massachusetts Children’s High-Risk Asthma Bundled Payment Demonstration Program (CHABP).....	8
3.3.1 Pediatric Asthma Pilot Program Background.....	8
3.4 Continued Monitoring of Population Level Measures (PLM)	8
3.4.1 PLM Background.....	8
3.4.2 PLM Methods	9
3.4.3 PLM Interim Findings	11
3.5 Intensive Early Intervention Evaluation (IEI)	15
3.5.1 IEI Background	15
3.5.2 IEI Methods.....	15
3.5.3 IEI Interim Findings	16
3.6 Patient Centered Medical Home Initiative (PCMHI)	16
3.6.1 PCMHI Background.....	16
4 Discussion	16
5 Conclusion.....	18
Appendix A DSTI Hospital Baseline Summaries (SFY12)	21
Appendix B Interim Report of the Patient-Centered Medical Home Evaluation - Executive Summary	35

List of Tables

Table 1. Demonstration Initiatives, Evaluation Study Organizations & Leads	1
Table 2. Demonstration Initiative and Goals.....	4
Table 3. Population Level Measures by Demonstration Goal and Data Source.....	9
Table 4. PLM 1: Number of Uninsured in Massachusetts (All Ages), 2010-2012.....	11
Table 5. PLM 4: Uncompensated Care and Supplemental Payments for 2010-2012 (in millions)	14
Table 6. PLM 5: Number of Individuals Accessing the Health Safety Net Trust Fund (HSN) for Federal Fiscal Years 2010-2012	14
Table 7. Population-Level Measure 6: Access to Usual Source of Medical Care for All Ages in Massachusetts, 2010-2012	15

List of Figures

Figure 1. PLM 2: Demonstration Eligibles with Employer Sponsored Insurance (ESI) Coverage	12
Figure 2. PLM 3: Enrollment in the Commonwealth Care (CommCare) Program	13

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) approved the extension of Commonwealth's Section 1115 Demonstration through June 2014. During this period, the Commonwealth continues its health care reform efforts with four established goals:

1. Maintain near universal coverage for all citizens of the Commonwealth;
2. Continue the redirection of spending from uncompensated care to insurance coverage;
3. Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and
4. Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

EOHHS contracted with the University of Massachusetts Medical School (UMMS) Center for Health Policy and Research (CHPR) to conduct the evaluation. Interim evaluation results suggest progress toward all four Demonstration goals.

The Economic Context

During the Demonstration period of December 2008-June 2011, the nation experienced the longest and most severe economic recession since the great depression (Hartman, Martin, Benson, Catlin, and the National Health Expenditure Accounts Team, 2013). Unemployment rose to its highest level since 1982, and median household income declined steadily, to its lowest rate in more than 10 years (Department of Labor, 2013; Martin, Lassman, Washington, Catlin, and the National Health Expenditure Accounts Team, 2012).

The recession had a profound effect on health care affordability. More than 11 million people across the United States lost employer-sponsored insurance coverage between 2007 and 2010. Increases in Medicaid enrollment (7.5 million) partially compensated for the loss. Nevertheless, the number of uninsured nationwide grew by 7 million during this period (Hartman et al., 2013).

These national trends continued after the recession officially ended in June 2009, a dynamic that is not unusual following severe economic downturns (Hartman et al., 2013). From 2010 to 2012, public health plan enrollment for persons under 65 years of age grew slightly (Cohen and Martinez, 2013), and employer-sponsored insurance continued its downward slide nationally (Kaiser Family Foundation, 2013). Throughout this period, healthcare costs continued to rise faster than the general inflation rate as families' ability to pay declined (Cuckler et al., 2013).

Consistent with the national experience, economic contraction and slow job growth profoundly influenced trends in private health insurance, Medicaid enrollment, and costs in Massachusetts. From 2009 to 2011, employer-sponsored insurance in the Commonwealth declined. At the same time, consumers saw increases in private health insurance premiums, health insurance deductibles, and other out-of-pocket costs (Center for Health Information and Analysis, 2013), shifting more of the burden of rising health care costs to individuals and families. Higher health care costs for workers came at a time when median household income was declining in Massachusetts (Office of Attorney General Martha Coakley, 2013). Even for workers with insurance, higher out-of-pocket costs may have led to increased reliance on Health Safety Net (HSN) services. We see indirect evidence of declining wages and the increasing burden of health care costs on working families in MassHealth, where the number of members receiving assistance with the costs of third party coverage (excluding Medicare) rose 19.1% from 2010 to 2013. During the same time period, MassHealth enrollment in programs for people who are long-term unemployed increased by 42.8%, suggesting that the slow employment recovery has continued to affect Massachusetts residents long after the official end of the recession.

The 1115 Waiver: Key Findings

The broader economic challenges facing the Commonwealth worked against the objectives of the Demonstration, but despite these external forces, Massachusetts was largely able to maintain the achievements of the Demonstration to date and continue to make incremental progress toward its four primary goals.

Near Universal Health Coverage (Goal 1): The percentage of insured residents from 2010 to 2011 remained relatively stable at 96%, the highest in the nation. In the context of the aftermath of a major recession, this demonstrates an accomplishment for the Commonwealth. From 2011-2012, the number of demonstration eligibles accessing employer sponsored insurance increased 3% from 15,501 to 16,201. During the same period, enrollment in Commonwealth Care rose steadily by 24.5% from 158,805 to 197,777 enrollees. Although Express Lane Eligibility implementation data were not available for inclusion in this interim report, ELE administrators report that from 9/24/2012 to 2/28/2013, a total of 27,618 households were selected to participate in the program. These measures indicate that the Commonwealth is demonstrating progress towards Goal 1.

Redirection of Spending (Goal 2): Variation in supplemental payments to hospitals and Health Safety Net (HSN) payments for uncompensated care from year-to-year make it difficult to discern progress toward redirecting spending. HSN payments remained relatively constant at \$271 million from 2010-2012, while the number of individuals accessing the HSN grew by 20%, which likely reflected a greater reliance on the safety net as residents experienced job loss or were unable to afford the cost of employer-sponsored insurance during the recession. Supplemental payments to hospitals rose

from \$177 to \$322 million over the same period, however this increase included one-time payments to hospitals to provide transitional relief.

Delivery System and Payment Reforms (Goals 3 and 4): The evaluation examined the availability of access to a usual source of medical care as one measure of the Commonwealth's efforts to achieve delivery system reform. Between 2010 and 2011, reported access to a usual source of medical care declined slightly, from 94.3% to 92.3%. While there was a slight decrease, these numbers demonstrate significantly higher access compared to the national average of 86.8% reported in 2011.

Preliminary data from the Delivery System Transformation Initiatives (DSTIs) and Patient Centered Medical Home Initiative (PCMHI), however, suggest progress toward Demonstration goals three and four. Based on the hospital reports from the first year of DSTI, it appears that the hospitals' implementation efforts are on track. Ninety-five percent of metrics across all participating hospitals were achieved in the first year. The first year's DSTI efforts focused heavily on foundational work to put in place the processes, policies and tracking mechanisms for the DSTI initiatives.

Data from the PCMHI Medical Home Implementation Quotient (MHIQ) and patient experience surveys collected during the first 18 months of the PCMHI demonstrate overall progress toward the adoption of "medical homeness" by participating practices. At baseline, practices scored well in the areas of patient-centered care, communication, and customer service. They scored moderately in competencies pertaining to quality assurance, health information technology, and patient-centered care. Lowest adoption was reported for care coordination and care management. Over time, both intervention and comparison practices reported the adoption of additional medical home competencies. Minimum scores of medical homeness rose from 11 to 47 and variations in scores across practices decreased. Care management, access, and patient-centeredness showed the largest improvement.

1 Introduction

The Centers for Medicare and Medicaid Services (CMS) authorizes Medicaid Research and Demonstration Waivers under Section 1115(a) of the Social Security Act. Medicaid Waivers allow states to test new approaches, expand existing delivery systems, and modify payment methods while maintaining “budget neutrality”, meaning that federal Medicaid expenditures will not exceed those spent without the waiver.¹ CMS awarded The Commonwealth of Massachusetts (the Commonwealth) its first 1115 Demonstration Waiver in July 1997.

On December 22, 2011, CMS approved the fourth extension of the MassHealth Medicaid Section 1115 Demonstration (the Demonstration) through June 30, 2014. The Commonwealth’s Executive Office of Health and Human Services (EOHHS) is responsible for evaluating the Demonstration, as described in the Special Terms and Conditions (STC) 84. To accomplish this, EOHHS enlisted the organizations named in Table 1 to conduct specific evaluation studies of six Demonstration initiatives.

Table 1. Demonstration Initiatives, Evaluation Study Organizations & Leads

Demonstration Initiatives	Evaluation Study Organization	Study Leads
Delivery System Transformation Initiatives (DSTI)	Center for Health Policy & Research (UMMS)	Teresa Anderson Georgia Willis
Express Lane Eligibility (ELE)	Center for Health Policy & Research (UMMS)	Teresa Anderson Georgia Willis
Massachusetts Children’s High-Risk Asthma Bundled Payment Demonstration Program (CHABP)	Center for Health Policy & Research (UMMS)	Wen-Chieh Lin
Continued Monitoring of Population Level Measures	Center for Health Policy & Research (UMMS)	Teresa Anderson Georgia Willis
The Intensive Early Intervention Services for Children with Autism Spectrum Disorder (IEI)	Massachusetts General Hospital/ Harvard Medical School Center for Child and Adolescent Health Research and Policy	Karen Kuhlthau Milt Kotelchuck
The Patient Centered Medical Home Initiative (PCMHI)	Commonwealth Medicine (UMMS)	Ann Lawthers Valerie Konar

EOHHS has also partnered with the University of Massachusetts Medical School (UMMS) Center for Health Policy and Research (CHPR) to coordinate all of the studies (Table 1) in order to develop the requisite reports detailed in STC 58(g) and 59. This interim evaluation report begins with a background section that provides the context for, and describes the goals of, the current Demonstration period. A findings section, devoted to the six studies, follows. Each study section includes either a description of the evaluation methods and interim findings, or a status update for each of the initiatives. The report concludes with a discussion of the Demonstration’s efforts through March 1, 2013.

¹ A description of Section 1115 Demonstrations can be found at, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>, accessed 04/20/2012.

2 Background

2.1 The Economic Context

During the Demonstration period of December 2008-June 2011, the nation experienced the longest and most severe economic recession since the great depression (Hartman et al., 2013). Unemployment rose to 9.9%, the highest level since 1982 (Department of Labor, 2013), and median household income declined steadily, to its lowest rate in more than 10 years (Martin, 2012).

The recession had a profound effect on health care affordability. More than 11 million people across the United States lost employer-sponsored insurance coverage between 2007 and 2010. Increases in Medicaid enrollment (7.5 million) partially compensated for the loss. Nevertheless, the number of uninsured nationwide grew by 7 million during this period (Hartman et al., 2013).

These national trends continued after the recession officially ended in June 2009, a dynamic that is not unusual following severe economic downturns (Hartman et al., 2013). From 2010 to 2012, public health plan enrollment for persons under 65 years of age grew slightly from 22.0% to 23.5% (Cohen and Martinez, 2013), while employer-sponsored insurance (ESI) continued its downward slide from 59% to 56% nationally (Kaiser Family Foundation, 2013). Throughout this period healthcare costs continued to rise faster than the general inflation rate as families' ability to pay declined (Cuckler et al., 2013).

Several trends within the private health insurance market may have contributed to higher Medicaid and Health Safety Net (HSN) enrollment and costs. From 2010 to 2012, average annual private insurance premiums increased by 5.3% for individuals and 8.1% for families, and health insurance deductibles rose by 19.6% for individuals (Kaiser Family Foundation, 2013) and 18.1% higher for families (Agency for Healthcare Research and Quality, 2013). During this period, enrollment in high-deductible health plans without health savings accounts increased by 2.7% (Cohen and Martinez, 2013). Concurrent with these trends, average out-of-pocket costs rose as well, reflecting higher cost sharing for private health insurance plans, increased enrollment in high-deductible health plans and higher healthcare costs overall (Hartman et al., 2013). All of these factors contribute to an increase in health care costs for individuals and families, which in turn may have led to greater demand for HSN services and higher HSN provider payments.

Economic contraction and slow job growth profoundly influenced trends in private health insurance and Medicaid enrollment and costs in Massachusetts. In 2011, 62% of Massachusetts residents received health care coverage through their employers, representing a 5% decline in ESI since 2009 (Center for Health Information and Analysis, 2013). From 2009 to 2011, worker premiums rose 9.7%, while benefit levels (average actuarial value of insurance policies) declined 5.1% (Center for Health Information and Analysis, 2013). In 2011, the average annual private health insurance premium was 19.1% of the median single-person household income and 17.5% of family income (Schoen, Lippa, Collins, and Radley, 2012). Concurrently, average worker deductibles grew by more than 40% and out-of-pocket costs increased as well (Center for Health Information and Analysis, 2013). In addition, enrollment in high deductible

health plans increased by 10% between 2008 and 2010 (Office of Attorney General Martha Coakley, 2013). Consistent with the national experience, higher health care costs for workers came at a time when median household income was declining in Massachusetts (Office of Attorney General Martha Coakley, 2013). Even for workers with insurance, higher out-of-pocket costs may have led to increased reliance on HSN services. From July 1, 2010 to June 30, 2013, the percentage of Medicaid members with third party coverage, excluding those with Medicare, increased by 19.1% (D. Bearce, personal communications, September 17 and 26, 2013). During the same time period, MassHealth enrollment in programs for long-term unemployed individuals increased by 42.8% (D. Bearce, personal communication, September 17, 2013), suggesting that the slow employment recovery has continued to affect Massachusetts residence long after the official end of the recession.

2.2 The 1115 Waiver and Massachusetts Health Reform

Under the 1115 Waiver, the Commonwealth redirected spending from uncompensated care to insurance coverage through the creation of the Safety Net Care Pool (SNCP) in 2005. The Waiver also allowed the Commonwealth to expand Medicaid (MassHealth) enrollment, paving the way for Chapter 58 of the Acts of 2006 (Chapter 58), the health care legislation that served as the model for the federal Patient Protection and Affordable Care Act of 2010 (ACA).

During the Demonstration period of December 2008-June 2011, the Commonwealth and CMS continued their health care reform efforts to advance the goals of expanding health insurance coverage, redirecting spending from uncompensated care towards insurance, containing costs, and improving care access and quality. By December 2011, an estimated 98.1% of Massachusetts' 6.4 million residents were insured. The Commonwealth's expansion of insurance coverage was intended not only to contain the volume and costs of uncompensated care, but also to enable access to quality care and to improve the health of low-income residents (Anderson, Cabral, Ellingwood, Lang, and Posner, 2012).

The Commonwealth realized that successful expansion of health coverage and access to primary care would be threatened without further cost containment efforts. Two laws enacted between 2008 and 2010² provided for greater scrutiny and transparency of payer and provider cost trends, regulation of insurance premiums, reporting of medical expenses and standardized quality outcome measures, and recommendations for more uniform payment methods.

In 2011, Governor Patrick proposed further cost control measures, and on August 6, 2012 he signed into law a sweeping cost containment bill, Chapter 224 of the Acts of 2012.³ This latest effort in the Commonwealth's trajectory of health reform initiatives expands upon the two previous laws by setting annual statewide spending targets, establishing the independent Health Policy Commission to oversee health care system performance, and requiring MassHealth to

² Chapter 305 of the Acts of 2008, and Chapter 288 of the Acts of 2010.

³ Chapter 224 of the Acts of 2012, an Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation. The law became effective November 5, 2012.

shift an increasing percentage of its enrollees to coverage that uses alternative payment methods (Mechanic, Altman, and McDonough, 2012).

The following goals of the current Demonstration period continue and expand upon the Commonwealth’s ongoing commitment to health care reform through its partnership with CMS.

Goal 1: Maintain near universal health care coverage for all citizens of the Commonwealth and reduce barriers to coverage (Near Universal Health Coverage);

Goal 2: Continue the redirection of spending from uncompensated care to insurance coverage (Redirection of Spending);

Goal 3: Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements (Delivery System Reforms); and

Goal 4: Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care (Payment Reform).

The Demonstration’s initiatives support the “triple aim” to improve population health and individuals’ experience (access, quality, etc.) of the health care system, while reducing costs. Table 2 presents the Demonstration goals advanced by each of the six initiatives in Table 1 (see page 1).

Table 2. Demonstration Initiative and Goals

Demonstration Initiative	Near Universal Health Coverage	Redirection of Spending	Delivery System Reforms	Payment Reforms
Delivery System Transformation Initiatives (DSTI)			X	X
Express Lane Eligibility (ELE)	X			
Massachusetts Children’s High-Risk Asthma Bundled Payment Demonstration Program (CHABP)			X	X
Continued Monitoring of Population Level Measures	X	X	X	
Intensive Early Intervention Services for Children with Autism Spectrum Disorder (IEI)			X	
Patient Centered Medical Home Initiative (PCMHI)			X	X

In its approval of the current Demonstration renewal (Tavener, 2011), CMS acknowledged the Commonwealth’s “two-pronged approach” of advancing health system and payment transformation (DSTI, PCMHI) and promoting health care coverage for children and adults (IEI,

CHABP, ELE). The following section presents interim evaluation findings for the six Demonstration initiatives.

3 Interim Evaluation Findings of the MassHealth 1115 Demonstration

3.1 Delivery System Transformation Initiatives (DSTI)

3.1.1 DSTI Background

CMS and MassHealth offer performance-based incentive payments to seven participating safety net hospital organizations. The incentive payments encourage and reward these hospital systems for making investments in healthcare delivery initiatives that support Demonstration Goals 3 and 4, Delivery System Reforms and Payment Reforms.

The seven safety net hospital systems are:

1. Boston Medical Center
2. Cambridge Health Alliance
3. Holyoke Medical Center
4. Lawrence General Hospital
5. Mercy Medical Center
6. Signature Healthcare Brockton Hospital
7. Steward Carney Hospital

Each hospital organization has its unique structure and community context in which to implement its specific CMS-approved DSTI plan, based on the DSTI master plan. Individual hospital DSTI plans include at least one project selected from a menu within the following categories:

DSTI Category 1: Development of a Fully Integrated Delivery System. Category 1 projects employ the concepts of the patient centered medical home (PCMH) model to increase delivery system efficiency and capacity.

DSTI Category 2: Health Outcomes and Quality. Category 2 projects develop, implement or expand innovative care models to improve care management and patient experience and to contain costs.

DSTI Category 3: Ability to Respond to Statewide Transformation to Value-Based Purchasing and to Accept Alternatives to Fee-For-Service Payments that Promote System Sustainability. Projects enhance performance improvement and reporting capabilities.

Each category may require significant investments of time and money by hospital systems in order to achieve the desired outcomes. For example, preliminary reports suggest that transforming traditional primary care practices into patient centered medical homes often requires freeing staff time for training in the skills necessary to implement the model effectively, developing or improving quality measurement systems, and coordinating care for patients with complex needs.

The Demonstration authorizes DSTI incentive payments through the Commonwealth's SNCP, which is administered by MassHealth. The incentives are allocated based on the relative volume of MassHealth patients that each hospital sees, as measured by patient service revenue. Incentive payments are distributed contingent on a hospital's meeting the metrics defined for each project in its specific DSTI plan.

The hospitals submit a DSTI Semi-Annual Report for Payment and a Summary Report for Payment to MassHealth. These reports describe and document progress made for each project milestone and metric, along with requests for incentive payment. DSTI funds are available as incentive payments based on the hospital successfully achieving and self-reporting the metrics associated with the CMS approved projects. These reports serve as the basis for authorizing payment. The STCs, Attachment I, specifies the proportional allowance of available DSTI funds for each provider. EOHHS determines the actual payment in accordance with the CMS approved Master DSTI Plan (Attachment J), Section VIII, Disbursement of DSTI Funds. For 2012, the annual total available amount was \$209.3 million.

DSTI Evaluation Study Aims

The specific DSTI study aim addressed in this interim evaluation report is:

1. Describe each hospital organization's plan for care delivery system transformation and performance at DSTI inception on specific projects during SFY 2012 (STC 49(c)(4); STC 52) (baseline qualitative):
 - a. Describe the key implementation processes and improvements planned with identified measures (baseline quantitative)
 - b. Identify the organizational units directly involved;
 - c. Identify the incentive payment amounts associated with each initiative project.

3.1.2 DSTI Evaluation Methods

The DSTI evaluation is a descriptive study using qualitative methods. The evaluation relies primarily on the following documents: 1) CMS approved Master DSTI plan; 2) the seven CMS approved hospital-specific DSTI plans; 3) the seven DSTI Semi-Annual Reports for Payment (July, 2012); 4) the seven DSTI Year End Reports (July, 2012); and 5) the seven Semi-Annual Request for Payment forms (July, 2012).

3.1.3 DSTI Interim Findings

The nature of DSTI projects is such that the outcomes are relatively long term. After just one year, evaluating progress against any measure beyond implementation of the DSTI projects would be premature. Based on hospital reports from the first year of DSTI, it appears that the hospitals' implementation efforts are on track. Ninety-five percent of metrics across all participating hospitals were achieved in the first year. The first year's DSTI efforts focused heavily on foundational work to put in place the processes, policies and tracking mechanisms for the DSTI initiatives. More information will be available to inform the DSTI evaluation at the final evaluation stage. A detailed summary of each hospital-specific plan is in Appendix A.

3.2 Express Lane Eligibility Program (ELE)

Express Lane Eligibility (ELE) renewal advances Demonstration Goal 1 by reducing barriers to continued coverage. Churning (moving in and out of Medicaid) has long been a problem within Medicaid (Fairbrother, Emerson, and Partridge, 2007; Short and Graefe, 2003). Forty-three percent of newly enrolled adults lose Medicaid coverage within twelve months (Sommers, 2009). Losing Medicaid coverage adversely affects access (Long, Coughlin, and King, 2005), continuity of care (Fairbrother, Emerson, and Partridge, 2007; Weissman, Witzburg, Linov, and Campbell, 1999), ambulatory care use (Carlson, DeVoe, and Wright, 2006), and health care costs (Rimsza, Butler, and Johnson, 2007).

Massachusetts' interest in implementing an ELE process resulted from its participation in the Robert Wood Johnson Foundation's "Maximizing Enrollment" grant program. One of the primary goals of the Maximizing Enrollment grant program is to increase enrollment and retention of children in Medicaid and the Children's Health Insurance Program (CHIP).

ELE is a streamlined application and renewal process, authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), intended to increase eligible children's enrollment and retention in Medicaid and CHIP. Through ELE, states are authorized to rely on findings from an approved Express Lane Agency, such as the Supplemental Nutrition Assistance Program (SNAP), to conduct simplified eligibility determinations. In so doing, ELE reduces paperwork submission requirements that are known to be a barrier to members' benefit re-determination and a burden for Medicaid enrollment center staff.

Since Massachusetts determines eligibility for subsidized insurance plans by looking at an entire family group, the Commonwealth requested Section 1115 Waiver Demonstration authority to expand Express Lane to parents and caretaker relatives. The STCs give Massachusetts such authority (Section IV). MassHealth utilizes Express Lane renewal for a select group of households who are receiving both subsidized insurance plan benefits and SNAP benefits. Subsequent to obtaining authority to include parents and caretaker relatives in an Express Lane renewal process, Massachusetts also received both Medicaid and CHIP State Plan Amendment (SPA) approval to include children in the process. The objective of this evaluation is to assess the ELE process' early implementation and to determine its impact on member re-determination and re-enrollment. The study's specific aims are:

1. Describe the adult and child populations using Express Lane renewal procedures for renewal including demographic characteristics such as gender, age and the adults' status as parents or caretakers.
2. Describe MassHealth staff experience with the Express Lane renewal process including factors that facilitate and inhibit program implementation.
3. Determine early progress in completing eligibility renewal for families.

3.2.1 ELE Methods

The evaluation used mixed quantitative and qualitative methods. Following Express Lane renewal implementation on September 24, 2012, CHPR reviewed project documents and

secured permission to use MassHealth and CommCare enrollment data for the period 7/1/2012-6/30/2014. However, the data transfer did not occur immediately. There was not sufficient time for analysis and the inclusion of results here. Therefore, for this interim report, the findings reported are limited to reports from ELE program staff.

3.2.2 ELE Interim Findings

For the period from 9/24/2012 to 2/28/2013, ELE administrators reported that 27,618 households have been selected for the Express Lane renewal.

3.3 Massachusetts Children’s High-Risk Asthma Bundled Payment Demonstration Program (CHABP)

3.3.1 Children’s High-Risk Asthma Pilot Program Background

The Massachusetts Children’s High-Risk Asthma Bundled Payment Demonstration Program⁴ uses a bundled payment for care provided to high-risk pediatric asthma patients (ages 2-18) enrolled in selected MassHealth Primary Care Clinician Plan (PCCP) sites.

This pilot program includes two phases. During Phase I, participating practice sites will receive per person per month bundled payments to fund required and optional services that are not traditionally covered by Medicaid and will allow for a comprehensive, multi-faceted approach to asthma management as determined by the practice site. Medically necessary services traditionally covered by Medicaid will continue to be reimbursed on a fee-for-service basis. Pending the results of Phase I and CMS approval, during Phase II the bundled payments to each site will be increased to cover certain medically necessary services as well as the new services provided during Phase I.

Once CMS approves Massachusetts’ protocols for pilot program and bundled payment methodology and the project is underway, the evaluation will examine the degree to which the program affects health care delivery, health outcomes and cost of care for high-risk pediatric asthma patients. The evaluation will include three components: a qualitative analysis of changes in how providers deliver services to program participants and how participants self-manage their asthma; a quantitative analysis of changes in health care utilization, quality of care, and MassHealth expenditures; and a synthesis of the quantitative and qualitative findings.

3.4 Continued Monitoring of Population Level Measures (PLM)

3.4.1 PLM Background

In accordance with STC 84(a), the evaluation of the Demonstration also addresses these six domains of focus:

- Decrease the number of uninsured
- Increase demonstration eligibles with ESI coverage
- Maintain enrollment in the Commonwealth Care Program
- Reduce uncompensated care and supplemental payments to hospitals

⁴ CHABP is referred to in the STCs as the Pediatric Asthma Pilot Program.

- Reduce the number of individuals accessing the HSN Trust Fund
- Increase the availability of access to primary care providers

EOHHS and CHPR associated the six domains with the three of the four Demonstration Goals and established six population level measures (PLM) to monitor progress towards these goals. Table 3 presents the six PLM, the associated Demonstration Goals (see Table 2, page 4), and the data sources for the PLM.

Table 3. Population Level Measures by Demonstration Goal and Data Source

PLM per STC 84(a)	Near Universal Health Coverage	Redirection of spending	Delivery system reforms	Data Source
1. The number of uninsured in the Commonwealth [yearly]	X			The Massachusetts Health Insurance Survey (MHIS) and National Health Interview Survey (NHIS)
2. The number of Demonstration eligibles with Employer Sponsored Insurance (ESI) coverage [monthly]	X			Premium Assistance and Enhanced Coordination of Benefits unit, UMMS Center for Healthcare Financing
3. Enrollment in the Commonwealth Care Program [monthly]	X			Monthly Health Connector Summary Reports
4. Uncompensated care and supplemental payments to hospitals [yearly]		X		MassHealth, including Health Safety Net Office
5. The number of individuals accessing the Health Safety Net Trust Fund [yearly]		X		Health Safety Net Office
6. Access to primary care providers [yearly]			X	The Massachusetts Health Insurance Survey (MHIS) and National Health Interview Survey (NHIS)

3.4.2 PLM Methods

For PLMs 1 and 6, the study population consists of MA residents of all ages. Demonstration enrollees who had or have access to ESI are the population enumerated for PLM 2 and 3. Safety net hospitals and clinics are counted for PLM 4. Uninsured individuals receiving health care covered by the Health Safety Net Trust are enumerated for PLM 5. The analytic approach for monitoring each measure varies with the data source available as described below.

PLM 1: The number of uninsured in the Commonwealth [yearly]

The CHIA Massachusetts Health Insurance Survey (MHIS) and National Health Interview Survey (NHIS) provide weighted proportional estimates of the proportion of individuals not covered by health insurance for the Massachusetts population. Historically, the primary data source for the number of uninsured in Massachusetts has been the MHIS. This survey was not administered in 2012. We therefore report percentages from both the MHIS and the NHIS for 2010 and 2011, and from the NHIS only for 2012. In future reports, only the NHIS will be the data source for this measure.

PLM 2: The number of Demonstration eligibles with employer sponsored insurance coverage [monthly]

For this interim report, data was provided by the Premium Assistance and Enhanced Coordination of Benefits group within the UMMS Center for Healthcare Financing.

PLM 3: Enrollment in the Commonwealth Care (CommCare) Program [monthly]

CommCare, administered by the Commonwealth Health Insurance Connector Authority (Health Connector), is a commercial insurance-based premium assistance program⁵ for nonelderly adults (age 19-64) with income up to 300% FPL who are not eligible for MassHealth. For this interim report, CommCare enrollment data was retrieved from Summary Reports, which are posted on the Health Connector website.

PLM 4: Uncompensated care and supplemental payments to hospitals [yearly]

For this interim report, annual summary statistics are reported from STC Attachment E, Safety Net Care Pool Payments, Chart B1.

PLM 5: The number of individuals accessing the Health Safety Net Trust Fund [yearly]

CHIA provided the aggregate number of individuals whose care was reimbursed by the Health Safety Net Trust fund in its Health Safety Net 2011 Annual Report issued in September, 2012.

PLM 6: Access to medical care providers [yearly]

The CHIA MHIS and the NHIS provide weighted proportional estimates of the proportion of Massachusetts residents who have reported a usual source of medical care.

⁵ MassHealth Medicaid Section 1115 Demonstration, Centers for Medicare & Medicaid Services Standard Terms and Conditions #36. December 20, 2011.

3.4.3 PLM Interim Findings

3.4.3.1 Near Universal Health Care Coverage

PLM 1: The number of uninsured in the Commonwealth

As seen in Table 4 on the next page, the MHIS and the NHIS yield slightly different estimates. The difference is due to a number of reasons including the population sampled, survey mode, survey fielding period, and method of handling missing data.

Both data sets show that less than 4% of the total Massachusetts population reported being uninsured when they were surveyed in 2011. In 2012, the NHIS data show a slight increase in the percentage of people uninsured to 4.8% (see Table 4). The rise in the number of uninsured is likely a result of the slow economic and employment recovery that persists in Massachusetts. In sharp contrast, at the national level (data not shown in Table 4) the percentage of people uninsured (all ages) declined slightly in 2011 from its recession peak but remained more than three times greater (14.7%) than in Massachusetts (Cohen and Martinez, 2013).

Table 4. PLM 1: Number of Uninsured in Massachusetts (All Ages), 2010-2012

Measure	2010	2011	2012
Number of uninsured from NHIS*, (%)	4.0%**	3.9%***	4.8%+
Number of uninsured from MHIS***, (%)	1.9%	3.1%§	N/A***

*Uninsured status at time of interview.

**Source: Cohen RA, Ward BW, and Schiller JS. *Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2010*. National Center for Health Statistics. June 2011.

***Source: Cohen RA and Martinez ME. *Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2011*. National Center for Health Statistics. June 2012.

+ Source: Cohen RA and Martinez ME. *Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2012*. National Center for Health Statistics, June 2013.

**Source: Center for Health Information and Analysis. *Massachusetts household and employer insurance surveys: Results from 2011*. January 2013.

§Differences between 2010 and 2011 are not statistically significant, suggesting uninsured rates have changed only slightly.

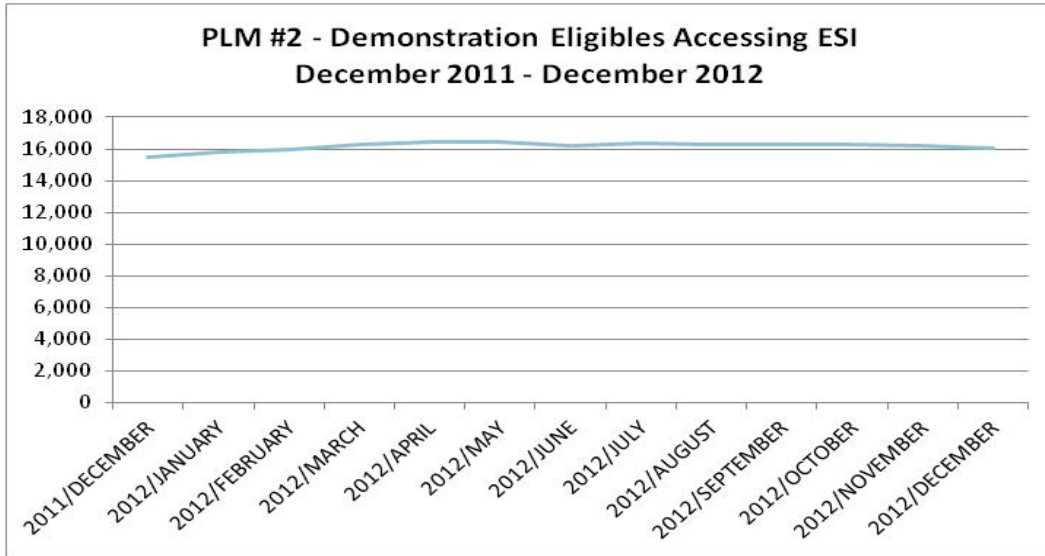
***Survey was not conducted in 2012.

PLM 2: The number of demonstration eligibles with ESI coverage

Employers are the primary source of health insurance in Massachusetts and the nation. In 2011, 62% of Massachusetts residents received health care coverage through their employers, representing a 5% decline in ESI since 2009 (Center for Health Information and Analysis, 2013). From January to December 2012, ESI among demonstration eligibles increased slightly in Massachusetts (see Figure 1 on next page). ESI enrollment rose from 15,501 eligible members in December 2011 to a high of 16,460 in May 2012, a 6% increase, then ended with 16,021

members in December 2012 for a 3% net gain in members accessing ESI in the 13-month period.

Figure 1. PLM 2: Demonstration Eligibles with Employer Sponsored Insurance (ESI) Coverage

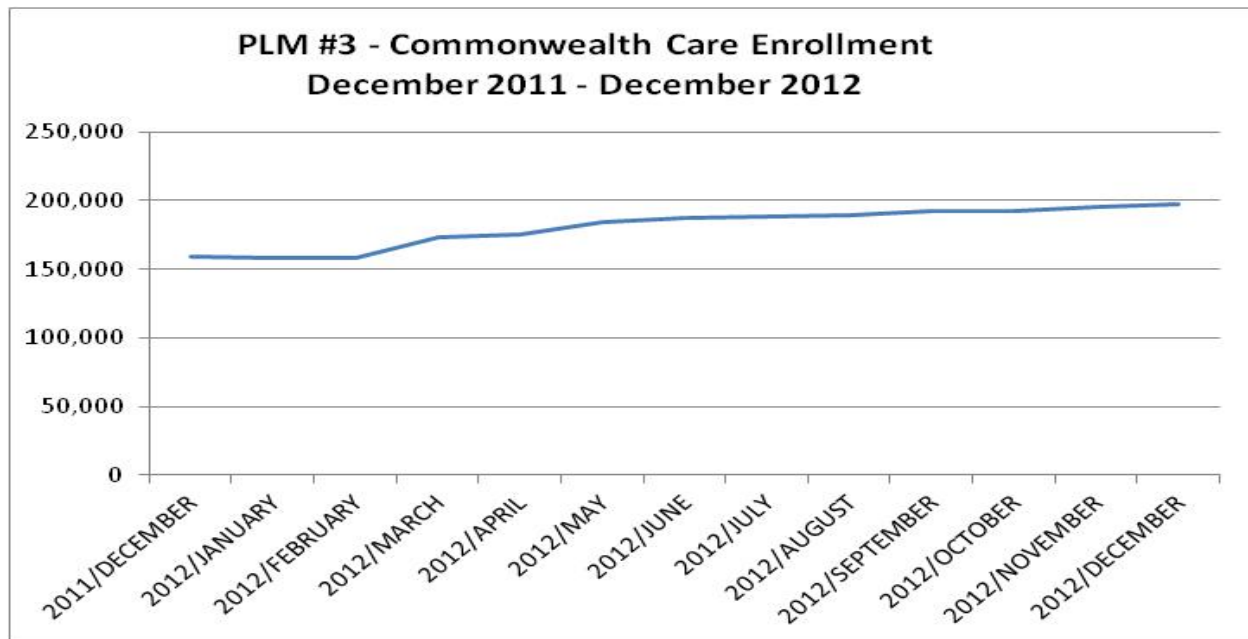


Source: Email communication from Premium Assistance and Enhanced Coordination of Benefits unit, University of Massachusetts Medical School, Center for Healthcare Financing, April 23, 2013.

PLM 3: Enrollment in the CommCare Program

Enrollment in the CommCare program rose 24.5% during the first year of the current Demonstration period, from 158,805 to 197,777 enrollees (see Figure 2 on next page). The increase is attributed in part to the re-instatement of 22,868 Aliens with Special Status (AWSS), who had lost eligibility in the program in 2009.⁶ The FY2013 open enrollment occurred between June 1 and June 22, 2012 with 187,377 members eligible to participate, including the AWSS members.

⁶ Massachusetts does not currently receive federal reimbursement for AWSS; however, their coverage will be eligible for federal subsidies under national reform in 2014 (Source: Massachusetts Health Connector 2012 Progress Report).

Figure 2. PLM 3: Enrollment in the Commonwealth Care (CommCare) Program

Source: Commonwealth Health Connector Authority, *Monthly Health Connector Summary Reports*, 2006-2012 Board Meeting Archives,

https://www.mahealthconnector.org/portal/site/connector/menuitem.be34eb79b090a7635734db47e6468a0c/?fiShow_n=default. Accessed on March 12, 2013.

3.4.3.2 Redirection of Spending

PLM 4: Uncompensated Care and Supplemental Payments

As mentioned in the background section of the report, the slow economic and employment recovery has influenced trends in private health insurance and Medicaid enrollment and costs, both in Massachusetts and nationwide. From 2009 to 2013, dual trends occurred, with a substantial increase in health care costs for individuals and families, and a decline in median household income. In Massachusetts, there is evidence that these trends may have increased utilization of HSN services and HSN provider payments. From July 1, 2009 to June 30, 2013, the number of Medicaid members with third party coverage rose from 152,357 to 178,984, a 17.5% increase (D. Bearce, personal communication, September 17, 2013). This may partially explain the slight increase in HSN uncompensated care payments seen in Table 5. It is likely that the recession contributed to the increase in utilization of HSN services and HSN provider payments among individuals with inadequate private insurance coverage.

Examination of supplemental payments suggests an upward trend in payments from 2010 to 2011, and then a downward trend from 2011 to 2012 (see Table 5 on next page). Following the 2010 Waiver amendment, supplemental payments previously agreed to in the 2008-2011 Waiver renewal increased. Cambridge Health Alliance's Public Service Hospital Safety Net Care payment increased from \$125.5 million to approximately \$341.3 million to align with state legislative authority, as granted in Section 119 of Chapter 27 of the Massachusetts Acts of 2009

and the FY 2011 state budget. Additionally, supplemental payments for transitional relief to private hospitals were approved in the 2010 Waiver amendment, authorizing up to \$270 million in payments. The Transitional Relief payments were only authorized for 2011, thus accounting for an increase in SNCP supplemental payments in 2011 that did not carry forward into 2012 (see Table 5).

Table 5. PLM 4: Uncompensated Care and Supplemental Payments for 2010-2012 (in millions)

Payment Type	2010	2011	2012
HSN payments for uncompensated care	\$272.1*	\$268*	\$271*
SNCP supplemental payments to all acute hospitals	\$177.5**	\$637.9**	\$332.0***

* Source: R. Balder, personal communication, February 28, 2013.

** Source: Demonstration Special Terms and Conditions, Attachment E (Safety Net Care Pool Pay), 54, Amended September 30, 2010; Approved January 19, 2011.

***Source: Demonstration Special Terms and Conditions, Attachment E (Safety Net Care Pool Pay), 103-104, Approved December 20, 2011.

PLM 5: Number of Individuals Accessing the HSN Trust Fund

The number of individuals accessing HSN increased from 316,000 in 2010 to 326,000 in 2011 to 380,000 in 2012, a 20% increase over the three year period (see Table 6). Trends discussed earlier in the report could result in an increase in the number of people accessing the HSN. These trends include increases in health care costs and declines in median household income, which may lead to an increase in the number of people accessing HSN for health care services they cannot afford.

Table 6. PLM 5: Number of Individuals Accessing the Health Safety Net Trust Fund (HSN) for Federal Fiscal Years 2010-2012

	FFY10	FFY11	FFY12
HSN Total Users, (n)	316,000***	326,000****	380,000****

* Source: Division of Health Care Finance and Policy. *Health Safety Net 2011 Annual Report*. September 2012. Accessed March 12, 2013 from: <http://www.mass.gov/chia/docs/r/pubs/11/hsn11-ar.pdf>.

**Reporting period is for 10/1-9/30 of each fiscal year. Users receiving services in more than one type of setting (e.g., community health center, hospital, or emergency room) are counted only once.

***Source: R. Balder, personal communication, February 1, 2013.

3.4.3.3 Delivery System Reform

PLM 6: Access to Usual Source of Medical Care

Historically, the data source for this measure was the MHIS. As previously mentioned, this survey was not administered in 2012. In its absence, the NHIS was used to provide data for the

measure. For transitional purposes, we report data from both the MHIS and NHIS. Between 2010 and 2011, there was a slight decrease in access to usual source of medical care in Massachusetts (94.3% to 92.3%, respectively) (see Table 7).

Despite this decrease, access to usual source of medical care is higher in Massachusetts than for the nation. On the national level (data not shown in Table 7), the percentage of people who reported a usual source of medical care in 2010 was 85.8%, which was lower than the Massachusetts estimate of 94.3%. In 2011, the national estimate was 86.8% compared to 92.3% in Massachusetts.

Table 7. Population-Level Measure 6: Access to Usual Source of Medical Care for All Ages in Massachusetts, 2010-2012

	2010	2011	2012
Access to usual source of care from NHIS*, (%)	94.3%	92.3%	N/A ⁺
Access to usual source of care from MHIS ⁺⁺ , (%)	92.9%	90.9%	N/A [‡]

* Source: R. Cohen, personal communication, January 23, 2013.

⁺Data not available.

⁺⁺Source: Division of Health Care Finance and Policy. *Access to Health Care in Massachusetts: Results from the 2008-2010 Massachusetts Health Insurance Surveys for Non-Elderly Adults (Ages 19-64)*. 2011.

[‡]Data not available.

3.5 Intensive Early Intervention Evaluation (IEI)

3.5.1 IEI Background

Starting with the current Demonstration period, the Demonstration supports early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved Section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements (STC40). Known as Intensive Early Intervention (IEI), this initiative is an innovative program to promote children's health which advances Demonstration Goal 3, the integration of services.

The IEI implementation team includes representatives from the Massachusetts General Hospital (MGH), the Massachusetts Department of Public Health, and MassHealth Community Services. The MGH team is conducting the IEI evaluation. The evaluation's objective is to understand "the benefits and cost savings of the 1115 waiver covering specific early intervention services for demonstration eligible children with autism."

3.5.1.1 IEI Methods

The evaluation team will employ a descriptive design with quantitative and qualitative methods. To strengthen their quantitative analyses of how costs and service use changed overall for the eligible group (from a time prior to the Waiver to the time of the Waiver), the evaluators will employ a comparison group of children who would be eligible based on diagnosis but are not covered by MassHealth. The evaluation will also include qualitative interviews of families and

providers. Finally, the team will collaborate with the Department of Public Health's Early Intervention (EI) evaluation team to examine the EI measures of the children's functional status.

3.5.2 IEI Interim Findings

IEI services are being provided to eligible children by the Department of Public Health. However, the implementation of evaluation activities including quantitative analysis of the IEI dataset and subject recruitment for interviews was delayed due to pending IRB approval from the Massachusetts Department of Public Health. On May 21, 2013, the IEI evaluation project was granted IRB approval. Since receiving IRB approval, recruiting and scheduling in preparation for the qualitative interviews has begun.

3.6 Patient Centered Medical Home Initiative (PCMHI)

3.6.1 PCMHI Background

In 2009, EOHHS partnered with UMMS and Bailit Health Purchasing to implement the Massachusetts Patient Centered Medical Home Initiative (MA-PCMHI) (STC 41c). MA-PCMHI is a multi-payer initiative to transform selected primary care practice sites into Patient Centered Medical Homes. As a participating payer, MassHealth assumes responsibility for enrollees in both its PCCP and its contracted Managed Care Organizations. The MA-PCMHI practices must meet (1) reporting requirements on clinical and operational measures and (2) benchmarks to indicate continued progress towards medical home transformation. A large multi-stakeholder Advisory Committee planned the three-year initiative prior to its March, 2011 inception.

MA-PCMHI advances Demonstration Goal 3, an integrated delivery system, and Goal 4, reformed payment models (Table 2, see page 4). Specifically, the Advisory Committee expects that the selected practices will transform to mature medical homes delivering patient-centered care that is coordinated across the care continuum. Further, the practices are expected to transition from fee-for service towards payment alternatives based on care quality. In order to monitor progress towards these goals, the MA-PCMHI evaluation collects information on the initiative's activities, outputs and outcomes. The Interim Report of the Patient-Centered Medical Home Evaluation, completed in January 2013, found that the PCMHI practices are making progress towards medical home adoption. The evaluation report's Executive Summary is included as Appendix B.

4 Discussion

In the Demonstration extension period, the Commonwealth and CMS continue their health reform efforts to advance the goals of maintaining near universal health care coverage (Goal 1), redirecting spending to insurance coverage (Goal 2), implementing delivery system reforms to advance the "triple aim" (Goal 3), and advancing payment reforms that incentivize care quality over volume (Goal 4). The evaluation examined how six Demonstration initiatives contribute to the attainment of one or more Demonstration goal (Table 2, see page 4) and reports interim findings from the four studies currently underway.

Regarding Goal 1, two sets of survey data indicate that the Commonwealth maintained near universal health insurance. These survey results, combined with CommCare enrollment and ESI access support the continued success of Chapter 58 in achieving near universal health coverage.

The Commonwealth advanced Goal 1 through its continued participation in the Robert Wood Johnson Foundation's "Maximizing Enrollment" grant program for children, and implementation of the Express Lane Eligibility program for parents or adult caretakers of children living in households with Supplemental Nutrition Assistance Program (SNAP) benefits. These two efforts eliminate paperwork submission requirements that are known to be a barrier to members' benefit re-determination and a burden for MassHealth enrollment center staff.

With respect to the Commonwealth's efforts to redirect spending towards insurance coverage (Goal 2), the evaluation examined uncompensated care and supplemental payments to hospitals. Supplemental care payments from the Safety Net Care Pool decreased from \$637.9 million in 2011 to \$332 million in 2012. Uncompensated care payments, however, increased from \$268 million in 2011 to \$271 million in 2012. The number of individuals who accessed payment from the Health Safety Net Trust increased by 64,000 during the period from 2010 to 2012. This increase may indicate a rise in uncompensated care payments. Further, the increase may reflect challenges to universal coverage experienced in this Demonstration extension period but originating in the 2009 nationwide economic recession that occurred in the previous Demonstration period (2008-2011). It is likely that the recession contributed to the increase in utilization of HSN services and the associated HSN provider payments.

In this Demonstration extension period, the Commonwealth implemented multiple efforts transforming the delivery system, (Demonstration Goal 3) while adopting sustainable alternative payment systems (Demonstration Goal 4). Evaluations of the Delivery System Transformation Initiatives and the Patient Centered Medical Home Initiative (PCMHI) suggest progress on Goal 3. Specifically, interim findings from the Patient Centered Medical Home Initiative indicate that the selected practices are adopting the core medical home competencies, improving care access and coordinating care to assist high risk patients in managing their chronic disease. Improvements to care access within PCMHI practices are particularly important in light of 2011 survey results that revealed a slight decrease from 2010 in population access to a usual source of medical care. Access to a usual source of medical care is higher in Massachusetts than in the nation. Improved patient access to high quality, primary care achieved via PCMHI is a more positive indicator of the advancement of the Commonwealth's delivery system reform and cost containment efforts begun with Chapter 58 in 2006.

The patient centered medical home model forms the foundation of the seven projects specified in the Commonwealth's Delivery System Transformation Initiatives (DSTI) Master Plan Category 1, Development of a Fully Integrated Delivery System. These projects include the integration of behavioral health care (1.2), specialty care (1.3) and the acute-post acute care continuum (1.7) as well as adoption of the patient centered medical home primary care model (1.1). Four DSTI hospitals successfully implemented patient centered medical home model projects (1.1), achieving all their CMS approved measures and metrics. Of these four, two DSTI hospitals,

Boston Medical Center and Cambridge Health Alliance, have primary care affiliates active in the Patient Centered Medical Home Initiative. Synergies across the PCMHI and DSTI Demonstration projects exemplify the Commonwealth's strategy to advance statewide reforms to the delivery system (Goals 3 & 4).

Finally, Demonstration Goal 4 advances payment reforms that seek to control costs through payment alternative structures, including bundled payments, global payments and targeted incentives. Three Demonstration projects address Goal 4. The Pediatric Asthma Program, once underway, will pilot bundled payments for care given to high-risk children enrolled in the Primary Care Clinician (PCC) Plan. Further, the PCMHI, which enrolled PCC Plan or MCO contracted practices, will ultimately assess the outcomes of three practice groups, one of which will receive this extra per-member-per month payments and, potentially, shared savings. Notably, one PCMHI interim result indicates that fee-for-service payment actually hinders practices' adoption of the patient centered medical home model.

Study Limitations

This interim report presents the progress that the Commonwealth and CMS made in their efforts to advance the Demonstration's four goals. The report is limited in several ways. First, results could not be presented for the Children's High-Risk Asthma Bundled Payment Pilot Program, nor for the Intensive Early Intervention Services for Children with Autism Spectrum Disorder, as the respective evaluations have yet to begin. Both evaluation studies will be underway and reporting results in 2014. A further limitation involves the DSTI results, which rely on data reported by the seven hospitals based on the first year's progress in a long term process.

5 Conclusion

During the remainder of this Demonstration extension through 2014, CMS and the Commonwealth plan to continue and expand progress towards the four goals of the 2011-14 Demonstration. Successful efforts towards maintaining near universal health care coverage and redirecting spending will continue. EOHHS will continue the delivery systems reforms (DSTI, Pedi Asthma, IEI and MA-PCMHI) and advance payment reforms (DSTI, Pedi Asthma, MA-PCMHI). With cost containment oversight from the Health Policy Commission, the Commonwealth will continue its health reform efforts.

References

- Anderson TE, Cabral L, Ellingwood J, Lang D, and Posner H. *The MassHealth Medicaid Section 1115 Demonstration 2008-2011*. (2012). Center for Health Policy and Research, University of Massachusetts Medical School.
- Carlson MJ, DeVoe J, and Wright BJ. (2006). Short-term impacts of coverage loss in a Medicaid population: Early results from a prospective cohort study of the Oregon Health Plan. *Ann Fam Med*. 4(5):391-398.
- Center for Health Information and Analysis. (2013). *Annual Report on the Massachusetts Health Care Market*.
- Cohen RA and Martinez ME. (2013). *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2012*. National Center for Health Statistics.
- Cohen RA and Martinez ME. (2012). *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2011*. National Center for Health Statistics.
- Cohen RA, Ward BW, and Schiller JS. (2011). *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2010*. National Center for Health Statistics..
- Cuckler GA, Sisko AM, Keehan SP, Smith SD, Madison AJ, Poisal JA, et al. (2013). National Health Expenditure Projections, 2012-22: Slow Growth Until Coverage Expands and Economy Improves. *Health Affairs*. 32(10):1-12.
- Department of Labor, Labor Force Statistics from the Current Population Survey. series title: Unemployment Rate, Series ID LNS14000000. Washington, DC, accessed from <http://data.bls.gov/cgi-bin/srgate> on March 28, 2013.
- Fairbrother GL, Emerson HP, Partridge L. (2007). How stable is Medicaid coverage for children? *Health Affairs*. 26(2):520-528.
- Hartman M, Martin AB, Benson J, Catlin A, the National Health Expenditure Accounts Team. (2013). National health spending in 2011: Overall growth remains low, but some payer and services show signs of acceleration. *Health Affairs*.;32(1):87-99.
- Kaiser Family Foundation. (2013). Employer Health Benefit: 2013 Annual Survey.
- Long SK, Coughlin T, King J. (2005). How well does Medicaid work in improving access to care? *Health Serv Res*.;40(1):39-58.
- Martin AB, Lassman D, Washington B, Catlin A, the National Health Expenditure Accounts Team. (2012). Growth in US health spending remained slow in 2010; Health share of gross domestic product was unchanged from 2009. *Health Affairs*. 31(1):208-219.

- Mechanic RE, Altman SH, and McDonough JE. (2012). The New Era of Payment Reform, Spending Targets, and Cost Containment in Massachusetts: Early Lessons for the Nation. *Health Affairs*. 31(10):2334-2342.
- Office of Attorney General Martha Coakley. (2013). *Examination of Health Care Cost Trends and Cost Drivers, Report for Annual Public Hearing Under G.L. c. 6D, § 8*.
- Rimsza ME, Butler RJ, Johnson WG. (2007). Impact of Medicaid disenrollment on health care use and cost. *Pediatrics*. 119(5):e1026-1032.
- Schoen C, Lippa J, Collins S, Radley D. (2012). *State Trends in Premiums and Deductibles, 2003-2011: Eroding Protection and Rising Costs Underscore Need for Action*. The Commonwealth Fund.
- Short PF, Graefe DR. (2003). Battery-powered health insurance? Stability in coverage of the uninsured. *Health Affairs*. 22(6):244-255.
- Sommers BD. (2009). Loss of health insurance among non-elderly adults in Medicaid. *J Gen Intern Med*. 24(1):1-7.
- Tavener M. (2011, December 20). [Letter to JudyAnn Bigby, Secretary, Massachusetts Executive Office of Health and Human Services (Approval for Current Demonstration Renewal)]. Centers for Medicare and Medicaid Services, U.S Department of Health and Human Services.
- Weissman JS, Witzburg R, Linov P, Campbell EG. (1999). Termination from Medicaid: how does it affect access, continuity of care, and willingness to purchase insurance? *J Health Care Poor Underserved*. 10(1):122-137.

Appendix A DSTI Hospital Baseline Summaries (SFY12)

The tables below presents a summary of the findings for DSTI evaluation Study Aim 1 - the implementation processes, planned improvements, achievement of identified metrics, and the organization units involved for each hospital's DSTI plan for the first year of the Demonstration (SFY12).

Appendix A.1 Boston Medical Center DSTI SFY12

Category 1 Project: Contribute to a fully integrated delivery system by expanding the PCMH model; and instituting a practice support center			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
1.1 Patient Centered Medical Home (Master Plan 1.1) <ul style="list-style-type: none"> • Spread of PCMH model across all PC practices 	Form PCMH work group; Perform gap analysis	√	√
1.2 Practice Support Center (Master Plan 1.5)	Establish infrastructure; hiring staff	√	√
Units involved: Geriatric Internal Medicine (GIM) Primary Care Practice; Family Medicine (FM) Primary Care Practice, IT			
Incentives: Category 1 Total \$ 16,568,532 : 1.1 \$8,284,265 1.2 \$8,284,264			
Category 2 Project: Improve health outcomes and quality by implementing care management interventions for patients with diabetes; establishing a Re-Engineered Discharge (RED) Process; and the developing a simulation center			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
2.1 BMC Simulation and Nursing Education Center (Master Plan 2.6)	Identify space; develop curriculum	n/a	√
2.2 Rapid Diabetes Referral and Follow-up (Master Plan 2.1)	Design system to ID high-risk diabetic pts; Identify staff involved in diabetes care; Engage community partners & assess resources	n/a	√

2.3 Project RED <ul style="list-style-type: none"> Re-engineered Discharge (RED) Program for Adult (18-65) MH, CommCare BMCHP members admitted to BMC (pts.) (Master Plan 2.4) 	Develop & implement Project RED for 500 pts.	√	√
Units involved: Surgery; Anesthesiology; Nursing; Pediatrics; Medicine; Ob/Gyn: ED: Outpatient: Endocrinology Clinic: Family Medicine			
Incentives: Category 2 Total \$ 24,852,798: 2.1 \$8,284,264 2.2 \$8,284,265 2.3 \$8,284,269			
Category 3 Project: Prepare for payment reform and alternative payment models by developing governance, administrative and operational capacities; and participating in a learning collaborative			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
3.1 ACO Development (Master Plan 3.3) <ul style="list-style-type: none"> ACO delivery system including BMC, 6 BNH-affiliated CHCs, 22 BMC physician practice plans) 	Create/convene ACO Steering Committee; estimate # of PCP pts; prepare ACO concept paper	√	√
3.2 Learning Collaborative (Master Plan 3.9)		n/a	√
Units involved: BMC; BHN CHCs; BMC physician practices; BMCHP			
Incentives: Category 3 Total \$10,355,332: 3.1 \$8,284,265 3.2 \$2,071,066			

n/a: Not applicable

Appendix A.2 Cambridge Health Alliance DSTI SFY12

Category 1 Project: Contribute to a fully integrated delivery system by expanding the PCMH model; and integrating physical and behavioral health			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
1.1 Expand PCMH Model (Master Plan 1.1) <ul style="list-style-type: none"> • Gap assessment, work plans • Assign pt. population to panel; Identify high-risk patients 	-Complete gap assessment for NCQA MH recognition -Criteria selected for patient empanelment	n/a	√
1.2 Integrate Primary Care and Behavioral Health (Master Plan 1.2) <ul style="list-style-type: none"> • Develop integrated PC & BH model 	Developed model for co-located, integrated, collaborative PC/BH	√	√
Units involved: CHA's Patient-Centered Medical Home leadership, CHA's primary care site leadership team, Behavioral Health, Primary Care			
Incentives: Category 1 Total \$7,176,533 : 1.1 \$3,588,264 1.2 \$3,588,267			
Category 2 Project: Improve health outcomes and quality by implementing care management interventions for Patients with Diabetes; and implementing a primary care based system of complex care management for high risk population.			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
2.1 Implement primary care-based system of complex care management (Master Plan 2.5) <ul style="list-style-type: none"> • Develop PC complex care management team-hire & train staff • Develop multi-payer high risk patient reports 	-Framework for complex-care management program complete -Sample multi-payer report	n/a	√
2.2 Improve management of patients with chronic disease-Diabetes improvement initiative (Master plan 2.1) <ul style="list-style-type: none"> • Develop protocol, policies & procedures for team-based diabetes care 	Key protocols developed and used for Pharmacy-led diabetes management Service and Nurse-led patient education & self - management coaching conducted at 1 site	n/a	√
Units involved: Community Health Workers, Complex Care Management Team, ED, Inpatient Department, Post-acute care, CHA Ambulatory Care Department			
Incentives: Category 2 Total \$7,176,533 2.1 \$3,588,267 2.2 \$3,588,264			

Category 3 Project: Prepare for payment reform and alternative payment models by developing risk stratification capabilities for patient populations and alternative payment models; developing capacity to address the population health of the community associated with the Triple aim and alternative payment models; and participating in learning collaborative.			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
3.1 Develop capacity to Address the Population Health of the community associated with the Triple Aim and Alternative Payment Models (Master Plan 3.7) <ul style="list-style-type: none"> Form workgroup with local health depts. & community agencies develop reporting tool on PC population Analyze health data; select intervention 	Intervention plan for tobacco use verification and cessation developed with data analytic tool.	√	√
3.2 Develop Risk Stratification Capabilities toward Participation in Alternative Payment Models (Master Plan 3.1) <ul style="list-style-type: none"> Collaborate with payers 	Risk stratification collaboration with MassHealth & Commonwealth Care [†] payers; identified top 3% high-risk patients for care management.	n/a	√
3.3 Participate in Learning Collaborative (Master Plan 3.9)	Examined 4 options for LC participation.	n/a	√
Units involved: Committee on Community and Public Health, Community Advisory Committee, Population Health Workgroup			
Incentives: Category 3 Total \$8,073,600 3.1 \$3,588,268 3.2 \$3,588,266 3.3 \$897,067			

n/a: Not applicable

Appendix A.3 Holyoke Medical Center DSTI SFY12

Category 1 Project: Contribute to a fully integrated delivery system by expanding the PCMH model; and establishing health data exchange capability			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
1.1 Develop a PCMH for HMC Affiliated PC practices (Master Plan 1.1) <ul style="list-style-type: none"> • Educate leadership re: PCMH • Gap analysis and action plans re: readiness for PCMH • Measure Western MA Physician Associate's compliance with NCQA 2011 standards 	<ul style="list-style-type: none"> • Assessed readiness to implement PCMH model 	√	√
1.2 Establish a HIE between HMC and affiliated providers (Master Plan 1.4) <ul style="list-style-type: none"> • Governance committee • ID stakeholders • Education re: benefits of HIE • Connectivity exchange of HIE 	<ul style="list-style-type: none"> • Governance and HIE infrastructure established. • Communication network will deliver lab & radiology results in real time 	√	√
Units involved: WMPA Physicians, HMC Administration & Staff, IT Department			
Incentives: Category 1 Total =\$ 1,304,533; 1.1=\$652,267 1.2= \$652,267			
Category 2 Project: Improve health outcomes and quality by establishing a chronic disease registry and implementing care management (HF/COPD)			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
2.1 Establish a Chronic Disease Registry (Master Plan 2.2) <ul style="list-style-type: none"> • Assess functionality of existing EHR systems 	<ul style="list-style-type: none"> • Established manual registry • Assessed existing IT systems for their capacity as registries 	√	√
2.2A -Improve management of patients with Heart Failure/Expand Chronic Disease Care Management Models (Master Plan 2.1) <ul style="list-style-type: none"> • Identify discharged HF patients 	Established follow-up program. <ul style="list-style-type: none"> • Pharmacist Medication Mgmt. for 25% of HF pts. • Teach Back Method used with 25% of HF pts. 	√	√

<p>2.2B -Improve management of patients with COPD/Expand Chronic Disease Care Management Models (Master Plan 2.1)</p> <ul style="list-style-type: none"> Identify discharged COPD patients 	<ul style="list-style-type: none"> Multi-Disciplinary team organized 	√	√
<p>Units involved: WMPA sites; STAAR (cross continuum) team; VNA; Respiratory therapists, RNs, Hospitalists, Pharmacy</p>			
<p>Incentives: Category 2 Total = \$ 1,956,800; 2.1=\$652,267 2.2A=\$652,267 2.2B=\$652,267</p>			
<p>Category 3 Project: Prepare for payment reform and alternative payment models by establishing an enterprise-wide strategy for information management and business intelligence; and participating in learning collaborative.</p>			
<p>Implementation Process (DSTI Master Plan Project #)</p>	<p>2012 Planned Improvements</p>	<p>Metric Achievement Summary</p>	
		<p>Quantitative</p>	<p>Qualitative</p>
<p>3.1 Establish enterprise-wide strategy for Data Management and Analysis (Master Plan 3.6)</p> <ul style="list-style-type: none"> Conduct Gap analysis Identify Value Based Purchasing and Key Performance Indicators data field requirements Document requirements for data warehouse and business intelligence s/w 	<ul style="list-style-type: none"> Gap analysis completed 	n/a	√
<p>3.2 Participate in a Learning Collaborative (Master Plan 3.9)</p>	<ul style="list-style-type: none"> Explore existing and/or potential for new LC opportunities 	n/a	√
<p>Units involved: Medical Staff office; Heads of clinical departments; HR; Programmer Analyst</p>			
<p>Incentives: Category 3 Total = \$ 815,334; 3.1=\$652,267 3.2=\$163,067</p>			

n/a: Not applicable

Appendix A.4 Lawrence General DSTI SFY12

Category 1 Project: Contribute to a fully integrated delivery system by expanding the PCMH model; and further developing an integrated primary/specialty care network			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
1.1 Hospital/PCMH Practice System Integration (Master Plan 1.1) <ul style="list-style-type: none"> Establish Joint Care Management Team (LGH, GLHFC) to conduct gap analysis, Identify existing data Determine priorities for care management & coordination for DM, CHF, COPD patients 	Explored shared data exchange <ul style="list-style-type: none"> Data agreement for IT infrastructure Agree on critical data elements to track DM, CHF, COPD pts. 	√	√
1.2 PCP, Specialty Care and Provider Care Expansion & Development (Master Plan 1.3) <ul style="list-style-type: none"> Gap analysis via interviews with referral staff and care coordinators, re: PC & Spec. care coverage in community 	Report developed on PC, Spec. care access issues in community <ul style="list-style-type: none"> Identify the need for primary and specialty care services based on national benchmarks 	n/a	√
Units involved: Hospital Director of Integrated Services, LGH Care Management Team, ED, Clinical Services, Care Managers, Diabetes Educators			
Incentives: Category 1 Total = \$2,309,334; 1.1=\$1,154,665 1.2=\$1,154,666			
Category 2 Project: Improve health outcomes and quality by implementing improvements in care transitions; and providing an alternative care setting for patients who seek non-emergent department care.			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
2.1 Identify Opportunities to Develop & Implement Care Transition Interventions that lead to fewer Unplanned Readmissions (Master Plan 2.3) <ul style="list-style-type: none"> Interview key staff Analyze 30-day all cause readmission data Hire care transitions expert 	Encouraged use of PC in lieu of ER care for non-emergent complaints <ul style="list-style-type: none"> Develop screening (assessment) tool to ID pts. at risk for readmission Implement assessment tool for pts. with SA and BH issues 	√	√
2.2 Develop and Co-locate a PCMH PC site on the Hospital campus as an alternative for	<ul style="list-style-type: none"> Designed Screening tool for Non-emergent Care 	n/a	√

<p>non-emergent ER complaints (Master Plan 2.8)</p> <ul style="list-style-type: none"> Analyze data on non-emergent patient complaints 	<ul style="list-style-type: none"> Establish GLFHC (PCMH PC) site on hospital campus 		
<p>Units involved: Social Work, Inpatient, PCMH practices, ER</p>			
<p>Incentives: Category 2 Total = \$2,309,333; 2.1=\$1,154,664 2.2=\$1,154,667</p>			
<p>Category 3 Project: Prepare for payment reform and alternative payment models by developing governance, administrative and operational capacities; developing an integrated care organization; and participating in a learning collaborative</p>			
<p>Implementation Process (DSTI Master Plan Project #)</p>	<p>2012 Planned Improvements</p>	<p>Metric Achievement Summary</p>	
		<p>Quantitative</p>	<p>Qualitative</p>
<p>3.1 Develop organizational infrastructure to enhance capacity to respond to alternative payment systems (Master Plan 3.4)</p>	<p>Restructure/redesign current Physician Hospital Organization to create an ICO</p> <ul style="list-style-type: none"> Incorporate, create by-laws, establish Governing Board Support clinical integration Continue implementation of EHR in community practices Pilot delivery of hospital lab results to 1 physician practice 	<p>n/a</p>	<p>√</p>
<p>3.2 Develop information management capabilities in preparation for accepting alternative payment methodologies (Master Plan 3.3)</p> <ul style="list-style-type: none"> Meet with commercial payers and Medicaid re: obtaining data Educate providers re: health care transformation 	<p>Assessed current utilization and costs, and available tools to control costs and improve quality</p>	<p>n/a</p>	<p>√</p>
<p>3.3 Participate in a Learning Collaborative (Master Plan 3.9)</p>	<p>Explore existing and/or potential new opportunities for participation in LC</p>	<p>n/a</p>	<p>√</p>
<p>Units involved: Care managers, data analysts, Admin. staff, HR, PHO Board, ICO Board</p>			
<p>Incentives: Category 3 Total = 2,597,999; 3.1=\$1,154,665 3.2=\$1,154,667; 3.3=\$288,667</p>			

n/a: Not applicable

Appendix A.5 Mercy Medical Center DSTI SFY12

Category 1 Project: Contribute to a fully integrated delivery system by integrating physical health and behavioral health: and further developing an integrated care network for primary and specialty care			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
1.1 Enhance Primary Care Access and Capacity (Master Plan 1.3) <ul style="list-style-type: none"> Establish Mercy Primary Care Committee Hire vendor to conduct data & process analysis, and analyze region's MD supply 	<ul style="list-style-type: none"> Infrastructure Capacity Assessment of Physical Space PCP clinical services building expansion plan Affiliation agreement with UMMS for 4th yr. Clerkship 	√	√
1.2 Integrate Physical and Behavioral Health Care in Mercy Medical Center ED (Master Plan 1.2) <ul style="list-style-type: none"> Vendor conducts ED site visit MH/SA case mgr. in ED Obtain DPH approval for ED Psych Pod 	<ul style="list-style-type: none"> Vendor report with recommendations to improve treatment and costs of MH/SA pts. in ED Establish Mercy ED BH Psych Pod 	√	√
Units involved: Mercy Emergency Department			
Incentives: Category 1 Total = \$2,434,133; 1.1=\$1,217,067 1.2=\$1,217,067			
Category 2 Project: Improve health outcomes and quality by implementing improvements in care transitions; and implementing process improvement methodologies to improve safety quality and efficiency			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
2.1 Align New Organizational Structures, Human Systems and IT Infrastructure to Improve Health Outcomes and Quality (Master Plan 2.7) <ul style="list-style-type: none"> Sr. Leadership adopts new pt. management model 	Integrate departmental and hospital workflows ("airport control tower") <ul style="list-style-type: none"> Implement Care Logistics™ Model 	n/a	√
2.2 Develop Patient-Centered Care Transitions for Patients at the Highest Risk of Readmission (Master Plan 2.3) <ul style="list-style-type: none"> Establish Health System Care Cross Continuum Team Analyze < 30-day readmission data 	Re-engineered hospital discharge process based on STAAR <ul style="list-style-type: none"> High Risk Tool & Discharge Checklist 	√	√
Units involved: All Mercy Departments			
Incentives: Category 2 Total = \$2,434,133; 2.1=\$1,217,067 2.2=\$1,217,067			
Category 3 Project: Prepare for payment reform and alternative payment models by developing governance, administrative and operational capacities; developing administrative, organizational and clinical capacities to manage			

the care for complex patients; and participating in a learning collaborative			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
3.1 Develop Governance, Administrative and Operational Capacities to Accept Global Payments/Alternative Payments (Master Plan 3.3) <ul style="list-style-type: none"> • Create legal entity to support ACO • Select HIT platform (Master Plan 3.3) 	<ul style="list-style-type: none"> • HIE implementation plan 	√	√
3.2 Develop Administrative, Organizational and Clinical Capacities to Manage the Care of Complex Patient Populations (Master Plan 3.5) <ul style="list-style-type: none"> • Select new site for care of complex pts., conduct engineering study • Analyze existing IT, care coordination and accounting systems 	Implementation plan for new HIT, care coordination and billing systems <ul style="list-style-type: none"> • Analysis report • Policies & procedures for new care mgmt. program for dual-eligibles 	n/a	√
3.3 Participate in Learning Collaborative (Master Plan 3.9)	Explore existing and/or potential new opportunities for participation in LC.	n/a	√
Units involved: Cardiology, Pulmonology, Oncology, Orthopedics, General surgery/GYN; Providence Board of Trustees			
Incentives: Category 3 Total = \$2,738,400; 3.1=\$1,217,067 3.2=\$1,217,067 3.3=\$304,267			

n/a: Not applicable

Appendix A.6 Signature Health DSTI SFY12

Category 1 Project: Contribute to a fully integrated delivery system by further developing integrated care network for primary and specialty care; and establishing a health data exchange capability to facilitate integrated patient care			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
<ul style="list-style-type: none"> 1.1 Improved Access to Care by Improving Primary Care (Master Plan 1.3) Develop PCP Access Plan 	<ul style="list-style-type: none"> Assessed Current PCP capacity Use non-PCPs & mid-levels for evening/weekend hrs.; Reconfigure space Protocols and baseline measures for same-day access 	n/a	√
1.2 Improve PCP Compliance with Preventative, Testing, Leveraging EHR Adoption and Data Warehouse (Master Plan 1.4)	<ul style="list-style-type: none"> Piloted a paper template & establish baseline compliance data for 6 preventative tests based on USPSTF recommendations 	√	√
Units involved: Physicians, Specialists, NPs,			
Incentives: Category 1 Total = \$2,674,133; 1.1=\$1,337,068 1.2=\$1,337,066			
Category 2 Project: Improve health outcomes and quality by implementing care management interventions for patients with CHF; and implementing process improvement methodologies to improve safety quality and efficiency			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
2.1-Apply process improvement methodology to improve quality and efficiency in primary care offices (Master Plan 2.7) <ul style="list-style-type: none"> Conduct LEAN training and implement LEAN system development 	<ul style="list-style-type: none"> Skills training Implement LEAN process in Practice A 	√	√
2.2 Development of CHF Disease Management Program (Master plan 2.1)	<ul style="list-style-type: none"> Established Registry for CHF pts. Follow-up protocol by Cardiology Access Coordinator Established Task Force 	√	√
Units involved: PC practices; Cardiology, IS, Case Management			
Incentives: Category 2 Total = 2,674,133; 2.1=\$1,337,068 2.2=\$1,337,070			

Category 3 Project: Prepare for payment reform and alternative payment models by developing risk stratification capabilities for patient populations and alternative payment models; designing and implementing a hospital-based 360 degree patient care program; and participating in learning collaborative			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
3.1 Hospital-based 360^o Patient Care Management Program (Master Plan 3.2) • For Tufts Medicare Preferred pts.	Infrastructure for PCMP • Physician/nurse team • Schedule for after-hours • % of TMP pts who complete post- discharged scheduled PC visit	√	√
3.2 Creation of a Comprehensive Diagnostic Patient Profile (Master Plan 3.1) • For Tufts Medicare Preferred pts. • Hire Documentation Specialists	• Organizational Plan • Managed Care Portal to ID pts. not seen by PCP • Chart review, pt. report	√	√
3.3 Participate in Learning Collaborative (Master Plan 3.9)		n/a	√
Units involved: ED; SHC PCPs			
Incentives: Category 3 Total=\$3,008,400; 3.1=\$1,337,070 3.2=\$1,337,064 3.3=\$334,267			

n/a: Not applicable

Appendix A.7 Steward Carney DSTI SFY12

Category 1 Project: Contribute to a fully integrated delivery system by implementing a patient navigation services; and developing an integrated acute and post-acute network across the continuum of care			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
1.1 Implement Patient Navigation Services (Master Plan 1.6) <ul style="list-style-type: none"> Develop the Community Health Worker Program 	CHWS assist patients with cross-provider communication to get 'the right care at the right time'.	n/a	√
1.2 Develop Integrated Acute and Post-Acute Network Across the Continuum of Care (Master Plan 1.7) <ul style="list-style-type: none"> Develop an Integrated Acute-Post Acute Network connecting SCH with 7 Skilled Nursing Facilities 	Post-Acute Care Transition (PACT) Committee established APRN and MD communication and workflows across facilities established.	√	n/a
Units involved: Emergency Department; Steward Primary Care; Inpatient Clinical; Dietary, Pharmacy, Physical Therapy			
Incentives: Category 1 Total \$1,024,896 1.1 \$512,448 1.2 \$512,448			
Category 2 Project: Improve Health Quality Outcomes through by implementing improvement in care transitions; implementing process improvement methodologies to improve safety, quality and efficiency; and reducing variations in care for patients with high risk conditions.			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
2.1 Enhance Patient Transitions (Master Plan 2.3) <ul style="list-style-type: none"> SCH and SNFs use the Interventions to Reduce Acute Care Transfers (INTERACT) Tool (Master Plan 2.3) 	Patient Care Experience Council (PCEC) formed. PACT reviews INTERACT use.	√	√
2.2 Implement Process Improvement Methodologies to Improve Safety, Quality & Efficiency (Master Plan 2.7) <ul style="list-style-type: none"> Adopt Nurses Improving Care for Health (system) Elders (NICHE) 	Four Nurse Leaders complete NICHE training. Carney receives NICHE designation. Falls Committee developed.	√	√
2.3 Reduce Variations in Care (Master Plan 2.9) <ul style="list-style-type: none"> Develop condition specific Clinical Care 	Clinical Care Maps for Congestive Heart Failure (CHF) are developed and introduced to staff and patients.	Carried Forward	√

Maps guide patients and families through inpatient care, discharge and post-hospital care.		2.3.6	
Units involved: Emergency Department			
Incentives: Category 2 Total \$1,464,137 2.1 \$ 512,448 2.2 \$512,448 [2.3 \$439,242 (2.3.6 \$0)]			
Category 3 Project: Prepare for payment reform and alternative payment models by implementing global payments; and participating in learning collaborative.			
Implementation Process (DSTI Master Plan Project #)	2012 Planned Improvements	Metric Achievement Summary	
		Quantitative	Qualitative
3.1 Implement Global Payment Pilot (Master Plan 3.8) • Align physician reimbursement to provide most appropriate care	Identify and engage payers including MassHealth.	n/a	√
3.2 Participate in Learning Collaborative (Master Plan 3.9) •	Participated in Pioneer ACO Learning Collaborative	n/a	√
Units involved: None			
Incentives: Category 3 Total \$ 640,560 3.1 \$512,448 3.2 \$128,112			

n/a: Not applicable

Appendix B Interim Report of the Patient-Centered Medical Home Evaluation - Executive Summary

Interim Report of the
Patient-Centered
Medical Home
Evaluation

Executive Summary

January 2013



The Massachusetts Patient-Centered
Medical Home Initiative
www.mass.gov/hhs/medicalhome

Table of Contents

Executive Summary 1

Background 1

 Theory Behind the Initiative 1

 Structure of Initiative 2

 Recruiting Practices 2

 Learning Collaborative 2

 Financial Incentives 2

 Overview of the Evaluation Design 2

Findings at 18 Months 4

 Medical Homeness - Findings from the MHIQ 4

 Methods 4

 Findings 4

 Comment 5

 Medical Homeness: Findings from the Qualitative Team 5

 Methods 6

 Findings 6

 Comment 6

 Findings from the Patient Experience Survey 7

 Methods 7

 Findings 8

 Comment 9

 Findings from the Staff Survey 10

 Methods 10

 Findings 11

 Comment 11

 Clinical Impact 12

 Methods 12

 Findings 12

 Comment 13

Summary 13

 Question 1: To what extent do practices transform to become medical homes? 13

 Baseline Medical Homeness 13

 18 Months Medical Homeness 14

 Facilitators and Barriers to Medical Home Adoption 14

 Question 2: To what extent do patients become active partners in their health care? 14

 Question 3: What is the initiative’s impact on service use, clinical quality, and patient and provider outcomes? 15

 Evaluation Challenges 16

 Looking to the Future 16

Executive Summary

Background

In 2009, the MA Executive Office of Health and Human Services (EOHHS) partnered with the University of Massachusetts Medical School (UMMS) and Bailit Health Purchasing to implement the Massachusetts Patient-Centered Medical Home Initiative (MA-PCMH). A two-year planning process preceded the kick-off of the initiative in March of 2011, during which time Secretary of EOHHS, Dr. JudyAnn Bigby, convened a large multi-stakeholder Advisory Committee to oversee the planning work of Bailit Health Purchasing, UMMS and EOHHS.

The Advisory Committee, facilitated by Bailit Health Purchasing, identified twelve initial core competencies of a medical home practice and focused the planning on these competencies. The thirteenth competency, behavioral health integration was added later. Recognizing that transformation takes time, the Advisory Committee marked seven of the thirteen competencies as high priority (Table E- 1).

Theory Behind the Initiative

The initiative designed by the Advisory Committee and EOHHS employed several key strategies to enable practices to change in the way primary care was delivered. The strategies selected for Massachusetts included a Learning Collaborative (described below) and financial incentives. These strategies, it was hypothesized, would assist practices to adopt the core competencies listed in Table E- 1. Acquiring the core competencies in turn would produce improved care delivery processes including management of chronic conditions, changes in patient behavior (including how they access care and manage their own health), and yield system changes including fewer emergency department visits, fewer hospitalization and slowed cost growth.

The stakeholders backing and developing the PCMH theorized that if Massachusetts trained primary care practices in specific medical home competencies and offered financial incentives for participation in the initiative, the practices would actively engage in transformation activities. Active engagement was expected to lead to the adoption of the core medical home competencies. To the extent that practices successfully adopted the core competencies, then care processes would improve with the first 18 months of the demonstration, especially for the initially-targeted conditions of diabetes and asthma. Other expected outcomes at 18 months included improved access to care and improved delivery of preventive services. By 18 months, it was also expected that patients would begin to perceive improvements in the care experience.

Table E- 1: Core Competencies of a Medical Home¹

1. Patient/family-centeredness
 2. Multi-disciplinary team-based approach to care*
 3. Planned visits and follow-up care*
 4. Population-based tracking and analysis with patient-specific reminders*
 5. Care coordination across settings, including referral and transition management
 6. Integrated care management focused on high-risk patients*
 7. Patient and family education
 8. Self-management support by all members of the practice team
 9. Involvement of the patient in goal setting, action planning, problem solving and follow-up*
 10. Evidence-based care delivery, including stepped care protocols
 11. Integration of quality improvement strategies and techniques
 12. Enhanced access*
 13. Integration of behavioral health care into primary practice*
- * High priority competency as designated by PCMH Council

Executive Summary

By the end of the three-year demonstration, stakeholders expect participating practices to become mature medical homes delivering fully patient-centered care. Patients are expected to perceive that they are partners in their care; clinical outcomes for patients with chronic conditions are expected to improve. Stakeholders expect fewer emergency department visits and hospitalizations for patients in medical homes. And perhaps most importantly for stakeholders, the rate of growth in healthcare costs is expected to have slowed.

Structure of Initiative

Recruiting Practices

EOHHS solicited prospective participants in the MA-PCMHI by issuing a Request for Response (RFR) in June 2010. Following the receipt of 82 applications, a procurement committee reviewed the submissions and selected 48 practices for participation in the demonstration in October of 2010. Two practices subsequently declined to participate, leaving 46 practices in the initiative.

Practices were selected to participate at two levels. Thirty-two practices, including 14 community health centers who had participated in an earlier medical home initiative sponsored by the Commonwealth Fund,¹ were selected to receive technical assistance as well as incentive payments. This group became known as the Technical Assistance Plus (TAP) group. Fourteen additional practices were chosen to receive technical assistance without incentive payments and became known as the Technical Assistance Only (TAO) group.

Learning Collaborative

The three-year Learning Collaborative for the practices included periodic one to two day-long Learning Sessions, monthly hour-long conference calls or webinars participation in on-line courses and submission and review of practice-level performance data through a web portal. Medical home facilitators employed by UMMS and the Massachusetts League of Community Health Centers work one-on-one with practice teams to achieve transformation goals and track progress. All of the practices are working to achieve recognition as NCQA Level 1 Medical Homes.

Financial Incentives

Practices in the TAP group received some start-up funding towards a care manager position and receive a per-member-per-month payment based on their panel size. TAP practices are also eligible for shared savings.

Overview of the Evaluation Design

The evaluation of the Massachusetts Patient-Centered Medical Home Initiative collects information on the activities, outputs and outcomes of the initiative so that different stakeholder groups may assess its value.

The evaluation asks three broad questions:

- Question 1: To what extent do practices transform to become medical homes?
- Question 2: To what extent and in what ways do patients become active partners in their health care?

Executive Summary

Question 3: What is the initiative’s impact on service use, clinical quality, and patient and provider outcomes?

The answer to each question requires multiple sources of data. The principal data collection activities for Question 1 include: (1) the administration of the TransformMED Medical Home Implementation Quotient (MHIQ) survey tool at three points in time (spring 2011, fall 2012 and spring 2014); (2) conducting interviews and focus groups with medical home facilitators and site visits at selected practices; and (3) using responses from a patient experience survey (PES) to assess patient-centered aspects of care. For Question 2, the principle data collection tool is the PES. The survey used was the PCMH-CAHPS-CG, administered at three points in time (fall 2011, spring 2013 and spring 2014). Question 3 relies on data collected for Question 1 and Question 2 as well as an analysis of claims data from the Massachusetts All-payer Claims Database (APCD). Question 3 data collection also includes a survey of practice staff to assess their experience with practice transformation. The staff survey is being administered in the fall of 2011, spring of 2013 and spring of 2014 (see Table E- 2).

Table E- 2: Data Availability at 18 Months

Question	Data Source	Data Collection Timing	Data Available at 18 Months
Question 1: To what extent do practices transform to become medical homes?	MHIQ *	Time 1: Spring 2011 Time 2: Fall 2012 Time 3: Spring 2014	Time 1 and Time 2
	Medical Home Facilitator interviews	Time 1: Spring 2011 Time 2: Fall 2011 Time 3: Summer 2012	All
	Practice site visits	Spring 2013	None
Question 2: To what extent and in what ways do patients become active partners in their health care?	Patient Experience Survey (PES) *	Time 1: Fall 2011 Time2: Spring 2013 Time 3: Spring 2014	Time 1
Question 3: What is the initiative’s impact on service use, clinical quality, and patient and provider outcomes?	Staff survey *	Time 1: Fall 2011 Time 2: Spring 2013 Time 3: Spring 2014	Time 1, Time 2
	PES	Time 1: Fall 2011 Time2: Spring 2013 Time 3: Spring 2014	Time 1
	APCD **	Time 1: Spring 2013 Time 2: Spring 2014	None

* Comparison practice data available **Comparison group data available

The design of the evaluation includes two comparison groups. The first comparison group participates in the MHIQ, patient experience survey, and staff survey data collection activities. The second comparison group will be selected using statistical matching based on patient and other characteristics of the intervention practices and will be drawn using the APCD. The second comparison group will be used for Question 3 analyses.

Executive Summary

For the first comparison group, the initial design called for a group of 30 primary care practices with characteristics similar to those of the intervention practices. The design also called for offering practices monetary incentives to encourage participation in the project. To allow all Massachusetts providers an equal opportunity to apply for the funding, the Evaluation Team conducted a public procurement for comparison sites. The solicitation, which closed on June 10, 2011, and two subsequent solicitations produced 24 applicants, 22 of whom met the minimum qualifications for a comparison site. As of November 2011, 22 comparison sites had completed contracts with the University. Three sites subsequently withdrew from the study, leaving 19 comparison sites for analysis..

Findings at 18 Months

Medical Homeness - Findings from the MHIQ

To provide a means of quantitatively assessing the movement of practices toward “medical homeness”, the TransformMED Medical Home Implementation Quotient (MHIQ) was chosen as the survey instrument to be used by practice staff to assess the medical homeness of the practice. The MHIQ was selected because its nine modules (see below) corresponded well with the 13 core competencies identified by the PCMH Advisory Committee.

The MHIQ consists of questions in nine modules plus a calculated total score:

- Access to Care and Information (Access)
- Practice Management (PMgmt)
- Practice-Based Services (Svcs)
- Patient-Centered Medical Home (PCMH)
- Practice-Based Care Team (Team)
- Quality and Safety (Quality)
- Health Information Technology (HIT)
- Care Coordination (Coord)
- Care Management (Care Mgt)
- Total across all modules (Total – calculated)

Methods

Each practice was asked to have three staff members (one physician, one nurse, and one administrator) complete the MHIQ at baseline (shortly before any Learning Sessions occurred in March, 2011) and at the mid-point of the demonstration project (18 months after the initiation of the Learning Collaborative) in September-December, 2012). The scores from staff members who completed the survey were averaged to determine the summary practice score.

Findings

At baseline, 58 practices and 138 staff members completed the MHIQ. At the mid-point data collection, 59 practices and 112 staff members completed the MHIQ.

At baseline, the Access module had the lowest score among the practices, with a mean score of 38%. The average scores for the other modules are closely grouped in the 60-75% range. There was

Executive Summary

marked variability between practices in several modules: practice management, practice-based services, health information technology, and coordination of care. At baseline, there were no significant differences among the three groups of practices (TAP, TAO, and comparison) in any of the modules. Overall, the practices are reporting a moderate level of “medical homeness” with an average total score of 66% (median of 69%). The total score for the practices ranges from a low of 11% to a high of 89%.

At 18 months, the Access module is still the lowest scoring module, with an average score of 47% (median of 46%), compared to the other modules with average scores ranging from 71% (Care Coordination: Coord) to 82% (Practice-based Care Team: Team). The variability is much less than observed at baseline, where there were several modules with variability that spanned the entire range of 0-100%. The most variable module is Quality and Safety (Quality) which spans a range of 30-98%. The total score has an average of 71% (median of 75%) at the mid-point, with a range from 47-91%, an absolute 5% higher than at baseline.

Comment

Among the nine MHIQ modules and the overall score, five modules (Access, PCMH, Practice-Based Team Care, Care Coordination, and Care Management) showed a significant increase in the scores across all practice groups (TAP, TAO, and Comparison), three modules (Practice Management, Quality and Safety, and Health Information Technology) showed no evidence of an increase in scores, and two modules (Practice-Based Services [$p=0.06$] and the Total score [$p=0.06$]) showed a non-significant trend toward higher scores. All modules and the total showed an increase in scores in all groups except for two modules in which the TAO group showed no change. There were no statistically detectable differences in the increase among the groups, although two modules did show significant difference among the group scores (but not the change). The Total (overall) score of medical homeness did show a non-significant ($p=0.06$) trend toward an overall increase (increase of an absolute 5%) among all of the groups.

At this point, it does not appear that any one group of practices will be significantly different (i.e., with consistently higher module or total scores) than the other groups, but that assessment will need to wait until the final responses to the MHIQ.

Medical Homeness: Findings from the Qualitative Team

Consistent with organizational theory, existing studies of PCMH demonstration projects report that successful practices change their management (core structure), staff roles (cultural system), mental models (political systems) and use of information technology.² In particular, they describe how physicians and other practice staff members undergo personal change.^{3,4} Further, these existing studies note: (1) wide variation in how practices change; (2) the critical role of the medical home facilitators; and (3) the need for ‘adaptive reserve’, a combination of teamwork, leadership, and material resources targeted to promote PCMH adoption.

Other factors work against transformation. First, the typical PCMH initiative lasts only 2-3 years which may not be sufficient for practice transformation. Second, initiative sponsors’ impatience to demonstrate results may add an administrative reporting burden that diverts energy from practice change and may hinder demonstration’s success. These factors may be mitigated if initiative sponsors can ensure that the practices maintain sufficient adaptive reserve.⁵

The qualitative study seeks to explore the themes of practice culture, organization, and infrastructure through two aims:

Executive Summary

1. Describe how practices become medical homes; and
2. Identify what hinders that process.

Methods

The Qualitative Team used multiple data collection techniques including in-depth, semi-structured individual interviews and focus groups with the Medical Home Facilitators (MHFs), field notes collected during Learning Sessions, and a review of practices' MA PCMH interventions.

Findings

Informed by organizational change theory and evidence from other PCMH initiatives, four key themes became apparent from the qualitative analyses:

1. Each practice has its own path to transformation;
2. Becoming a medical home requires organizational as well as personal transformation;
3. Practice leaders drive transformation; and
4. Information technology adaptations facilitate practice transformation.

Three themes emerged that describe factors hindering medical home adoption:

1. Competing priorities distract leaders;
2. Fee-for-service reimbursement hinders PCMH model care; and
3. Patient care demands challenge time available for MA PCMH activities.

Comment

These findings are consistent with those reported from the National PCMH Demonstration Pilot (NDP).**Error! Bookmark not defined.**⁶ The role of leadership is of particular importance to this and future initiatives. Leaders in many, but not all, practices have diverted their attention and full support away from the MA PCMH. Initially, practice leaders fully and enthusiastically supported the initiative, but as implementation of the demonstration continued, leaders found their time and energy diverted to other priorities. Both organizational theory and evidence from other PCMH demonstrations suggest that reduced leadership support may actually undermine a practice's redesign efforts by reducing its adaptive reserve, that combination of teamwork and material resources which leaders supply. Since adaptive reserve is critical for practice transformation, the MA PCMH Project Team and Steering Committee should continue their efforts to engage the 46 practices' leaders.

Further, organizational change theory suggests that the MA PCMH aids practice transformation by aligning the intervention's activities and requirements with each practice's core structure. The results confirm that the MA PCMH Steering Committee and Project Team have done this in several ways. First, the MHFs have established a unique consultative relationship with each of their assigned practices, assisting the practice to understand the MA PCMH requirements and align its operational systems accordingly. In one frequently mentioned example, the MHF helped the practice to structure its teams, to develop its teamwork skill and to adopt the team process into its operational system. Also, the MA PCMH Project Team organized Electronic Medical Record (EMR) user groups and Learning Session activities to meet the practices' need for technical system adaptations. By continuing efforts to align the intervention with each practice's core structure, the MA PCMH should promote medical home transformation.

Executive Summary

However, the ‘implementation climate’ in which all 46 practices operate may inhibit their transformation efforts. In particular, the results indicate how current fee-for-service policies actually reduce reimbursement when the practice ‘max-packs’ care into a single office visit. Certainly no practice welcomes lower revenue but the loss may differentially impact the eight group and independent physician practices which operate without institutional support. To mitigate this situation and to provide support for PCMH model adoption, MassHealth is developing alternative payment methodologies including the Primary Care Payment Reform Initiative (PCPR). By targeting the MA PCMH practices for PCPR participation, MassHealth may provide additional incentive for them to continue with medical home transformation.

Findings from the Patient Experience Survey

The Massachusetts Patient-Centered Medical Home (PCMH) Initiative is expected to affect the experiences of patients seeking medical care from participating medical practices. The principles of a medical home include enhanced access,⁷ having a personal provider who knows the patient personally,⁸ a whole-person orientation to care delivery across the life span,⁹ and an emphasis on strategies to fully engage patients in self-management.¹⁰ As the Massachusetts model evolves, the expectation is that patients will notice changes in the way their care is delivered.

This report presents findings from a survey of patients enrolled in practices participating in the PCMH and from patients enrolled in the group of comparison practices. The survey was administered between December 2011 and February 2012 and represents the first of three surveys planned as part of a comprehensive evaluation of the initiative. The survey will be repeated in the spring of 2013 and the spring of 2014. The results presented in the section are from the Time 1 survey.

The aims of the Time 1 survey include determining:

1. To what extent do patient experiences confirm that their primary care practices have adopted medical home competencies?
2. Where do opportunities for improvement exist and where might future surveys reveal change?

Methods

The survey instruments used for this project were developed by the MA-PES Survey Development team which included UMMS Office of Survey Research staff, MassHealth staff, Massachusetts Health Quality Partners (MHQP) staff, and survey methods experts. Survey content was primarily drawn from the initial versions of the CAHPS® Patient-Centered Medical Home instruments (under development by the Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance (NCQA) as this project was being planned), and MHQP’s Patient Experience Survey (PES) instrument.

The survey was administered under a contract with MHQP. The survey data were collected from November 28, 2011 to February 21, 2012 by Center for Study of Services using a two-wave mailing with telephone follow-up. A total of 17,261 patients from 65 practices participating in the Massachusetts PCMH were invited to complete the mailed survey.

Executive Summary

CAHPS Composites include Access, Communication, Office Staff, Self-Management, Comprehensiveness-Prevention (children only), Comprehensiveness-Development (children only), Follow-up, Comprehensiveness-mental/emotional health (adult only).

In addition to the CAHPS composites listed above, responses for selected individual questions were combined to further capture the patient’s perception of the practice’s achievement of medical home competency. These composites, the PCMHI composites, include urgent access, patient engagement, coordination, self-management knowledge, shared decision making (adult only), wellness (adult only), and behavioral health integration.

Findings

Adults

At Time 1, adult patients reported experiences consistent with their primary care practice having a fairly high adoption of patient-centered care (communication and courteous office staff), self-management support, care coordination, and comprehensive preventive care (a score of 80 and above). Scores for access, other aspects of patient-centered care (encouraging questions, knowledge of patient as a person) and for shared decision-making were moderate (scores in the 60-79 range). Attention to behavioral health was borderline between moderate and low at 60. Experiences with behavioral health integration and access to urgent care suggest that practices have not fully embraced these medical home competencies.

Findings related to access demonstrated moderate to low adoption of medical home competency. At baseline, adult patients reported moderate overall access to care (CAHPS Access score = 70.5) but rather poor access to urgent care. Only about 37% of adult respondents were able to get same-day appointments for urgent problems or were able to get care from the primary care office after-hours and on weekends (PCMH composite).

Patient-centeredness demonstrated by practices mixed high to moderate adoption. The two CAHPS composites scored fairly high at Time 1 at 88% for Communication and 84% for Office Staff. However, the slightly different aspects of patient-centeredness captured by the PCMHI Patient-Engagement composite suggest moderate adoption of patient-centeredness in other areas. The PCMHI composite assesses whether a provider encourages questions, whether a provider makes sure the patient understands instructions, and whether the provider knows the patient as a person. About 67% of respondents reported that their provider always encouraged questions, checked understanding, and knew them as a person.

Shared Decision-Making and other involvement of the patient in their care, while not as low as the Urgent Access and Behavioral Health Integration composites, showed only moderate scores. Between 62% and 70% of respondents felt their provider always engaged them in discussions about medication decisions.

Patients reported moderate to low attention to their behavioral health needs (CAHPS Comprehensiveness composite = 60). They also reported that practices only sometimes were able to help them with personal or emotional issues and were only sometimes aware of other behavioral health treatment being received by the patient (PCMH BH Integration composite = 40%).

Executive Summary

Child

At Time 1, the parents and guardians of sampled children reported experiences consistent with their primary care practice having a fairly high degree of adoption of several medical home competencies: good communication and courteous office staff (patient-centered competencies) and providing information and training in chronic condition management for parents of children with chronic conditions. Adoption of the access competencies, including access to urgent services was moderate, as was adoption of comprehensive care.

The two areas where reported patient experience suggests insufficient adoption of medical home competencies were supporting parents in taking care of their child’s health (CAHPS Self-Management composite = 49.3) and in integrating behavioral health care into primary practice (PCMHI BH Integration composite = 42%).

Comment

At baseline, both adult and child survey respondents report experiences consistent with high adoption of several medical home competencies. Both the CAHPS Communication and Office Staff composites scored well above 80. In addition, the PMCH composite, Self-Management Knowledge, demonstrated that patients believe they have the knowledge and skills to manage chronic conditions.

Areas of moderate adoption of medical home competency include general access, urgent access for children, activities designed to engage the patient, self-management support for adults, care coordination, shared decision-making, and comprehensive care delivery. These areas had scores in the 60 to 80 range. While moderate adoption of a competency is completely appropriate given the early stage of the PMCHI when the survey was conducted, it suggests possible opportunities for future quality improvement.

De-constructing composites into individual questions may offer clues about where to focus quality improvement efforts. For example, 63% of adult respondents reported that their provider always encouraged questions and 67% said their provider always checked for understanding. Viewed through a slightly different lens, out of every 100 patients, about 33 to 37 patients walk away from an office visit with unanswered questions or confused about what they heard.

Three areas deserve special attention by practices moving forward as the respondent’s experiences with care seem to indicate that much needs to be done towards achieving competency. The first area is urgent access for adults. Between 60 and 70% of the adults sampled required urgent or after-hours care at some point in the prior 12 months. Of these, only 37% were always able to get the care they needed in a timely manner. The remaining 63 out of 100 people waited several days for care or perhaps turned to the Emergency Department at their local hospital for care.

The second area for special attention is supporting parents and guardians in the management of their child’s health (CAHPS Self-Management Support score = 49.3). The questions included in the composite (goal-setting, things that make it hard to manage health) are more often associated with chronic illness management in adults. To the extent that these probes are appropriate for the entire child population, it may require pediatricians to consistently encourage dialog with parents and guardians.

Executive Summary

The final area where practices lag in the adoption of medical home competency is integration of behavioral health care with medical care. In addition to being a major thrust of the MA PCMH, it also represents a challenge for the health care system. Historically, primary care providers do not receive significant training in behavioral health management within the primary care setting. The comfort of most primary care clinicians is with medical rather than behavioral care. Additional support, including training of primary care providers, co-location or enhanced consultation with behavioral health providers or integrated care practices may be necessary to address this core competency of the PCMH.¹¹

Findings from the Staff Survey

The Massachusetts Patient-Centered Medical Home Initiative (PCMH) is expected to affect the work of clinicians, administrators, and support staff in participating medical practices. One approach to assessing the impact of change on work life is to ask workers about their experiences using the same survey over time.

To date, several national initiatives have explored the experiences of staff in practices participating in medical home demonstrations. Jaen and Nutting reported on the National Demonstration Project (NDP),^{12,13} Reid et al described the Group Health Medical Home project,¹⁴ and Lewis et al reported on the Safety Net Medical Home Initiative funded by the Commonwealth Fund.¹⁵

Each group used a somewhat different framework for assessing staff experiences. The National Demonstration Project's Clinician Staff Survey grouped items into five scales: adaptive reserve, community knowledge, health information technology integration, cultural sensitivity, and patient safety. The NDP described a practice's *adaptive reserve* as central to its transformation process. Adaptive reserve represents the practice's ability to keep pace with change and its ability to adapt to change. "A strong adaptive reserve includes such capabilities as a strong relationship system within the practice, shared leadership, protected group reflection time, and attention to the local environment."¹⁶ Thus, adaptive reserve defines a practice's capacity to be resilient and survive under pressure especially during times of dramatic change. Five qualities often define adaptive reserve, including: (1) *leadership* that facilitates change; (2) *sensemaking* to understand problems; (3) an enjoyable *work environment*; (4) a *culture that promotes learning*; and (5) an *infrastructure of relationships* among workers that promotes reflection and open discussion.

In developing its tool to assess staff experience, the Massachusetts PCMH evaluation team sought to link survey development to prior research as well as align with the core principles underlying the Massachusetts demonstration. Thus, the Massachusetts survey focuses on aspects of a practice's capacity to change, its adaptive reserve, and the relationship of that capacity to two of the core competencies outlined by the Massachusetts PMCHI Steering Committee – adoption of a culture of quality and the development of team work. The survey was administered in the fall of 2012 and will be repeated in the spring of 2013 and the spring of 2014.

Methods

Staff members from all 65 comparison and intervention practices (doctors, nurses and all support staff) were identified at the time of the survey as 'eligible' to participate. Each practice was asked to provide email addresses of its on-site staff members. If email addresses were unavailable, practices were asked to provide staff names so that individuals could be contacted through postal mail. All workers were asked to complete the survey using an internet URL address. Those with email addresses were sent an electronic invitation with the survey's URL hyperlink. Those with postal addresses were

Executive Summary

sent an invitation letter indicating where the survey could be located by typing in the URL address online. A total of 55 practices participated in the staff survey.

The MA PMCHI Staff Member Survey drew upon questions from several surveys used to evaluate national demonstrations of patient-centered medical home transformations. The selected questions measure a practice's ability to change, its success in achieving selected transformations, and the initiatives impact on staff. Each question asked the staff member the extent to which he/she either agreed or disagreed with the statement or answer how often events occurred in their practice.

Findings

At Time 1, the study and comparison practices were virtually identical in terms of the adaptive reserve components of leadership and knowledge of the community. Where the groups differed is on the integration of technology and work environment. The comparison sites reported, on average, higher levels of technology integration and a more pleasant work environment than the intervention practices.

Statistical testing showed that at Time 1, the comparison group appeared to have higher levels of quality improvement culture and of teamwork.

Size of a practice may make a difference in the adoption of PMCH competencies. Only small to medium-sized practices appear to have high levels of quality culture and teamwork.

At Time 1, there were no differences between the Study and Comparison groups on job satisfaction ($p=0.39$). The strongest correlates of job satisfaction were work environment, leadership, adoption of a QI culture, and teamwork.

Across the nearly 1,000 respondents, those with a clinical background reported a more positive perception of the practice's progress towards becoming a medical home. However, for only a few domains were the differences significant. Clinical staff in the two intervention groups perceived a greater culture of quality and of teamwork than the non-clinical staff. Clinical staff in the comparison group sites also reported greater teamwork. Clinical staff in both study and comparison groups reported greater job satisfaction and a more positive work environment than non-clinical staff.

Comment

This survey presents the data from nearly 1,000 respondents in 55 practices participating in the MA PMCHI Demonstration, approximately nine months into the implementation of the initiative.

At Time 1, intervention and comparison practices appeared similar in terms of adaptive reserve characteristics of leadership and connection of the community. Ample literature documents the importance of strong leadership in shepherding change.¹⁶ Comparison and intervention practices differed in the extent to which the practices effectively use technology, with staff in the comparison practices reporting more comfort with HIT integration.

Intervention and comparison practice staff also reported differing degrees of transformation towards a medical home related to the adoption of a quality improvement culture and teamwork. At Time 1, comparison practices had a slight, but statistically significant, edge over the TAP and TAO practices.

Executive Summary

The finding that practices with strong facilitative leadership are more likely to achieve a quality culture and teamwork suggests that focusing change support on leadership development may reap substantial benefits in terms of a practice’s ability to engage in transformative change.

Finally, the finding that non-clinical staff reported a lower job satisfaction and seemed less engaged in the medical home transformation, may have implications for future change. To the extent that the medical home transformation is intended to reach all levels of staff, non-clinical as well as clinical staff should be involved.

Clinical Impact

The Massachusetts PCMH Initiative presupposes that a combination of strategies will lead to changes in primary care practice and produce measurable results. As described above, strategies encompass both those external to a practice as well those to be enacted within a practice. External strategies include participation in Learning Collaboratives, coaching provided by external facilitators, and feedback of aggregated data. Internal strategies include multidisciplinary team-based care, a dedicated clinical care manager, use of registries with reporting capability, quality improvement embedded in care delivery, and linkages to the medical neighborhood.

This section of the report examines the overall impact of these strategies on a practice’s delivery of selected clinical services, including preventive care, care coordination and care management, and its processes and outcomes of care related to the initiative’s targeted conditions of diabetes and asthma. The data, collected monthly, cover the time period from April 2011 through September of 2012.

Methods

The Learning Collaborative team developed a core set of clinical quality measures for use during the Collaborative. The measures were divided into adult and pediatric sets and covered the domains of chronic condition management, care transitions and care management, continuity of care, and preventive care. Measures were selected to be clinically meaningful and aligned, where possible, with HEDIS, Meaningful Use, NCQA requirements, and other existing Massachusetts initiatives such as the Qualis Safety Net Medical Home Project. Some measures were developed as indicators of implementation of PCMH processes. The entire measure set was designed to foster the further development of practices’ quality improvement activities and skill set and thus required practice-based, as opposed to claims-based, reporting. Measures were grouped into four categories:

- Management of certain chronic conditions for adult and pediatric populations
- Care transitions & care management
- Continuity of care
- Preventive care for certain conditions in adult and pediatric populations

Findings

There was a significant improvement in the one diabetes process measure, screening for depression, but no significant change in the diabetes outcome measures over this time period. The other significant improvement was in follow-up after discharge from the hospital. None of the other measures demonstrated a significant improvement. It should be noted, however, that the number of reporting practices for the pediatric asthma measures was quite small. Only five practices reported at baseline and 18 months for the asthma medication measure and only six practices reported at both time periods for the asthma action plan measure.

Executive Summary

Both pediatric asthma measures showed improvement over time, but did not reach a level of statistically significant improvement. Nearly 70% of patients received appropriate medications for persistent asthma since the outset of the initiative and this continued to increase over time to approximately 90%.

Tobacco use assessment was performed at a high rate – approximately 80% of adult patients received this screening. The provision of a tobacco cessation intervention showed a slight, but non-significant, upward trend over time. Similarly, although not statistically significant from baseline to last reporting month, there was a trend toward improvement in adult weight screening and follow-up.

Comment

This analysis finds that practices are improving in care transitions and care management measures. Care coordination and care management are important components of the PCMH model and, in general, are new services for primary care practices. Other demonstration projects have shown significant reductions in hospitalizations and ED visits, which may be outcomes of care management.^{14 17 18} We have chosen to use process measures to help guide and monitor the implementation of these important PCMH components. The MA PCMH evaluation will include an analysis of hospital and ED unit utilization in its final report at the end of the initiative.

Limitations to these findings relate to the data reporting by practices, small sample sizes, and the lack of data from the evaluation comparison group. In addition, the small number of enrolled practices and the short time period of analysis may have reduced the ability to detect statistically significant differences. Finally, the comparison practices did not report clinical quality data, and therefore we cannot infer whether or not observed differences represent true changes related to our interventions or whether these noted changes are due to other factors, such as changes in health care law, regulations, and other environmental factors.

Summary

Question 1: To what extent do practices transform to become medical homes?

Baseline Medical Homeness

Both practice self-assessment and patient report suggest that participating practices had adopted some of the characteristics of the PCMH prior to the initiation of the MA PCMH. At baseline, practices showed high adoption of selected aspects of the first competency, patient-centered care (Sections 1 and 4). Providers had good communication practices and a customer service culture as exhibited through courteous office staff (Section 4).

At baseline, practices had moderate levels of competency in activities related to a quality and safety culture, use of health information technology, teamwork, and supporting patients to become active partners in their care (Sections 1 and 5). Section 3 of this report documents the struggles of practices to extract data from recalcitrant HIT systems and the challenges of changing old habits and patterns of communication as the practices sought to develop competency in teamwork.

Care coordination and care management activities were somewhat less well developed in that they showed low to moderate adoption at baseline, at least as measured by the MHIQ and the patient

Executive Summary

experience survey (Sections 1 and 4). Access to care, especially urgent care access, seemed to be an elusive competency at baseline.

18 Months Medical Homeness

At 18 months, changes were noted. Both intervention and comparison practices showed evidence of adoption of additional medical home competencies over the 18-month period, per the MHIQ survey (Section 1). As expected, practices entered the demonstration at differing levels of medical homeness. Overall medical home adoption ranged from a minimum score of medical homeness of 11 to a maximum of 89. By the 18-month measurement, adoption had improved with the minimum score rising to 47. In addition variation between scores decreased. Interestingly, both intervention practices and comparison practices improved their medical home scores by about the same amount – 4.5% overall.

Care management, access, and patient-centeredness showed the largest improvements between the two MHIQ measurement points (median changes 13 point, 10 points and 10 points, respectively). This may reflect the projects support activities. The Learning Sessions have focused on care management and patient-centered care and the Medical Home Facilitators have worked extensively with the practices to improve access to care.

Facilitators and Barriers to Medical Home Adoption

As the interviews conducted for this evaluation show, practices find transformation hard work requiring both organizational transformation and personal transformation at the staff level. Although EMR software ultimately should improve a practice's ability to monitor patients and provide care, the changes in the software and workflow required to get useful information from the systems has been a daunting task for practices. Both the interviews (Section 3) and the staff survey (Section 5) found that practices had a way to go to achieve full integration of technology into their workflow.

Data from the staff survey and the qualitative interviews also show that leadership drives transformation. The staff survey suggests that practices with strong leadership achieve teamwork and adopt a quality culture. The medical home facilitators make the point that leaders must decide to forgo billable time so that staff can do transformation activities such as meeting as a team.

The staff survey revealed that at Time 1, the development of the team work competency and the culture of quality competency may be related to practice size. Smaller practices, perhaps organizationally more nimble than larger practices, were the most likely to demonstrate both teamwork and a quality culture. The next iteration of the staff survey to be fielded in the spring of 2013 may demonstrate other areas of change in the adoption of core competencies.

Question 2: To what extent do patients become active partners in their health care?

The patient-experience survey conducted as part of this evaluation captures the experiences of individuals enrolled at intervention and comparison sites, approximately eight months after the first Learning Session (Section 4). Given the look-back period of the survey, last 12 months, the survey also captures about four months of experiences before the kick-off of the PCMH. Without the "time 2" survey, which is being fielded in the spring of 2013, it is impossible to directly address the impact of PCMH practice transformation on patient engagement. The baseline findings, however, reveal strengths and areas for improvement among the participating practices. The findings also demonstrate differences in the way in which patients and families engage in adult- and child-focused practices at baseline, which may lead to difference in the changes perceived by those different age groups.

Executive Summary

Adult and child-focused practices were similarly competent in the patient experience of communication with providers and office staff, leaving little room for improvement. Other competencies assessed by the CAHPS and PCMHI composites, however, had marked room for improvement, particularly self-management support, urgent access to care and behavioral health integration. In general, at baseline, patients reported being moderately engaged in their care. Shared decision-making occurred some of the time and patients sometimes reported that their provider knew them as a person.

The experience of adult patients, however, seemed different for those patients with one or more chronic diseases and those without a chronic disease. The chronic disease sample began with better scores than the general adult sample in access, self-management support, comprehensiveness (behavioral health), coordination, and shared decision-making. The patient experience of the caregivers of children, however, showed little difference between the chronic disease sample and the general child sample. As practices transform into medical homes, it will be interesting to see if the impact of the initiative spreads differently in the child-focused and adult-focused practices. While we expect the families and patients in the chronic disease samples to see the change in care first, the culture of pediatric practice may be such that the improvement is perceived by both general and chronic disease populations.

In addition, the pediatric practices that volunteered to participate in the PCMHI had better patient experience scores in more composite domains than comparison practices, unlike the composite scores in the adult practices which show no difference between participating and comparison practices. This will need to be accounted for as we look for evidence of change in the Time 2 survey.

Question 3: What is the initiative's impact on service use, clinical quality, and patient and provider outcomes?

The logic model for the initiative anticipated that the acquisition of medical home competencies would lead to improved care processes at 18 months, especially for the initially-targeted conditions of diabetes and asthma. Other expected 18-month outcomes included improved access to care and improved delivery of preventive services. By 18 months, it was also expected that patients would begin to perceive improvements in the care experience.

However, 18 months into the PMCHI demonstration we have limited data with which to assess impact. For example, the service use and Time 2 patient outcome measures are not yet available. The Massachusetts All-Payer Claims Database is providing data for the PCMHI Evaluation and the receipt of that data is expected for February 2013. The patient and staff experience surveys are being repeated in the late winter/early spring of 2013. Thus, full data on the impact of PMCHI won't be available until the summer of 2013.

The evidence to date for the initiative's impact on clinical processes and outcomes shows improvement in many measures, but not at a statistical level (Section 6). Statistically significant change was noted in the screening of patients with diabetes for depression and in the follow-up of patients who had been hospitalized. In the pediatric arena, data clearly show an upward trend in performance; the limited number of practices reporting pediatric measures limited the ability to detect statistically significant differences. The perennial question is of course, to what extent does a statistically important change reflect a clinically important difference? It is quite possible that although many of the metrics did not achieve statistical change, the improvement was clinically noticeable. Change occurs slowly. As one author noted: "Overall, the rate of improvement per year is probably not what national policy makers are hoping to see from transformation to medical homes." (page 520).¹⁹

Executive Summary

Evaluation Challenges

Data collection and formation of a comparison group have been the principal challenges for the evaluation team. Patient survey data collection was delayed over six months due to the need to negotiate stringent data use agreements with each of the participating payers. Staff survey data collection was hampered by the unwillingness of some practices to share contact information with the evaluation team.

Perhaps the biggest challenge was forming a comparison group. The process for recruiting comparison practices for this evaluation was unusual and probably contributed to the comparison group being somewhat different from the intervention group. As shown repeatedly throughout this report, the resulting comparison group of 19 practices differs from the intervention practices in many ways: baseline medical homeness, patient populations, and staff characteristics. Moving ahead, it will be extremely important to place these differences in context and not draw unwarranted conclusions about the impact of the PMCHI intervention because of baseline differences in groups. The comparison group is not a control group. Statistical techniques to be used in analyzing time 2 data will help in appropriately assessing performance between groups and between time periods.

Looking to the Future

As the PCMH gains attention and popularity, it is important to keep in mind that transforming primary care practices into medical homes is a complex endeavor that requires substantial money, time, and energy for systemic transformation and sustainability. If proper attention is not given to building the infrastructure necessary to support and develop all the components of the PCMH, the result will be a temporary, surface change. Practices need engaged leadership on both the executive and practice levels to influence transformation process innovation and to facilitate implementation and improving clinical performance.²⁰ They also need financial incentives that support the development and sustainability of medical home core competencies.

The risk in today's environment as PCMH has become more mainstream is that rushing to show results will be counterproductive. Practices in the MA PCMH that have taken the time to build a solid infrastructure are making the most progress. The transformation of the whole system of primary care through implementation of PCMH must not be viewed as an effortless prescheduled set of steps in practice redesign or as part of certification requirements. Instead, it represents a long lasting commitment to transformation and adaptability to patient needs and achieving the ultimate goals of improved health and patient satisfaction, and reduced costs.

Furthermore, state and national healthcare systems continue moving towards transformation of incentives, payment structures and practice environments. Change is happening, with and without the engagement of Massachusetts primary care practices. A solid patient-centered medical home structure with its protective adaptive reserve characteristics should help practices weather future turmoil. Consequently, PCMHs are best thought of as a stepping-stone to larger health care system transformation.

Executive Summary

Executive Summary: References

- ¹ The Safety Net Medical Home Initiative. Commonwealth Fund.
<http://www.commonwealthfund.org/Resources/2010/The-Safety-Net-Medical-Home-Initiative.aspx> :
accessed January 12, 2013.
- ² Nutting, P. A., Crabtree, B. F., Miller, W. L., Stewart, E. E., Stange, K. C., & Jaén, C. R. Journey to the patient-centered medical home: A qualitative analysis of the experiences of practices in the national demonstration project. *The Annals of Family Medicine*. 2010 8(Suppl 1); S45-S56.
- ³ Caldwell, D. F., Chatman, J., O'Reilly III, C. A., Ormiston, M., & Lapiz, M. Implementing strategic change in a health care system: The importance of leadership and change readiness. *Health Care Management Review*. 2010; 33(2), 124-133.
- ⁴ Miller, W. L., Crabtree, B. F., Nutting, P. A., Stange, K. C., & Jaén, C. R. Primary care practice development: A relationship-centered approach. *The Annals of Family Medicine*. 2010; 8 (Suppl 1), S68-S79
- ⁵ Patel, U. B., Rathjen, C., & Rubin, E. Horizon's patient-centered medical home program shows practices need much more than payment changes to transform. *Health Affairs*. 2012; 31(9), 2018-2027.
- ⁶ Nutting, P. A., Miller, W. L., Crabtree, B. F., Jaen, C. R., Stewart, E. E., & Stange, K. C. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *The Annals of Family Medicine*. 2009; 7(3), 254-260.
- ⁷ Carrier E, Gourevitch MN and Shah N. Challenges in translating theory into practice. *Medical Care*. 2009; 47(7): 714-722.
- ⁸ Van Berckelaer A, DiRocco Danae, Ferguson M, Gray P, Marcus N, Day S. Building a patient-centered medical home: obtaining the patient's voice. *JABFM*. 2012; 25(2): 192-198.
- ⁹ Rosenthal, Thomas C. The medical home: growing evidence to support a new approach to primary care. *JABFM*. 2008; 21(5): 427-440.
- ¹⁰ Flottemesch, TJ, Scholle SH, O'Connor PJ, Solberg LI, Asche S, Pawlson LG. Are characteristics of the medical home associated with diabetes care costs. *Medical Care*. 2012; 50(8): 676-684.
- ¹¹ DM Keller and B Sarvet. Is there a Psychiatrist in the House?: Integrating Child Psychiatry into the Pediatric Medical Home. *J American Assoc Child Adol Psychiatry*. 2013; 52: 3-5.
- ¹² Jaen CR, Crabtree BF, Palmer RF, Ferrer RL, Nutting PA, Miller WL, et al. Methods for Evaluating Practice Change Towards a Patient-Centered Medical Home. *Annals of Family Medicine*, 2010; 8(Supplement 1): s9-s20.
- ¹³ Nutting PA, Crabtree BF, Miller WL, Stange KC, Stewart E, Jaen C. Transforming Physician Practices to Patients-Centered Medical Homes: Lessons From the National Demonstration Project. *Health Affairs*. 2011; 30(3): 439-445.

Executive Summary

- ¹⁴ Reid RJ, Coleman K, Johnson EA, Fishman PA, Hsu C, Soman MP et al. The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers. *Health Affairs*. 2010; 29(5): 835-843.
- ¹⁵ Lewis SE, Nocon RS, Tang H, Park SY, Vable AM, Casalino LP, et al. Patient-Centered medical Home Characteristics and Staff Morale in Safety Net Clinics. *Archives of Internal Medicine*. 2012; 172(1): 23-31.
- ¹⁶ Sloane PD, Wroth T, Halladay J, Bray P, Spragens L, Stearns S and Zimmerman S. How Eight Primary care Practices Initiated and maintained quality monitoring and reporting. *JABFM*. 2011; 24(4): 360-369.
- ¹⁷ Peikes D, Zutshi A, Genevro J, Smith K, Parchman M, Meyers D. Early Evidence on the Patient-Centered Medical Home. Final Report Prepared by Mathematica Policy Research, for Agency for Healthcare Research and Quality (AHRQ). AHRQ Publication No. 12-0020-EF. Rockville, MD: 2012. Available at http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_evidence_evaluation_v2.
- ¹⁸ Nielsen M, Langner B, Zema C, Hacker T and Grundy P. Benefits of Implementing the PCMH: A Review of Cost & Quality Results. Patient Centered Primary Care Collaborative Report. 2012/ Available at http://www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pcmh_0.pdf
- ¹⁹ Solberg L, Asche S, Fontaine P, Flottenmesch T, Anderson L. Trends in Quality During medical Home Transformation. *Annals of Family Medicine*. 2011; 9: 515-521.
- ²⁰ Wagner EH, Coleman K, Reid RJ, Phillips K, Sugarman JR. Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes. The Commonwealth Fund: 2012.

For more information, please
contact Georgiana Willis at
(508)856-4039.



333 South Street, Shrewsbury, MA 01545
healthpolicy@umassmed.edu
www.umassmed.edu/chpr

Appendix C. Requested Safety Net Care Pool Funding

					SNCP expenditures for dates of service in SFY 2015-2019 (projected and rounded)					
#	Type	Applic. caps	State Law or regulation	Eligible providers	Total SNCP expenditure per SFY 15-19					5-year total: SFY 15-19
					SFY2015	SFY2016	SFY2017	SFY2018	SFY2019	
1	Public Service Hospital Safety Net Care Payment	SNCP		Boston Medical Center	\$ 52.0	\$ 52.0	\$ 52.0	\$ 52.0	\$ 52.0	\$ 260.0
2	Health Safety Net Trust Fund Safety Net Care Payment	SNCP	114.6 CMR 13.00, 14.00	All acute hospitals	\$ 200.0	\$ 190.0	\$ 180.5	\$ 171.5	\$ 162.9	\$ 904.9
3	Institutions for Mental Disease (IMD)	SNCP	130 CMR 425.408, 114.3 CMR 46.04	Psychiatric Inpatient Hospitals Community-based detoxification centers	\$ 26.6	\$ 29.3	\$ 32.2	\$ 35.4	\$ 39.0	\$ 162.5
4	Special Population State-Owned Non- Acute Hospitals Operated by the Department of Public Health	SNCP		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Mass. Hospital	\$ 46.4	\$ 47.1	\$ 47.9	\$ 48.6	\$ 49.3	\$ 239.3

5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	SNCP		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	\$ 84.1	\$ 85.4	\$ 86.7	\$ 88.1	\$ 89.5	\$ 433.8
6	Public Hospital Safety Net System Funding			Cambridge Health Alliance	\$ 312.0	\$ 292.0	\$ 280.0	\$ 272.0	\$ 264.0	\$1,420.0
7	Delivery System Transformation Initiatives	DSTI		Cambridge Health Alliance Boston Medical Center Holyoke Medical Center Lawrence General Hospital Mercy Medical Center Signature Healthcare Brockton Hospital Steward Carney Hospital	\$ 262.0	\$ 262.0	\$ 262.0	\$ 262.0	\$ 262.0	\$1,310.0
8	Public Hospital Incentive Initiative			Cambridge Health Alliance	\$ -	\$ 20.0	\$ 32.0	\$ 40.0	\$ 48.0	\$ 140.0
9	Designated State Health Programs	DSHP		n/a	\$ 457.2	\$ 454.9	\$ 461.9	\$ 454.3	\$ 446.3	\$ 2,274.6
10	DSHP – ConnectorCare Subsidies	Overall SNCP			\$ 142.8	\$ 230.1	\$ 238.1	\$ 245.7	\$ 253.7	\$ 1,110.4
11	Infrastructure and Capacity-building	Infra.		Eligible providers	\$ 45.0	\$ 45.0	\$ 45.0	\$ 45.0	\$ 45.0	\$ 225.0
									Total	\$ 8,480.5

Federal Budget Neutrality Summary

Room Under the Budget Neutrality Cap \$ 33,648,040,613

State Fiscal Year	Total			
	Date of Service Budget Neutrality Ceiling	CMS 64 Waiver Date of Service Expenditures	SNCP Expenditures	Variance
Third Waiver Extension Period				
SFY09 Actual	\$ 6,777,034,966	\$ 4,802,688,184		\$ 1,974,346,783
SFY10 Actual	\$ 7,738,084,084	\$ 5,348,418,034		\$ 2,389,666,050
SFY11 Actual	\$ 8,727,896,582	\$ 6,052,684,431		\$ 2,675,212,152
SFY09-11 SNCP			\$ 4,750,359,454	\$ (4,750,359,454)
	\$ 23,243,015,633	\$ 16,203,790,648	\$ 4,750,359,454	\$ 2,288,865,531
Fourth Waiver Extension Period				
SFY12 Actual	\$ 9,299,577,055	\$ 6,096,281,598		\$ 3,203,295,457
SFY13 Projected	\$ 10,067,950,670	\$ 6,422,105,493		\$ 3,645,845,177
SFY14 Projected	\$ 11,523,190,936	\$ 6,932,726,412		\$ 4,590,464,524
SFY12-14 SNCP			\$ 4,089,451,766	\$ (4,089,451,766)
	\$ 30,890,718,661	\$ 19,451,113,503	\$ 4,089,451,766	\$ 7,350,153,392
Fifth Waiver Extension Period				
SFY15 Projected	\$ 12,376,399,790	\$ 7,331,292,427		\$ 5,045,107,364
SFY16 Projected	\$ 13,321,959,902	\$ 7,613,180,378		\$ 5,708,779,524
SFY17 Projected	\$ 14,340,091,318	\$ 7,907,573,573		\$ 6,432,517,746
SFY18 Projected	\$ 15,436,381,038	\$ 8,214,814,419		\$ 7,221,566,619
SFY19 Projected	\$ 16,616,847,260	\$ 8,535,296,822		\$ 8,081,550,438
SFY15-19 SNCP			\$ 8,480,500,000	\$ (8,480,500,000)
	\$ 72,091,679,309	\$ 39,602,157,618	\$ 8,480,500,000	\$ 24,009,021,691
Total	\$ 126,225,413,602	\$ 75,257,061,769	\$ 17,320,311,220	\$ 33,648,040,613

Note:

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES WITH DSH \$ 6,777,034,966 \$ 7,738,084,084 \$ 8,727,896,582 \$ 9,299,577,055 \$ 10,067,950,670 **ACA Changes 1/1/14** \$ 11,523,190,936 \$ 12,376,399,790 \$ 13,321,959,902 \$ 14,340,091,318 \$ 15,436,381,038 \$ 16,616,847,260

	Total WY12-SFY09	Total WY13-SFY10	Total WY14-SFY11	Total WY15-SFY12	Total WY16-SFY13	Total WY17-SFY14 Q1&Q2	Total WY17-SFY14 Q3&Q4	Total WY18-SFY15	Total WY19-SFY16	Total WY20-SFY17	Total WY21-SFY18	Total WY22-SFY19
--	---------------------	---------------------	---------------------	---------------------	---------------------	---------------------------	---------------------------	---------------------	---------------------	---------------------	---------------------	---------------------

MEMBER MONTHS

	actual	actual	actual	actual	projected	projected	projected	projected	projected	projected	projected	projected
Base Populations Member Months (1)												
Families	7,235,254	7,553,008	7,810,583	7,992,106	8,231,870	4,239,413	4,231,634	8,632,533	8,805,184	8,981,287	9,160,913	9,344,131
Disabled	2,394,643	2,647,107	2,704,781	2,755,997	2,838,677	1,461,919	1,473,285	3,005,502	3,065,612	3,126,924	3,189,462	3,253,252
MCB	1,630	-	-	-	-	-	-	-	-	-	-	-
Total Base	9,631,528	10,200,115	10,515,364	10,748,104	11,070,547	5,701,332	5,704,919	11,638,035	11,870,795	12,108,211	12,350,376	12,597,383
1902(r)(2) Expansion Member Months (2)												
Kids	153,654	112,048	113,022	111,660	115,010	59,230	64,750	132,090	134,732	137,427	140,175	142,979
Disabled	164,093	170,737	178,269	183,064	188,555	97,106	97,106	198,096	202,058	206,099	210,221	214,426
Breast and Cervical Cancer Treatment Program	3,597	4,146	4,479	4,459	4,593	2,365	1,465	2,989	3,049	3,110	3,172	3,236
Total 1902(r)(2)	321,344	286,931	295,770	299,183	308,158	158,701	163,321	333,176	339,839	346,636	353,569	360,640
Category 8 (new population-Hypothetical)							projected	projected	projected	projected	projected	projected
							1,952,933	3,983,984	4,063,664	4,144,937	4,227,836	4,312,393
Total Waiver Member Months	9,952,872	10,487,046	10,811,134	11,047,286	11,378,705	5,860,033	7,821,174	15,955,195	16,274,299	16,599,785	16,931,780	17,270,416

PER MEMBER PER MONTH COSTS (PMPM)

														Trend Rate
Base Population PMPM														
Families	\$ 466.84	\$ 499.05	\$ 533.73	\$ 562.02	\$ 591.81	\$ 623.17	\$ 623.17	\$ 656.20	\$ 690.98	\$ 727.60	\$ 766.16	\$ 806.77	\$ 806.77	5.30%
Disabled	\$ 1,011.95	\$ 1,081.37	\$ 1,155.55	\$ 1,224.88	\$ 1,298.38	\$ 1,376.28	\$ 1,376.28	\$ 1,458.86	\$ 1,546.39	\$ 1,639.17	\$ 1,737.52	\$ 1,841.77	\$ 1,841.77	6.00%
MCB														
1902(r)(2) Population PMPM														
Kids	\$ 382.45	\$ 407.87	\$ 436.22	\$ 457.59	\$ 480.02	\$ 503.54	\$ 503.54	\$ 528.21	\$ 554.10	\$ 581.25	\$ 609.73	\$ 639.60	\$ 639.60	4.90%
Disabled	\$ 791.46	\$ 846.68	\$ 904.76	\$ 959.04	\$ 1,016.59	\$ 1,077.58	\$ 1,077.58	\$ 1,142.23	\$ 1,210.77	\$ 1,283.42	\$ 1,360.42	\$ 1,442.05	\$ 1,442.05	6.00%
Breast and Cervical Cancer Treatment Program	\$ 3,052.78	\$ 3,265.69	\$ 3,489.72	\$ 3,674.67	\$ 3,869.43	\$ 4,074.51	\$ 4,074.51	\$ 4,290.46	\$ 4,517.85	\$ 4,757.30	\$ 5,009.44	\$ 5,274.94	\$ 5,274.94	5.30%
Category 8 (new population-Hypothetical)							\$ 461.23	\$ 485.67	\$ 511.42	\$ 538.52	\$ 567.06	\$ 597.12	\$ 597.12	5.30%

TOTAL EXPENDITURES (Member Months x PMPM)

Base Population Expenditures													
Families	\$ 3,377,704,449	\$ 3,769,304,024	\$ 4,168,745,986	\$ 4,491,723,681	\$ 4,871,702,788	\$ 2,641,874,924	\$ 2,637,027,284	\$ 5,664,651,050	\$ 6,084,175,107	\$ 6,534,769,116	\$ 7,018,734,116	\$ 7,538,541,565	
Disabled/MCB	\$ 2,424,912,570	\$ 2,862,501,484	\$ 3,125,515,061	\$ 3,375,765,748	\$ 3,685,681,482	\$ 2,012,009,428	\$ 2,027,652,809	\$ 4,384,596,435	\$ 4,740,625,665	\$ 5,125,564,469	\$ 5,541,760,304	\$ 5,991,751,241	
1902(r)(2) Population Expenditures													
Kids	\$ 58,764,675	\$ 45,701,219	\$ 49,302,486	\$ 51,094,589	\$ 55,207,102	\$ 29,824,750	\$ 32,604,291	\$ 69,771,879	\$ 74,654,515	\$ 79,878,838	\$ 85,468,759	\$ 91,449,863	
Disabled	\$ 129,873,580	\$ 144,558,896	\$ 161,289,838	\$ 175,565,253	\$ 191,683,576	\$ 104,639,540	\$ 104,639,540	\$ 226,272,541	\$ 244,645,872	\$ 264,511,116	\$ 285,989,419	\$ 309,211,760	
Breast and Cervical Cancer Treatment Program	\$ 10,980,841	\$ 13,538,298	\$ 15,628,935	\$ 16,385,166	\$ 17,771,199	\$ 9,637,233	\$ 5,970,174	\$ 12,824,650	\$ 13,774,444	\$ 14,794,579	\$ 15,890,265	\$ 17,067,099	
Category 8 (new population-Hypothetical)							\$ 900,750,337	\$ 1,934,919,815	\$ 2,078,219,976	\$ 2,232,132,948	\$ 2,397,444,714	\$ 2,574,999,469	
Total Base + 1902 (r)(2) Expenditures + Benchmarks	\$ 6,002,236,116	\$ 6,835,603,920	\$ 7,520,482,305	\$ 8,110,534,438	\$ 8,822,046,147	\$ 4,797,985,875	\$ 5,708,644,436	\$ 12,293,036,370	\$ 13,236,095,579	\$ 14,251,651,066	\$ 15,345,287,578	\$ 16,523,020,996	
Hypothetical Population Expenditures													
CommonHealth hypothetical	\$ 76,624,474	\$ 73,192,792	\$ 79,710,504	\$ 78,578,019	\$ 80,935,360	\$ 40,467,679.79	\$ 40,467,679.79	\$ 83,363,420.36	\$ 85,864,322.97	\$ 88,440,252.66	\$ 91,093,460.24	\$ 93,826,264.04	
CommCare Parents hypothetical	\$ 32,544,698	\$ 37,677,624	\$ 45,484,664	\$ 43,815,208	\$ 47,521,537	\$ 25,770,691.68	\$ 25,770,691.68	\$ 51,541,383.36	\$ 51,541,383.36	\$ 51,541,383.36	\$ 51,541,383.36	\$ 51,541,383.36	
Essential 19-20 hypothetical	\$ 16,925,270	\$ 25,457,917	\$ 24,476,670	\$ 26,168,100	\$ 28,381,659	\$ 15,391,231.84	\$ 15,391,231.84	\$ 30,782,463.68	\$ 30,782,463.68	\$ 30,782,463.68	\$ 30,782,463.68	\$ 30,782,463.68	
CommCare 19-20 hypothetical	\$ 43,925,128	\$ 42,673,532	\$ 38,541,369	\$ 28,367,948	\$ 30,767,593	\$ 16,685,111.69	\$ 16,685,111.69	\$ 33,370,223.38	\$ 33,370,223.38	\$ 33,370,223.38	\$ 33,370,223.38	\$ 33,370,223.38	
CommCare <133% FPL hypothetical	N/A	\$ 97,101,247	\$ 403,658,851	\$ 387,422,325	\$ 420,194,379	\$ 227,869,310.86	\$ 227,869,310.86	\$ 455,738,621.72	\$ 455,738,621.72	\$ 455,738,621.72	\$ 455,738,621.72	\$ 455,738,621.72	
Total Base + 1902 (r)(2) + hypotheticals	\$ 6,172,255,686	\$ 7,111,707,032	\$ 8,112,354,363	\$ 8,674,886,037	\$ 9,429,846,675	\$ 5,124,169,901	\$ 5,749,112,116	\$ 12,376,399,790	\$ 13,321,959,902	\$ 14,340,091,318	\$ 15,436,381,038	\$ 16,616,847,260	
DSH	\$ 604,779,280	\$ 626,377,052	\$ 615,542,220	\$ 624,691,018	\$ 638,103,995	\$ 649,908,919	\$ 649,908,919	\$ -	\$ -	\$ -	\$ -	\$ -	
TOTAL EXPENDITURES WITH DSH	\$ 6,777,034,966	\$ 7,738,084,084	\$ 8,727,896,582	\$ 9,299,577,055	\$ 10,067,950,670	\$ 11,523,190,936	\$ 12,376,399,790	\$ 13,321,959,902	\$ 14,340,091,318	\$ 15,436,381,038	\$ 16,616,847,260		

Note:
Beginning with SFY 2009, CMS and the Commonwealth have agreed to craft the budget neutrality agreement from zero, with no deficit or savings carried over to SFY 2009 or subsequent renewal periods. Accordingly, prior period without waiver calculations have been omitted here.

With Waiver Non-SNCP Expenditures

Based on WY 15 expenditures reported on CMS-64.9W as of Period Ended 03/31/2013

MEGs	<<based on actuals					forecast>>		ACA Changes Take Effect (1/1/2014)				
	WY12-SFY2009	WY13-SFY2010	WY14-SFY2011	WY15-SFY2012	WY16-SFY2013	WY17-SFY2014 Q1&Q2	WY17-SFY2014 Q3&Q4	WY18-SFY2015	WY19-SFY2016	WY20-SFY2017	WY21-SFY2018	WY22-SFY2019
(1) 1902 (r) (2) Children	\$ 30,634,034	\$ 45,052,830	\$ (18,019,636)	\$ 55,045,121	\$ 55,793,735	\$ 28,276,265	\$ 34,092,985	\$ 69,399,679.69	\$ 70,634,994	\$ 71,892,297	\$ 73,171,980	\$ 74,474,441
(2) 1902 (r) (2) Disabled	\$ 58,100,426	\$ 52,808,403	\$ 53,556,046	\$ 48,700,398	\$ 48,700,398	\$ 24,350,199	\$ 24,350,199	\$ 47,025,104.31	\$ 45,407,441	\$ 43,845,425	\$ 42,337,142	\$ 40,880,744
(3) Base Disabled	\$ 1,891,545,176	\$ 1,936,109,162	\$ 2,285,598,192	\$ 2,095,138,623	\$ 2,178,315,626	\$ 1,132,397,378	\$ 1,138,251,251	\$ 2,367,562,602.81	\$ 2,462,265,107	\$ 2,560,755,711	\$ 2,663,185,940	\$ 2,769,713,377
(4) Base Families	\$ 2,200,268,545	\$ 2,421,624,435	\$ 2,354,173,733	\$ 2,495,106,657	\$ 2,603,643,797	\$ 1,358,451,151	\$ 1,358,651,151	\$ 2,835,504,952	\$ 2,958,849,417	\$ 3,087,559,367	\$ 3,221,868,199	\$ 3,362,019,466
(5) E - Family Assistance	\$ 6,864,268	\$ 11,672,531	\$ 13,420,464	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
(6) E - HIV/FA	\$ 19,793,685	\$ 23,780,384	\$ 25,074,405	\$ 24,470,521	\$ 26,349,857	\$ 14,186,763	\$ 5,602,274	\$ 11,334,521	\$ 11,466,002	\$ 11,599,008	\$ 11,733,556	\$ 11,869,665
(7) Basic	\$ 122,868,060	\$ 129,691,413	\$ 157,102,741	\$ 166,072,174	\$ 183,941,540	\$ 101,866,825	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
(8) BCCTP	\$ 4,596,243	\$ 6,043,624	\$ 4,762,257	\$ 3,896,346	\$ 3,792,314	\$ 1,845,529	\$ 863,708	\$ 1,591,813	\$ 1,466,856	\$ 1,351,708	\$ 1,245,599	\$ 1,147,819
(9) CommonHealth (hypothetical)	\$ 87,494,615	\$ 73,192,792	\$ 79,710,504	\$ 78,578,019	\$ 78,578,019	\$ 39,289,010	\$ 39,289,010	\$ 77,140,041	\$ 75,728,378	\$ 74,342,549	\$ 72,982,081	\$ 71,646,508
(10) Essential	\$ 328,077,521	\$ 381,820,277	\$ 409,155,645	\$ 472,964,179	\$ 534,354,929	\$ 301,857,100	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
(11) Insurance Partnership (IRP)	\$ 38,048,147	\$ 31,098,635	\$ 26,158,629	\$ 22,079,592	\$ 18,418,796	\$ 9,209,398	\$ 20,790,602	\$ 14,473,490	\$ 11,373,268	\$ 8,937,114	\$ 7,022,784	\$ 5,518,504
(12) Medical Savings Plan (MSP)	\$ 62,815,797	\$ 133,238,682	\$ 148,855,740	\$ 140,022,251	\$ 142,724,680	\$ 72,739,633	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
(13) Mental Health Special Program for Youth	\$ 4,354,267	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Category 8 (new population-Hypothetical)							\$ 900,750,337	\$ 1,866,354,699	\$ 1,933,543,468	\$ 2,003,151,033	\$ 2,075,264,470	\$ 2,149,973,991
Prelim Total Expenditures	\$ 4,838,535,514	\$ 5,220,675,251	\$ 5,515,072,050	\$ 5,575,905,781	\$ 5,846,232,031	\$ 3,069,078,019	\$ 3,522,641,517	\$ 7,290,386,903	\$ 7,570,734,932	\$ 7,863,434,211	\$ 8,168,811,751	\$ 8,487,244,517
CommCare Parents hypothetical	\$ 32,544,698	\$ 37,677,624	\$ 45,484,664	\$ 43,815,208	\$ 47,521,537	\$ 25,770,692	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CommCare 19-20 hypothetical		\$ 42,673,532	\$ 38,541,369	\$ 28,367,948	\$ 30,767,593	\$ 16,685,112	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CommCare <133 FPL hypothetical		\$ 97,101,247	\$ 404,633,007	\$ 387,422,325	\$ 420,194,379	\$ 227,869,311	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Essential 19-20 hypothetical	\$ 16,925,270	\$ 25,457,917	\$ 24,476,670	\$ 26,168,100	\$ 28,381,659	\$ 15,391,232	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medical Homes				\$ 4,034,137	\$ 7,900,000	\$ 3,950,000	\$ 3,950,000	\$ 7,900,000	\$ 7,900,000	\$ 7,900,000	\$ 7,900,000	\$ 7,900,000
Pediatric Asthma					\$ 126,635	\$ 69,649	\$ 69,649	\$ 153,228	\$ 168,551	\$ 185,406	\$ 203,946	\$ 224,341
Early Intervention Specialty Services				\$ 4,400,000	\$ 12,600,000	\$ 6,930,000	\$ 6,930,000	\$ 15,246,000	\$ 16,770,600	\$ 18,447,660	\$ 20,292,426	\$ 22,321,669
Provisional Eligibility							\$ 11,000,000	\$ 3,545,188	\$ 3,545,188	\$ 3,545,188	\$ 3,545,188	\$ 3,545,188
End-of-Month Coverage							\$ 7,000,000	\$ 14,061,108	\$ 14,061,108	\$ 14,061,108	\$ 14,061,108	\$ 14,061,108
1915(c) adjustment	\$ (102,242,569)	\$ (100,625,454)										
Total Projected Expenditures (non-SNCP)	\$ 4,802,688,184	\$ 5,348,418,034	\$ 6,052,684,431	\$ 6,096,281,598	\$ 6,422,105,493	\$ 3,381,135,246	\$ 3,551,591,166	\$ 7,331,292,427	\$ 7,613,180,378	\$ 7,907,573,573	\$ 8,214,814,419	\$ 8,535,296,822
Schedule C Total	\$ 6,510,725,983	\$ 6,704,519,968	\$ 7,513,292,944	\$ 7,411,748,211	\$ 4,974,285,787							
Exclude Sch. C SNCP expenditures	\$ (1,655,265,199)	\$ (1,318,612,021)	\$ (1,531,076,687)	\$ (1,393,884,056)	\$ (690,821,704)							
Exclude Sch. C CC Hypo expenditures	\$ -	\$ (139,774,779)	\$ (442,667,537)	\$ (415,790,274)	\$ (287,753,163)							
Exclude Essential 19-20 Hypo expend.	\$ (16,925,270)	\$ (25,457,917)	\$ (24,476,670)	\$ (26,168,100)	\$ (28,381,659)							
Subtotal: Non-SNCP non-Hypo Sch. C	\$ 4,838,535,514	\$ 5,220,675,251	\$ 5,515,072,050	\$ 5,575,905,781	\$ 3,967,329,261							
Completion (claims run out)				\$ -	\$ 1,796,308,331							
Actual / Estimated P4P	\$ 35,725,564	\$ 55,623,075	\$ 38,711,363	\$ 43,744,719	\$ 50,000,000							
Total expenditures not yet reported on Schedule C	\$ -	\$ -	\$ -	\$ -	\$ 1,796,308,331							
Total Schedule C with Adjustments	\$ 4,838,535,514	\$ 5,220,675,251	\$ 5,515,072,050	\$ 5,575,905,781	\$ 5,763,637,592							
Total from above (line 19)	\$ 4,838,535,514	\$ 5,220,675,251	\$ 5,515,072,050	\$ 5,575,905,781	\$ 5,846,232,031							
Tie	\$ -	\$ -	\$ -	\$ -	\$ (82,594,439)							

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 group will be more generous than they have been in these demonstration programs.

		= (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	
	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	

SNCP expenditures for dates of service in SFY 2012-2014 (projected and rounded)								SNCP expenditures for dates of service in SFY 2015-2019 (projected and rounded)						
#	Type	Applic. caps	State law or regulation	Eligible providers	Total SNCP expenditure per SFY 12-14			3-year total 12-14	Total SNCP expenditure per SFY 15-19					5-year total 15-19
					SFY 2012	SFY 2013	SFY 2014		SFY2015	SFY2016	SFY2017	SFY2018	SFY2019	
1	Public Service Hospital Safety Net Care Payment	Prov		Boston Medical Center Cambridge Health Alliance	\$ 332.0	\$ 332.0	\$ 332.0	\$ 996.0	\$ 52.0	\$ 52.0	\$ 52.0	\$ 52.0	\$ 52.0	\$ 260.0
2	Health Safety Net Trust Fund Safety Net Care Payment	Prov	114.6 CMR 13.00, 14.00	All acute hospitals	\$ 77.7	\$ 159.4	\$ 156.3	\$ 393.4	\$ 200.0	\$ 190.0	\$ 180.5	\$ 171.5	\$ 162.9	\$ 904.9
3	Institutions for Mental Disease (IMD)	Prov	130 CMR 425.408, 114.3 CMR 46.04	Psychiatric Inpatient Hospitals Community-based detoxification centers	\$ 9.9	\$ 22.0	\$ 24.0	\$ 55.8	\$ 26.6	\$ 29.3	\$ 32.2	\$ 35.4	\$ 39.0	\$ 162.5
4	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	Prov		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Mass. Hospital	\$ 40.0	\$ 43.0	\$ 45.0	\$ 128.0	\$ 46.4	\$ 47.1	\$ 47.9	\$ 48.6	\$ 49.3	\$ 239.3
5	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	Prov		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	\$ 84.1	\$ 85.4	\$ 86.7	\$ 88.1	\$ 89.5	\$ 433.8
6	Essential Public Hospital			Cambridge Health Alliance					\$ 312.0	\$ 292.0	\$ 280.0	\$ 272.0	\$ 264.0	\$ 1,420.0
7	Delivery System Transformation Incentives	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	\$ 262.0	\$ 262.0	\$ 262.0	\$ 262.0	\$ 262.0	\$ 1,310.0
8	Public Hospital Incentive Initiative			Cambridge Health Alliance					\$ -	\$ 20.0	\$ 32.0	\$ 40.0	\$ 48.0	\$ 140.0
9	Designated State Health Programs	DSHP		n/a	\$ 360.0	\$ 310.0	\$ 130.0	\$ 800.0	\$ 457.2	\$ 454.9	\$ 461.9	\$ 454.3	\$ 446.3	\$ 2,274.6
10	DSHP - Connector Care subsidies	Overall SNCP		n/a	n/a	n/a	\$ 55.0	\$ 55.0	\$ 142.8	\$ 230.1	\$ 238.1	\$ 245.7	\$ 253.7	\$ 1,110.4
11	DSHP Commonwealth Care Transition	Overall SNCP		n/a	n/a	n/a	\$ 8.0	\$ 8.0						\$ -
12	Commonwealth Care	n/a	C. 58 (2006)	n/a	\$ 305.1	\$ 303.1	\$ 152.5	\$ 760.7						\$ -
13	Infrastructure and Capacity-building	Infra.		Eligible providers	\$ 3.0	\$ 14.5	\$ 26.0	\$ 43.5	\$ 45.0	\$ 45.0	\$ 45.0	\$ 45.0	\$ 45.0	\$ 225.0
								\$ 4,089.5	Total					\$ 8,480.5

Expenditure Limits (STC 146)	SNCP Aggregate Cap (approved)	\$ 4,400.0		
	(over)/under	\$ 310.5		
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	\$ 79.8
	DSHP Subcap	\$ 800.0	\$ 800.0	\$ -

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 as follows:
For dates of service in SFY 2012, BMC, \$52,000,000; CHA, \$280,000,000 (\$125,500,000 already authorized).
For dates of service in SFY 2013, BMC, \$52,000,000; CHA, \$280,000,000.
For dates of service in SFY 2014, BMC, \$52,000,000; CHA, \$280,000,000.
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) DSHP programs are listed separately in Attachment E. Authority for DSHP applies only to expenditures for dates of service through December 31, 2013.

(8) Expenditures for Commonwealth Care Premium Assistance are based on actual enrollment, capitation rates, and expected enrollee contributions, and are approved by CMS on an aggregate basis. Consequently, the amount for each year may vary. Expenditures for Commonwealth Care Premium Assistance for Hypothetical populations (CommCare-19-20, CommCareParents, and CommCare-133 EGs) are excluded from the SNCP. Authority for Commonwealth Care applies only to expenditures for dates of service through December 31, 2013.

(9) Infrastructure and Capacity-Building (ICB) funds support Commonwealth-defined health systems improvement projects, and are approved by CMS on an aggregate basis, pursuant to STC 49(d). Spending for ICB is subject to the limit described in STC 50(b).

Hypothetical Population Analysis

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	73,116		
SFY 2014	75,309		
Actual / Projected PMPM		Trended PMPM	
CommCare 19+20		CommCare 19+20	
SFY 2009	\$ 374.33	SFY 2009	\$ 374.33
SFY 2010	\$ 392.71	SFY 2010	\$ 400.35 7.0%
SFY 2011	\$ 338.05	SFY 2011	\$ 428.17 7.0%
SFY 2012	\$ 399.63	SFY 2012	\$ 447.13 5.3%
SFY 2013	\$ 420.81	SFY 2013	\$ 470.83 5.3%
SFY 2014	\$ 443.11	SFY 2014	\$ 495.78 5.3%
Actual / Projected total expenditures		Trended baseline costs	
Used for WW Expenditures			
SFY 2009	\$ 43,925,128	SFY 2009	\$ 43,925,128
SFY 2010	\$ 42,673,532	SFY 2010	\$ 43,609,471
SFY 2011	\$ 38,541,369	SFY 2011	\$ 39,365,262
SFY 2012	\$ 28,367,948	SFY 2012	\$ 31,739,970
SFY 2013	\$ 30,767,593	SFY 2013	\$ 34,425,009
SFY 2014	\$ 33,370,223	SFY 2014	\$ 37,336,720
	\$ 217,645,793		
		Lesser of Actuals or Trended	
		Used for WOW Cap	
SFY 2009	\$ 43,925,128	SFY 2009	\$ 43,925,128
SFY 2010	\$ 42,673,532	SFY 2010	\$ 42,673,532
SFY 2011	\$ 38,541,369	SFY 2011	\$ 38,541,369
SFY 2012	\$ 28,367,948	SFY 2012	\$ 28,367,948
SFY 2013	\$ 30,767,593	SFY 2013	\$ 30,767,593
SFY 2014	\$ 33,370,223	SFY 2014	\$ 33,370,223

CommCare Parents			
Member Months			
CommCare Parents			
SFY 2009	86,941		
SFY 2010	101,210		
SFY 2011	113,240		
SFY 2012	116,834		
SFY 2013	120,339		
SFY 2014	123,949		
Actual / Projected PMPM		Trended PMPM	
CommCare Parents		CommCare Parents	
SFY 2009	\$ 374.33	SFY 2009	\$ 374.33
SFY 2010	\$ 372.27	SFY 2010	\$ 400.35 7.0%
SFY 2011	\$ 413.22	SFY 2011	\$ 428.17 7.0%
SFY 2012	\$ 375.02	SFY 2012	\$ 498.35 5.3%
SFY 2013	\$ 394.90	SFY 2013	\$ 524.77 5.3%
SFY 2014	\$ 415.83	SFY 2014	\$ 552.58 5.3%
Actual / Projected total expenditures		Trended baseline costs	
Used for WW Expenditures			
SFY 2009	\$ 32,544,698	SFY 2009	\$ 32,544,698
SFY 2010	\$ 37,677,624	SFY 2010	\$ 40,519,364
SFY 2011	\$ 45,484,664	SFY 2011	\$ 48,486,027
SFY 2012	\$ 43,815,208	SFY 2012	\$ 58,224,347
SFY 2013	\$ 47,521,537	SFY 2013	\$ 63,150,442
SFY 2014	\$ 51,541,383	SFY 2014	\$ 68,491,989
	\$ 258,585,115		
		Lesser of Actuals or Trended	
		Used for WOW Cap	
SFY 2009	\$ 32,544,698	SFY 2009	\$ 32,544,698
SFY 2010	\$ 37,677,624	SFY 2010	\$ 37,677,624
SFY 2011	\$ 45,484,664	SFY 2011	\$ 45,484,664
SFY 2012	\$ 43,815,208	SFY 2012	\$ 43,815,208
SFY 2013	\$ 47,521,537	SFY 2013	\$ 47,521,537
SFY 2014	\$ 51,541,383	SFY 2014	\$ 51,541,383

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	978,304		
SFY 2014	1,007,653		
Actual / Projected PMPM		Trended PMPM	
CommCare <133 (k)(2)		CommCare <133 (k)(2)	
SFY 2009	N/A	SFY 2009	N/A
SFY 2010	\$ 397.48	SFY 2010	\$ 397.48
SFY 2011	\$ 393.82	SFY 2011	\$ 425.11 7.0%
SFY 2012	\$ 407.89	SFY 2012	\$ 498.36 5.3%
SFY 2013	\$ 429.51	SFY 2013	\$ 524.77 5.3%
SFY 2014	\$ 452.28	SFY 2014	\$ 552.58 5.3%
Actual / Projected total expenditures		Trended baseline costs	
Used for WW Expenditures			
SFY 2009	N/A	SFY 2009	N/A
SFY 2010	\$ 97,101,247	SFY 2010	\$ 97,317,635
SFY 2011	\$ 404,633,007	SFY 2011	\$ 403,658,851
SFY 2012	\$ 387,422,325	SFY 2012	\$ 473,347,312
SFY 2013	\$ 420,194,379	SFY 2013	\$ 513,384,748
SFY 2014	\$ 455,738,622	SFY 2014	\$ 556,809,132
	\$ 1,765,089,580		
		Lesser of Actuals or Trended	
		Used for WOW Cap	
SFY 2009	N/A	SFY 2009	N/A
SFY 2010	\$ 97,101,247	SFY 2010	\$ 97,101,247
SFY 2011	\$ 404,633,007	SFY 2011	\$ 403,658,851
SFY 2012	\$ 387,422,325	SFY 2012	\$ 387,422,325
SFY 2013	\$ 420,194,379	SFY 2013	\$ 420,194,379
SFY 2014	\$ 455,738,622	SFY 2014	\$ 455,738,622

Essential 19+20 Hypothetical Population

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 2009-2011.

Member Months	
Essential 19+20	
SFY 2009	57,938
SFY 2010	81,721
SFY 2011	89,883
SFY 2012	87,936
SFY 2013	90,574
SFY 2014	93,291

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
Actual / Projected total expenditures	
Used for WW Expenditures	
SFY 2009	\$ 16,925,270
SFY 2010	\$ 25,457,917
SFY 2011	\$ 24,476,670
SFY 2012	\$ 26,168,100
SFY 2013	\$ 28,381,659
SFY 2014	\$ 30,782,464
	\$ 152,192,080

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

Actual
 From 3rd Renewal STCs
 From 3rd Renewal STCs
 From December 2011 Renewal STCs
 From December 2011 Renewal STCs
 From December 2011 Renewal STCs

Lesser of Actuals or Trended	
Used for WOW Cap	
SFY 2009	\$ 16,925,270
SFY 2010	\$ 25,457,917
SFY 2011	\$ 24,476,670
SFY 2012	\$ 26,168,100
SFY 2013	\$ 28,381,659
SFY 2014	\$ 30,782,464

CommonHealth

March 2, 2011

STC language

d) Starting in SFY 2006, actual expenditures for the CommonHealth EG 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 CommonHealth costs [using recent base year experience and approved trend rates] or actual CommonHealth per member per month (PMPM) cost experience for SFYs 2009-2011 [DYs 12, 13, and 14].

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%

	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 2014

From WW Expenditu Used for WOW Cap

	Member Months	Trended PMPM	Trended spending	Actual / projected spending	Lesser of Actuals or Trended
SFY 2006	137,818	\$ 380.49	\$ 52,438,828	\$ 52,438,828	\$ 52,438,828
SFY 2007	147,218	\$ 407.13	\$ 59,936,748	\$ 61,576,778	\$ 59,936,748
SFY 2008	157,887	\$ 435.63	\$ 68,779,809	\$ 61,721,922	\$ 61,721,922
SFY 2009	164,603	\$ 465.51	\$ 76,624,474	\$ 87,494,615	\$ 76,624,474
SFY 2010	185,138	\$ 497.44	\$ 92,095,935	\$ 73,192,792	\$ 73,192,792
SFY 2011	201,460	\$ 531.57	\$ 107,089,890	\$ 79,710,504	\$ 79,710,504
SFY 2012	214,279	\$ 563.46	\$ 120,737,583	\$ 78,578,019	\$ 78,578,019
SFY 2013	220,707	\$ 597.27	\$ 131,821,823	\$ 80,935,360	\$ 80,935,360
SFY 2014	227,328	\$ 633.11	\$ 143,923,930	\$ 80,935,360	\$ 80,935,360
SFY 2015	234,148	\$ 671.10	\$ 157,136,147	\$ 83,363,420	\$ 83,363,420
SFY 2016	241,173	\$ 711.36	\$ 171,561,245	\$ 85,864,323	\$ 85,864,323
SFY 2017	248,408	\$ 754.04	\$ 187,310,567	\$ 88,440,253	\$ 88,440,253
SFY 2018	255,860	\$ 799.29	\$ 204,505,677	\$ 91,093,460	\$ 91,093,460
SFY 2019	263,536	\$ 847.24	\$ 223,279,299	\$ 93,826,264	\$ 93,826,264

\$ 469,976,508 2009-2019

PMPM Trends (€MM trends (forecast))

2007	7.0%	
2008	7.0%	
2009	6.9%	
2010	6.9%	
2011	6.9%	4.4%
2012	6.0%	3.8%
2013	6.0%	3.9%
2014	6.0%	3.9%

	?	

2015	6.00%
2016	6.00%
2017	6.00%
2018	6.00%
2019	6.00%

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: t
2011-2
(per CI)

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

These trends reflect a
2013 aggregate trend
(MS direction)

Projected DSH allotment

FFY	Allot W/O ARRA (Federal share)	Allot W/ ARRA (Federal share)	Allotment w/ ARRA (Total Computable)	Source
2008	287,285,600		574,571,200	Federal Register
2009	299,926,166	307,424,320	614,848,640	Federal Register
2010	299,926,166	315,109,928	630,219,856	Federal Register
2011	305,324,837		610,649,674	Federal Register
2012	314,685,733		629,371,466	CMS
2013	320,507,419		641,014,838	Projected using CPI-U
2014	326,436,806		652,873,613	Projected using CPI-U
2015	-		-	
2016	-		-	
2017	-		-	
2018	-		-	
2019	-		-	

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	\$ 649,908,919
SFY 2015	\$ -
SFY 2016	\$ -
SFY 2017	\$ -
SFY 2018	\$ -
SFY 2019	\$ -

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

Change in SNCP

Base	\$ 4,600,000,000	
Old DSH	\$ 1,723,713,600	
New DSH	\$ 1,874,073,054	<i>used for SNCP cap and provider subcap</i>
Change	\$ 150,359,454	
New SNCP (SFY 2009 to 2011)	\$ 4,750,359,454	

DSH Allotment grows based on CPI-U - Consumer Price Index for all Urban Consumers

FFY 2010	0.8 to 1.0	Core PCE inflation 0.90% 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		

Sources:

FY 2009 Revised Preliminary Allotment U/ARRA

FY 2010 Preliminary Allotment

<http://edocket.access.gpo.gov/2010/pdf/2010-8502.pdf>

p. 21314 Federal Register / Vol. 75, No. 78 / Friday, April 23, 2010 / Notices

estimate
estimate

**Submission of a Request to Extend the MassHealth Section 1115 Demonstration:
Summary and Public Comment Period**

August 20, 2013

The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a request to extend the MassHealth Section 1115 Demonstration (Demonstration Extension Request) to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2013.

Public Comment Period:

EOHHS will accept comments on the proposed Demonstration Extension Request through September 19, 2013. Written comments may be delivered by email or mail. By email, please send comments to laxmi.tierney@state.ma.us and include "Comments for Demonstration Extension Request" in the subject line. By mail, please send comments to: Laxmi Tierney, EOHHS Office of Medicaid, One Ashburton Place, 11th Floor, Boston, MA 02108. Comments must be received by 5pm on September 19, 2013 in order to be considered.

EOHHS will host two Stakeholder Meetings open to the public on the proposed Demonstration Extension Request. The meeting details are as follows:

Stakeholder Meeting #1, in conjunction with a meeting of the MassHealth Medical Care Advisory Committee and the MassHealth Payment Policy Advisory Board:

Date: Tuesday, August 27
Time: 10:00am-12:00pm
Location: Transportation Building
10 Park Plaza
Boston, MA

Stakeholder Meeting #2:

Date: Thursday, August 29
Time: 10:00am-12:00pm
Location: Worcester Public Library
3 Salem Square
Worcester, MA

The Demonstration Extension Request documents may be obtained on the MassHealth 1115 Demonstration website: <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html>. Additional updates and final submissions to CMS will also be posted on this website.

Paper copies of the documents may be obtained in person by request from 9am-5pm at EOHHS, One Ashburton Place, 11th Floor, Boston, MA 02108.

Background:

The MassHealth 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs. The current 1115 Demonstration is authorized through June 30, 2014.

The Commonwealth's Demonstration Extension Request outlines the specific authorities being requested from CMS from July 1, 2014 to June 30, 2019 to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration.

The MassHealth 1115 Demonstration has been a key element in the Commonwealth's achievement of near-universal coverage since the enactment of Chapter 58 of the Acts of 2006. Now, as required by the federal Affordable Care Act (ACA) and recent state legislation (Chapter 224 of the Acts of 2012), the next phase of health care reform focuses on cost containment and delivery system reforms. MassHealth is well positioned to continue its leadership role in these areas by advancing alternative payment methodologies and delivery system transformation including medical homes and integrated care for high risk populations. To meet the 1115 Demonstration's goals and gain additional benefits through reform, the Commonwealth's partnership with CMS through the Demonstration remains central to the Demonstration's continued success.

The Demonstration Extension Request affects eligibility, benefits, payment methodologies and delivery systems, as well as changes to expenditure authorities under the Demonstration.

Summary of Requested Changes to the Demonstration:

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

A five-year renewal term, as authorized by the Social Security Act, will support the full implementation of the Commonwealth's Duals Demonstration and its integrated care model known as One Care, which provides coverage for individuals under age 65 who are eligible for Medicaid and Medicare. The Duals Demonstration and the 1115 Demonstration are closely interrelated and provide complementary authorities that enable the Commonwealth's efforts to institute a fully integrated and fully capitated delivery model for disabled members. Massachusetts aims to learn from the Duals Demonstration and explore expanding the One Care model to non-dual eligible disabled members through the 1115 Demonstration in future years.

Advancing Alternative Payment Models

MassHealth's new Primary Care Payment Reform Initiative (PCPRI) is the primary vehicle to transition MassHealth members to alternative payment methodologies, as required by Chapter 224, the Commonwealth's pioneering 2012 payment reform and cost containment legislation. To transform health care delivery and payment through the PCPRI, the Commonwealth requests authority to set shared savings / risk targets for providers and to make shared savings payments or, as applicable, recoup payments to providers under alternative payment arrangements involving shared risk. This authority will establish the basis for the Commonwealth to fully implement both the PCPRI and an Accountable Care Organization (ACO) model currently in development. With

PCPRI as its foundation, MassHealth would consider making three key changes to the future ACO model: shifting the contracting entity from a Primary Care Clinician (PCC) to an ACO; adjusting the payment model to encourage providers to take on higher levels of risk; and modifying quality metrics and delivery model requirements to extend beyond a medical home to a “medical neighborhood.”

Pediatric Asthma Pilot Program

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

Safety Net Care Pool

The Commonwealth requests the following authorities for the Safety Net Care Pool:

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

Express Lane Renewal

The Commonwealth is proposing to continue its current Express Lane renewal process for families, with certain changes to account for implementation of the ACA on January 1, 2014. In addition, the Commonwealth is seeking authority to expand the Express Lane renewal process to childless adults receiving Medicaid benefits with MassHealth-verified income at or below 133 percent FPL and income verified by the Supplemental Nutrition Assistance Program at or below 163 percent FPL.

Medicare Cost Sharing Assistance

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

Early Intervention / Applied Behavioral Analysis for Autism

MassHealth requests continued authority for coverage of enhanced early intervention program services including medically necessary Applied Behavioral Analysis-based treatment services for children with autism spectrum disorders.

NOTICE OF AGENCY ACTION

SUBJECT: MassHealth: Notice of Submission of a Request to extend the MassHealth Section 1115 Demonstration

AGENCY: Massachusetts Executive Office of Health and Human Services

The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a Request to extend the MassHealth Section 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2013.

The MassHealth Section 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

The Demonstration Extension Request outlines the specific authorities being requested from CMS from July 1, 2014 to June 30, 2019 to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration. Consistent with Chapter 224 and the Affordable Care Act, the next phase of the Demonstration focuses on cost containment and delivery system reforms. This request will affect eligibility, benefits, payment methodologies and delivery systems, as well as changes to expenditure authorities under the Demonstration.

Public Comment Period: EOHHS will accept comments on the proposed Demonstration Extension request through September 19, 2013. In addition, EOHHS will host two public hearings on the proposed Extension Request in Boston on August 27 and in Worcester on August 29. The proposed Extension Request; details on where to submit comments; the date, time, and location of the public hearing; and additional relevant information are available at:

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

MassHealth and State Health Care Reform

www.mass.gov/eohhs/gov/departments/mashealth/mashealth-and-health-care-reform.html

Mass.gov State Offices & Courts | State A-Z Topics | State Forms | No Active Alerts | Skip to main content | English | Search

The Official Website of the Executive Office of Health and Human Services (EOHHS)

Health and Human Services
Departments & Divisions

A-Z Topic Index | Consumer | Provider | Researcher | **Government**

Home > Government > Departments > MassHealth > MassHealth and Health Care Reform

MassHealth and State Health Care Reform

Draft 1115 Demonstration ("Waiver") Renewal Request (as posted for public comment August 20, 2013)

The public-comment period is now open and will close at 5:00 p.m. on Thursday, September 19, 2013.

- [Section 1115 Demonstration Slides from Public Stakeholder Meetings](#) PDF 6MB PDF
- [Submission of a Request to Extend the MassHealth Section 1115 Demonstration Summary and Public Comment Period](#) PDF PDF
- [Section 1115 Demonstration Project Extension Request](#) PDF 1MB PDF 9MB
- [Appendix A List of Frequently Used Abbreviations](#) PDF PDF
- [Appendix B Requested Safety Net Care Pool Funding](#) PDF PDF
- [Appendix C Budget Neutrality Worksheets](#) PDF

1115 Demonstration ("Waiver") Amendment Request (Filed June 4, 2013)

- [Cover Letter](#) PDF PDF
- [Amendment Request Proposal Submitted to CMS](#) PDF PDF
- [ACA Transition Plan](#) PDF PDF

Draft 1115 Demonstration ("Waiver") Amendment Request (As posted for Public Comment May 1, 2013)

Tierney, Laxmi (EHS)

From: MA-ACA Update <ma-aca-update@umassmed.edu>

Sent: Thursday, August 22, 2013 5:01 PM

To: Tierney, Laxmi (EHS)

Subject: MA-ACA Update

Having trouble viewing this email? [Click here](#)



AFFORDABLE CARE ACT MASSACHUSETTS IMPLEMENTATION ANNOUNCEMENT

August 22, 2013

Quick Links

[MA-ACA Website](#)



Join Our
Mailing List

These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a request to extend the MassHealth Section 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2013. The Demonstration documents can be found here: <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html>

Paper copies can be obtained at EOHHS' office at 1 Ashburton Place, 11th Floor in Boston.

EOHHS will host two Stakeholder Meetings open to the public on the proposed Demonstration Extension Request. The meeting details are as follows:

Stakeholder Meeting #1 (in conjunction with a meeting of the MassHealth

Medical Care Advisory Committee and the MassHealth Payment Policy Advisory Board):

Date: Tuesday, August 27

Time: 10:00am-12:00pm

Location: Transportation Building

10 Park Plaza

Boston, MA

Stakeholder Meeting #2:

Date: Thursday, August 29

Time: 10:00am-12:00pm

Location: Worcester Public Library

3 Salem Square

Worcester, MA

Public Comment Period:

EOHHS will accept comments on the proposed Demonstration Extension Request through September 19, 2013. Written comments may be delivered by email or mail. By email, please send comments to laxmi.tierney@state.ma.us and include "Comments for Demonstration Extension Request" in the subject line. By mail, please send comments to: Laxmi Tierney, EOHHS Office of Medicaid, One Ashburton Place, 11th Floor, Boston, MA 02108. Comments must be received by 5pm on September 19, 2013 in order to be considered.

We encourage you all to attend the stakeholder hearings and submit comments. We look forward to seeing you and receiving your feedback!

Bookmark the **Massachusetts National Health Care Reform website** at: [National Health Care Reform](#) to read updates on ACA implementation in Massachusetts.

Remember to check the Mass.Gov website at: [Dual Eligibles](#) for information on the "**Integrating Medicare and Medicaid for Dual Eligible Individuals**" initiative.

[Forward email](#)



Try it FREE today.

This email was sent to laxmi.tierney@state.ma.us by ma-aca-update@umassmed.edu | [Update Profile/Email Address](#) | Instant removal with [SafeUnsubscribe™](#) | [Privacy Policy](#).
UMass Medical School | 333 South Street | Shrewsbury | MA | 01545

PUBLIC NOTICES

Home

Print Selected Notice(s)

Revise your Search

Page 1 of 1 (10 total results)

Search Results Show 25 complete notices Go

MASSHEALTH SECTION 1115 DEMONSTRATION

NOTICE OF AGENCY ACTION SUBJECT: MassHealth: Notice of Submission of a Request to extend the MassHealth Section 1115 Demonstration AGENCY: Massachusetts Executive Office of Health and Human Services The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a Request to extend the MassHealth Section 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2013. The MassHealth Section 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs. The Demonstration Extension Request outlines the specific authorities being requested from CMS from July 1, 2014 to June 30, 2019 to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration. Consistent with Chapter 224 and the Affordable Care Act, the next phase of the Demonstration focuses on cost containment and delivery system reforms. This request will affect eligibility, benefits, payment methodologies and delivery systems, as well as changes to expenditure authorities under the Demonstration. Public Comment Period: EOHHS will accept comments on the proposed Demonstration Extension request through September 19, 2013. In addition, EOHHS will host two public hearings on the proposed Extension Request in Boston on August 27 and in Worcester on August 29. The proposed Extension Request details on where to submit comments; the date, time, and location of the public hearing; and additional relevant information are available at: <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html>.

Appeared in: **Boston Globe** on Friday, 08/23/2013

Select notice to print

EBI PROJECT # 61133990

AT&T Mobility, LLC is proposing to collocate wireless telecommunications antennas, on an existing building located at 42 Park Street, Boston, Suffolk County, MA. A total of twelve antennas and support equipment will be installed at top heights of 72 feet and 70 feet above grade. Any interested party wishing to submit comments regarding the potential effects the proposed facility may have on any historic property may do so by sending such comments to: Project 61133990-MB c/o EBI Consulting, 21 B Street, Burlington, MA 01803, or via telephone at 781-572-0698.

Appeared in: **Boston Globe** on Wednesday, 08/21/2013

Ask about our Residential Mortgage Loans Jumbo Loans Commercial/Investment Property Loans
Click here for more information

MIDDLESEX FEDERAL
We're here to help
A Davis Square institution for more than 120 years
Davis Square • Teelo Square • Medford Square
617-666-4700 • MiddlesexFederal.com

Public Notices x Legal Notice Notices and Announcements x

classifieds.masslive.com/?cur_cat=6869&orig_prop=ma_republican_merch&temp_type=browse&category=results&tp=ME_mass&property=ma_republican_merch&classification=

Suggested Sites Imported From IE ACO

by this court or Section 3.02 of the Regulations or the Judicial Conference of the United States Establishing Standards and Procedures for the Appointment and Reappointment of United States Magistrate Judges, it is hereby ORDERED that the following persons are appo...

[Notices and Announcements - Legal Notice](#)

Published in *The Republican* 8/26. Updated 8/26.

Legal Notices

NOTICE OF AGENCY ACTION SUBJECT: MassHealth: Notice of Submission of a Request to extend the MassHealth Section 1115 Demonstration AGENCY: Massachusetts Executive Office of Health and Human Services The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a Request to extend the MassHealth Section 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2013. The MassHealth Section 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs. The Demonstration Extension Request outlines the specific authorities being requested from CMS from July 1, 2014 to June 30, 2019 to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration. Consistent with Chapter 234 and the Affordable Care Act, the next phase of the Demonstration focuses on cost containment and delivery system reforms. This request will affect eligibility, benefits, payment methodologies and delivery systems, as well as changes to expenditure authorities under the Demonstration. Public Comment Period: EOHHS will accept comments on the proposed Demonstration Extension request through September 19, 2013. In addition, EOHHS will host two public hearings on the proposed Extension Request in Boston on August 27 and in Worcester on August 29. The proposed Extension Request details on where to submit comments; the date, time, and location of the public hearing; and additional relevant information are available at: <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth/masshealth-and-health-care-reform.html>. (August 26)

[Notices and Announcements - Legal Notice](#)

Published in *The Republican* 8/26. Updated 8/26.

Springfield

BOARD OF LICENSE COMMISSIONERS FOR THE CITY OF SPRINGFIELD Application for: Transfer of License Date: August 23, 2013 Notice is hereby given, under Chapter 138 of the General Laws, that Pride Convenience, Inc. DBA Pride, located at 1225 Parker Street, has petitioned the Springfield Board of License Commissioners for a Transfer

NO IMAGE

[MORE INFO >](#)

[E-MAIL FRIEND >](#)

[SAVE LISTING >](#)

NO IMAGE

[MORE INFO >](#)

[E-MAIL FRIEND >](#)

[SAVE LISTING >](#)

B10 TELEGRAM & GAZETTE

MONDAY, AUGUST 26, 2013

LEGAL NOTICES

LICENSE COMMISSION
CITY OF WORCESTER
August 26, 2013

Notice is hereby given under Chapter 138 of the General Laws as amended that Title Form 171 (old) car Boulevard has applied to be allowed to have outside seating. Hearing on this matter will take place Thursday, September 5, 2013 at 10:00 a.m. in the Esther Howland Chambers, 3rd floor, City Hall, 455 Main Street.

The License Commission is committed to ensuring that its public meetings are accessible to people with disabilities. Should you require auxiliary aids, services, written materials in other formats, reasonable modifications in policies and procedures, please call 508-799-1400 X260 in advance of the scheduled meeting.

KARON SHEA
PAUL MILLAN
ANTHONY SALVIO
Board of License Commission

LEGAL NOTICES

TOWN OF STERLING
BOARD OF APPEALS

Notice is hereby given that application has been filed with the Sterling Board of Appeals by Pamela J. McCaskey to vary the terms of the Protective By-law of the Town of Sterling with regard to property owned by her and situated on the westerly side of Westchester Avenue in said Sterling, known as Parcel 20. Westchester Avenue shown in the Assessors Map Plan Book as Map # 92 Lot # 63 and being zoned Neighborhood Residential and to require a variance to do roof and screen walls to deck.

A hearing will be given on this application in the Mary Ellen Bunker Municipal Building, 1 Park Street, starting on Tuesday, September 10th, 2013 at 6:30 p.m. at which time you may appear either in person or by Agent or your Attorney and present any objection which you may have to the allowance of this application.

A copy of this application is on file in the office of the Town Clerk and may be seen during regular business hours.

William Bird, Chairman
Board of Appeals
August 26, September 2, 2013

LEGAL NOTICES

Commonwealth of Massachusetts
The Trial Court
Probate and Family Court
Docket No. W013P2571EA

Worcester Probate and Family Court
225 Main Street, Worcester, MA 01608
(508) 831-2000

CITATION ON PETITION FOR FORMAL ADJUDICATION
Estate of Evelyn Nina Schryvers
Date of Death: 07/04/2013

To all interested persons: A Petition has been filed by **Christine J. Silva of Ludlow, MA** requesting that the court enter a formal Decree and Order of intestacy and for such other relief as requested in the Petition, and also requesting that **Christine J. Silva of Ludlow, MA** be appointed as Personal Representative of said estate to serve **With Personal Survey** on the bond.

You have the right to obtain a copy of the Petition from the Petitioner or at the Court. You have a right to object to this proceeding. To do so, you or your attorney must file a written appearance and objection at this Court before: **10:00 a.m. on 09/10/2013**

This is **NOT** a hearing date, but a deadline by which you must file a written appearance and objection if you object to this proceeding. If you fail to file a timely written appearance and objection followed by an Affidavit of Objections within thirty (30) days of the return date, action may be taken without further notice to you.

The estate is being administered under formal procedure by the Personal Representative under the Massachusetts Uniform Probate Code without supervision by the Court. Inventory and accounts are not required to be filed with the Court, but recipients are entitled to notice regarding the administration from the Personal Representative and can petition the Court in any matter relating to the estate, including distribution of assets and expenses of administration.

WITNESSES: Hon. Dennis L. Meagher, First Justice of this Court.
Date: August 15, 2013
Stephen G. Abraham, Register of Probate
August 26, 2013

LEGAL NOTICES

NOTICE OF FINAL AGENCY ACTION

SUBJECT: MassHealth: Payment for Services at Newly Operating Psychiatric Hospital Outpatient Department

AGENCY: Massachusetts Executive Office of Health and Human Services

SUMMARY OF FINAL ACTION: Pursuant to the provisions of M.G.L. c. 118E, §13A, rates and terms of payment for services rendered by psychiatric hospitals, to patients entitled to medical assistance under M.G.L. c. 118E, §1 et seq., are established by contract between the MassHealth program and participating hospitals. This notice describes the methods and standards for the establishment of rates of payment by contract, effective August 27, 2013, for services at newly operating psychiatric hospital outpatient departments that are licensed by the Department of Mental Health and for which historical cost and charge information used to establish standard MassHealth outpatient psychiatric hospital rates is not available. The contract does not cover services provided to patients enrolled with MassHealth's Primary Care Clinician Flex+ behavioral health contractor, or with a MassHealth contracted managed care entity.

DESCRIPTION OF METHODS AND STANDARDS: MassHealth utilizes a hospital-specific cost-to-charge ratio for outpatient services, derived from historical cost and charge information filed with the Center for Health Information and Analysis, the successor agency to the Division of Health Care Finance and Policy. For any newly operating psychiatric hospital outpatient department for which historical cost and charge information used to establish standard MassHealth outpatient psychiatric hospital rates is not available, MassHealth pays using the median of the cost-to-charge ratios for the other private psychiatric hospitals in Massachusetts that provide outpatient care. The median cost-to-charge ratio is derived by calculating the midpoint of the six hospitals that provide outpatient services.

The method described herein is projected to result in a \$20,000 increase in annual aggregate expenditures. The actual change in annual aggregate expenditures may vary depending on actual utilization of services. The rate of payment for outpatient services provided by Whitaker Psychiatric Hospital, the sole qualifying hospital at this time, is to apply a cost-to-charge ratio of 25.2%.

To request any written comments regarding the matters described in this notice or to request copies of this notice please contact:

Maurel Freeman
MassHealth Office of Behavioral Health
100 Hancock Street, 4th Floor
Quincy, MA 02271

Or by e-mail: Maurel.Freeman@state.ma.us
Statutory Authority: M.G.L. c. 118E, §42 USC 1396 Related Regulations: 42 CFR Part 447
August 26, 2013

LEGAL NOTICES

NOTICE OF MORTGAGEE'S SALE OF REAL ESTATE

By virtue and in execution of the Power of Sale contained in a certain mortgage given by David N. Mura, Akira David Mouri and Lucy Mouri to Mortgage Electronic Registration Systems, Inc., dated May 3, 2009 and recorded with the Worcester County Worcester District Registry of Deeds at Book 36233, Page 220, of which mortgage the undersigned is the present holder by assignment from Mortgage Electronic Registration Systems, Inc. to Plaintiff Chase Bank, National Association dated May 15, 2012 and recorded with said registry on June 4, 2012 at Book 49072 Page 197 for breach of the conditions of said mortgage and for the purpose of foreclosing, the same will be sold at Public Auction at 2:00 p.m. on September 3, 2013, on the mortgaged premises located at 15 South Bulfinch Street, Unit 15, 15-17 South Bulfinch Street Condominium, Worcester, Worcester County, Massachusetts, all and singular the premises described in said mortgage.

TO WHOM:

The Unit known as Unit 15 of the 15-17 South Bulfinch Street Condominium Unit Condominium in Worcester, Massachusetts, established pursuant to Massachusetts General Laws, Chapter 183A by Master Deed dated 5/3/2009 and recorded herewith in Book 36233, Page 154, and on the copy of the portion of said plan attached hereto and made a part hereof, to which is affixed the verified statement in the form required by Section 9 of said Chapter 183A.

Said Unit is conveyed together with an undivided 50% interest in the common areas and facilities of the Condominium described in said Master Deed. Said Unit is conveyed subject to and with the benefit of:

1. Provisions of said Chapter 183A.
2. The provisions of the Master Deed and the floor plans of the Condominium recorded simultaneously with and as a part of the Master Deed, and the Declaration of Trust, recorded herewith in Book 36233, Page 160 ("Trust"), in each case as the same may be amended from time to time by instruments recorded with said Deeds, which provisions, together with any amendments thereto, shall constitute covenants running with the land and shall bind any person having at any time any interest or estate in the Unit, his/her employees, mortgagees, tenants, invitees, and visitors at the premises recorded with said Deeds, which provisions are amended at length herein;
3. Provisions of existing building and zoning laws; and
4. The rights, reservations, and restrictions described in the Master Deed.
5. The limitation that the unit may be used only for residential purposes subject to the zoning by laws of the City of Worcester and the restrictions set forth in the Master Deed and the restrictions set forth in the Declaration of Trust.

These premises will be sold and conveyed subject to and with the benefit of all rights, rights of way, restrictions, easements, covenants, liens or claims in the nature of liens, improvements, public as-

LEGAL NOTICES

NOTICE OF AGENCY ACTION

SUBJECT: MassHealth: Notice of Submission of a Request to extend the MassHealth Section 1115 Demonstration

AGENCY: Massachusetts Executive Office of Health and Human Services

The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a Request to extend the MassHealth Section 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2013.

The MassHealth Section 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, other services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

The Demonstration Extension Request outlines the specific authorities being requested from CMS from July 1, 2014 to June 30, 2019 to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration. Consistent with Chapter 224 and the Affordable Care Act, the next phase of the Demonstration focuses on cost containment and delivery system reforms. This request will affect eligibility, benefits, payment methodologies and delivery systems, as well as changes to expenditure authorities under the Demonstration.

Public Comment Period: EOHHS will accept comments on the proposed Demonstration Extension Request through September 15, 2013. In addition, EOHHS will hold two public hearings on the proposed Extension Request in Boston on August 27 and in Worcester on August 29. The proposed Extension Request details on where to submit comments, the date, time, and location of the public hearing, and additional relevant information are available at: <http://www.mass.gov/eohhs/government/masshealth/masshealth-and-health-care-reform.html>

August 26, 2013

Yard Sale
DIRECTORY
Place an ad at
www.telegram.com/classified
Call 508.793.9393 Fax 508.793.9308

Flea Markets

ANNUAL MARKET FESTIVAL Free market, live entertainment, food vendors, crafts, local artists, farmer's market. Join us Sept. 7th from 9:00-5:00. PAM-SPM at 223 Oliver St., Worcester. Space and tables still available. Free parking and admission. Contact: marketfestival@apppchurch.com

MONA'S FLEA MARKET Shop 6 rooms in the BIG RED BUILDING, 85 Southbridge St., Auburn next to Biggan Outlet. Open Sat. 8:30am year-round 8:00-3:00

TOWN OF DOUGLAS
CONSERVATION COMMISSION
29 DEPOT STREET, DOUGLAS, MA 01516

LEGAL NOTICE FOR PUBLIC MEETING
REQUEST FOR DETERMINATION OF APPLICABILITY

THE TOWN OF DOUGLAS CONSERVATION COMMISSION WILL HOLD A PUBLIC MEETING FOR THE TOWN OF DOUGLAS HIGHWAY DEPARTMENT ON SEPTEMBER 3, 2013 AT 7:30 PM IN THE MUNICIPAL CENTER, 29 DEPOT STREET, FOR WORK TO BE DONE PURSUANT TO THE TOWN OF DOUGLAS WETLAND BYLAW AND THE WETLAND PROTECTION ACT, MEX CHAPTER 157, SECTION 40. THE PROPOSED REQUEST FOR DETERMINATION OF APPLICABILITY WORK LOCATION IS SOUTH STREET POLE #1 - POLE #60, MARTIN ROAD PARK PARKING AREA AND ACCESS DRIVE, DAVIS STREET, NORTHEAST MAIN STREET, WEST STREET, REDELL ROAD AND 91 MARTIN ROAD MAP 190 PARCELS 220 AND THE APPLICANT IS REQUESTING PERMISSION TO PAVE SOUTH STREET POLE #1 - POLE #60 AND PLACE TALKINGS ON MARTIN ROAD PARK PARKING LOT AND ACCESS DRIVE. CONTACT SEAL AT DAVIS STREET, NORTHEAST MAIN STREET, WEST STREET & REDELL ROAD, AND ID GRADING AT 91 MARTIN ROAD MAP 190 PARCELS 220 FOR SIGHT LINE DISTANCE FOR CARS EXITING MARTIN ROAD PARK.

August 26, 2013

TOWN OF DOUGLAS
CONSERVATION COMMISSION
29 DEPOT STREET, DOUGLAS, MA 01516

LEGAL NOTICE FOR PUBLIC MEETING
REQUEST FOR DETERMINATION OF APPLICABILITY

THE TOWN OF DOUGLAS CONSERVATION COMMISSION WILL HOLD A PUBLIC MEETING FOR THE TOWN OF DOUGLAS HIGHWAY DEPARTMENT ON SEPTEMBER 3, 2013 AT 7:30 PM IN THE MUNICIPAL CENTER, 29 DEPOT STREET, FOR WORK TO BE DONE PURSUANT TO THE TOWN OF DOUGLAS WETLAND BYLAW AND THE WETLAND PROTECTION ACT, MEX CHAPTER 157, SECTION 40. THE PROPOSED REQUEST FOR DETERMINATION OF APPLICABILITY WORK LOCATION IS SOUTH STREET POLE #1 - POLE #60, MARTIN ROAD PARK PARKING AREA AND ACCESS DRIVE, DAVIS STREET, NORTHEAST MAIN STREET, WEST STREET, REDELL ROAD AND 91 MARTIN ROAD MAP 190 PARCELS 220 AND THE APPLICANT IS REQUESTING PERMISSION TO PAVE SOUTH STREET POLE #1 - POLE #60 AND PLACE TALKINGS ON MARTIN ROAD PARK PARKING LOT AND ACCESS DRIVE. CONTACT SEAL AT DAVIS STREET, NORTHEAST MAIN STREET, WEST STREET & REDELL ROAD, AND ID GRADING AT 91 MARTIN ROAD MAP 190 PARCELS 220 FOR SIGHT LINE DISTANCE FOR CARS EXITING MARTIN ROAD PARK.

August 26, 2013

MORE LEGALS ON B4

Place an ad at
www.anytimeads.com
- Services from \$50.00

NOTICE OF MORTGAGEE'S SALE OF REAL ESTATE

By virtue and in execution of the Power of Sale contained in a certain mortgage given by David N. Mura, Akira David Mouri and Lucy Mouri to Mortgage Electronic Registration Systems, Inc., dated May 3, 2009 and recorded with the Worcester County Worcester District Registry of Deeds at Book 36233, Page 220, of which mortgage the undersigned is the present holder by assignment from Mortgage Electronic Registration Systems, Inc. to Plaintiff Chase Bank, National Association dated May 15, 2012 and recorded with said registry on June 4, 2012 at Book 49072 Page 197 for breach of the conditions of said mortgage and for the purpose of foreclosing, the same will be sold at Public Auction at 2:00 p.m. on September 3, 2013, on the mortgaged premises located at 15 South Bulfinch Street, Unit 15, 15-17 South Bulfinch Street Condominium, Worcester, Worcester County, Massachusetts, all and singular the premises described in said mortgage.

TO WHOM:

The Unit known as Unit 15 of the 15-17 South Bulfinch Street Condominium Unit Condominium in Worcester, Massachusetts, established pursuant to Massachusetts General Laws, Chapter 183A by Master Deed dated 5/3/2009 and recorded herewith in Book 36233, Page 154, and on the copy of the portion of said plan attached hereto and made a part hereof, to which is affixed the verified statement in the form required by Section 9 of said Chapter 183A.

Said Unit is conveyed together with an undivided 50% interest in the common areas and facilities of the Condominium described in said Master Deed. Said Unit is conveyed subject to and with the benefit of:

1. Provisions of said Chapter 183A.
2. The provisions of the Master Deed and the floor plans of the Condominium recorded simultaneously with and as a part of the Master Deed, and the Declaration of Trust, recorded herewith in Book 36233, Page 160 ("Trust"), in each case as the same may be amended from time to time by instruments recorded with said Deeds, which provisions, together with any amendments thereto, shall constitute covenants running with the land and shall bind any person having at any time any interest or estate in the Unit, his/her employees, mortgagees, tenants, invitees, and visitors at the premises recorded with said Deeds, which provisions are amended at length herein;
3. Provisions of existing building and zoning laws; and
4. The rights, reservations, and restrictions described in the Master Deed.
5. The limitation that the unit may be used only for residential purposes subject to the zoning by laws of the City of Worcester and the restrictions set forth in the Master Deed and the restrictions set forth in the Declaration of Trust.

These premises will be sold and conveyed subject to and with the benefit of all rights, rights of way, restrictions, easements, covenants, liens or claims in the nature of liens, improvements, public as-

NOTICE OF MORTGAGEE'S SALE OF REAL ESTATE

By virtue and in execution of the Power of Sale contained in a certain mortgage given by David N. Mura, Akira David Mouri and Lucy Mouri to Mortgage Electronic Registration Systems, Inc., dated May 3, 2009 and recorded with the Worcester County Worcester District Registry of Deeds at Book 36233, Page 220, of which mortgage the undersigned is the present holder by assignment from Mortgage Electronic Registration Systems, Inc. to Plaintiff Chase Bank, National Association dated May 15, 2012 and recorded with said registry on June 4, 2012 at Book 49072 Page 197 for breach of the conditions of said mortgage and for the purpose of foreclosing, the same will be sold at Public Auction at 2:00 p.m. on September 3, 2013, on the mortgaged premises located at 15 South Bulfinch Street, Unit 15, 15-17 South Bulfinch Street Condominium, Worcester, Worcester County, Massachusetts, all and singular the premises described in said mortgage.

TO WHOM:

The Unit known as Unit 15 of the 15-17 South Bulfinch Street Condominium Unit Condominium in Worcester, Massachusetts, established pursuant to Massachusetts General Laws, Chapter 183A by Master Deed dated 5/3/2009 and recorded herewith in Book 36233, Page 154, and on the copy of the portion of said plan attached hereto and made a part hereof, to which is affixed the verified statement in the form required by Section 9 of said Chapter 183A.

Said Unit is conveyed together with an undivided 50% interest in the common areas and facilities of the Condominium described in said Master Deed. Said Unit is conveyed subject to and with the benefit of:

1. Provisions of said Chapter 183A.
2. The provisions of the Master Deed and the floor plans of the Condominium recorded simultaneously with and as a part of the Master Deed, and the Declaration of Trust, recorded herewith in Book 36233, Page 160 ("Trust"), in each case as the same may be amended from time to time by instruments recorded with said Deeds, which provisions, together with any amendments thereto, shall constitute covenants running with the land and shall bind any person having at any time any interest or estate in the Unit, his/her employees, mortgagees, tenants, invitees, and visitors at the premises recorded with said Deeds, which provisions are amended at length herein;
3. Provisions of existing building and zoning laws; and
4. The rights, reservations, and restrictions described in the Master Deed.
5. The limitation that the unit may be used only for residential purposes subject to the zoning by laws of the City of Worcester and the restrictions set forth in the Master Deed and the restrictions set forth in the Declaration of Trust.

These premises will be sold and conveyed subject to and with the benefit of all rights, rights of way, restrictions, easements, covenants, liens or claims in the nature of liens, improvements, public as-

MARKETPLACE

MARKETPLACE

MARKETPLACE

MARKETPLACE

MARKETPLACE

MARKETPLACE

Tierney, Laxmi (EHS)**From:** Kirchgasser, Alison (EHS)**Sent:** Friday, August 02, 2013 3:05 PM**To:** Cheryl Andrews-Maltais; 'Chris Knowles'; Durwood Vanderhoop; Stephanie White; 'Ryan Malonson'; Cheryl Frye-Cromwell; Wendy Pocknett; 'KFrye@mwtribe.com'; Leslie Jonas; 'Gonsalves, Rita (IHS/NAS)'; Kathleen.Bird@ihs.gov; Reels, Lorraine (IHS/NAS); 'Susan.nal@verizon.net'; hope.nal@live.com**Cc:** Wong, Shirley (EHS); Coleman, Michael (EHS); Schmidt, Bill (EHS); Guerino, Robert (EHS); Kemp, Julie (EHS); Chiev, Sokmeakara (EHS); Rudin, Whitney (EHS); Cassel Kraft, Amanda (EHS); Dunbar-Hester, Anna (EHS); Callahan, Robin (EHS); Pitz, Carolyn (EHS); Tierney, Laxmi (EHS); Bennett, Joan (EHS); Theriault, Anne (EHS)**Subject:** Notice of 1115 waiver renewal

Good Afternoon,

As we discussed on the Tribal Consultation call on July 31, 2013, The MassHealth Section 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

The current 1115 Demonstration is authorized through June 30, 2014. The Executive Office of Health and Human Services is requesting an Extension to the Demonstration, in order to continue providing the services that are currently offered, as well as creating additional authorities to achieve the goals of health care reform. MassHealth plans to submit our request to extend the 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS) on September 30 of this year.

The Extension request will build on the Amendment request that was recently submitted to CMS, which proposes significant changes to programs in conjunction with implementation of the Affordable Care Act. The Extension request will propose to continue many of the changes established in the Amendment. It will also include requests for authority to expand the use of alternative payment models rather than fee-for-service payment models, requests to further streamline some of MassHealth's eligibility processes, and requests related to certain payments to hospitals and community health centers that are authorized through the Demonstration.

As our 1115 Demonstration grants the state the authority for a variety of programs and policies, it impacts nearly all MassHealth members, including Tribal members. We therefore want to be sure you have the opportunity to share any concerns or any ideas with us of items you would like to see included in the Demonstration. MassHealth plans to submit the Extension request to CMS on September 30, 2013. We are providing 60 days notice of our intent to extend the Demonstration, and you also will have at least 30 days to review the 1115 Demonstration Extension request documents and share with us any questions, concerns, feedback or advice before we submit the request to CMS.

The Extension request documents will be posted online and available in paper format for comment. As we prepare to submit our completed 1115 Demonstration Extension request, we will send out information to you about where the renewal request documents will be found online or in paper form and the exact time period for comments and questions. We will also send additional information regarding the two public hearings held in Boston and Worcester.

While we encourage you to take advantage of the regular public comment process, you also are welcome to reach out directly to Carolyn Pitzzi by email (carolyn.pitzzi@state.ma.us) or phone (617-573-1776) with any comments or questions. Also, as noted on the call, Tribal governments may request that MassHealth meet in-person with tribal representatives to discuss any issues related to the proposed renewal. Please let Carolyn know if you would be interested in such a meeting.

Sincerely,

Alison Kirchgasser
Massachusetts Office of Medicaid
617-573-1741

Tierney, Laxmi (EHS)**From:** Pitz, Carolyn (EHS)**Sent:** Wednesday, August 21, 2013 2:37 PM**To:** 'Susan.nal@verizon.net'; 'hope.nal@live.com'; 'Cheryl Frye-Cromwell'; Kym Frye; Wendy Pocknett; 'Leslie Jonas'; Gonsalves, Rita (IHS/NAS); Reels, Lorraine (IHS/NAS); 'chairwoman@wampanoagtribe.net'; Durwood Vanderhoop; Stephanie White; 'Chris Knowles'; 'Ryan Malonson'; Richard Randolph; Cheron Watchman**Cc:** Kirchgasser, Alison (EHS); Coleman, Michael (EHS); Worstell, Pamela (EHS); Schmidt, Bill (EHS); Wong, Shirley (EHS); Chiev, Sokmeakara (EHS); Dunbar-Hester, Anna (EHS); Tierney, Laxmi (EHS); Cassel Kraft, Amanda (EHS); Bennett, Joan (EHS); Theriault, Anne (EHS); Rudin, Whitney (EHS); Kemp, Julie (EHS); Guerino, Robert (EHS); Callahan, Robin (EHS)**Subject:** Notice of 1115 waiver renewal - documents posted online

Good afternoon,

As a follow up to our Tribal Consultation call on July 31, 2013 and our August 2, 2013 email we wanted to notify you that our 1115 Demonstration Extension documents have been posted online and are also available in paper format for comment. Below you will find information on where you can view these documents online as well as information regarding two public hearings that we held in Boston and Worcester.

While we encourage you to take advantage of the regular public comment process, you also are welcome to reach out directly to me by email (carolyn.pitzi@state.ma.us) or phone (617-573-1776) with any comments or questions by September 19, 2013. Also, as noted on the call, Tribal governments may request that MassHealth meet in-person with tribal representatives to discuss any issues related to the proposed renewal. Please let me know if you would be interested in such a meeting.

Sincerely,

Carolyn Pitz
Director Outreach and Education
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108
(617) 573-1776
Carolyn.Pitzi@state.ma.us

The Massachusetts Executive Office of Health and Human Services (EOHHS) announces its intent to submit a request to extend the MassHealth Section 1115 Demonstration (Demonstration Extension Request) to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2013.

Public Comment Period:

EOHHS will accept comments on the proposed Demonstration Extension Request through September 19, 2013. Written comments may be delivered by email or mail. By email, please send

comments to laxmi.tierney@state.ma.us and include “Comments for Demonstration Extension Request” in the subject line. By mail, please send comments to: Laxmi Tierney, EOHHS Office of Medicaid, One Ashburton Place, 11th Floor, Boston, MA 02108. Comments must be received by 5pm on September 19, 2013 in order to be considered.

EOHHS will host two Stakeholder Meetings open to the public on the proposed Demonstration Extension Request. The meeting details are as follows:

Stakeholder Meeting #1, in conjunction with a meeting of the MassHealth Medical Care Advisory Committee and the MassHealth Payment Policy Advisory Board:

Date: Tuesday, August 27
Time: 10:00am-12:00pm
Location: Transportation Building
10 Park Plaza
Boston, MA

Stakeholder Meeting #2:

Date: Thursday, August 29
Time: 10:00am-12:00pm
Location: Worcester Public Library
3 Salem Square
Worcester, MA

The Demonstration Extension Request documents may be obtained on the MassHealth 1115 Demonstration website: <http://www.mass.gov/eohhs/gov/departments/masshealth/masshealth-and-health-care-reform.html>. Additional updates and final submissions to CMS will also be posted on this website. Paper copies of the documents may be obtained in person by request from 9am-5pm at EOHHS, One Ashburton Place, 11th Floor, Boston, MA 02108.

Background:

The MassHealth 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs. The current 1115 Demonstration is authorized through June 30, 2014.

The Commonwealth’s Demonstration Extension Request outlines the specific authorities being requested from CMS from July 1, 2014 to June 30, 2019 to sustain and improve upon the gains in coverage, affordability and access to health care achieved to date under the Demonstration.

The MassHealth 1115 Demonstration has been a key element in the Commonwealth’s achievement of near-universal coverage since the enactment of Chapter 58 of the Acts of 2006. Now, as required by the federal Affordable Care Act (ACA) and recent state legislation (Chapter 224 of the Acts of 2012), the next phase of health care reform focuses on cost containment and delivery system reforms. MassHealth is well positioned to continue its leadership role in these areas by advancing alternative payment methodologies and delivery system transformation including medical homes and integrated care for high risk populations. To meet the 1115 Demonstration’s goals and gain additional benefits through reform, the Commonwealth’s partnership with CMS through the Demonstration remains central to the Demonstration’s continued success. The Demonstration Extension Request affects eligibility, benefits, payment methodologies and delivery systems, as well as changes to expenditure authorities under the Demonstration.

Summary of Requested Changes to the Demonstration:

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

A five-year renewal term, as authorized by the Social Security Act, will support the full implementation of the Commonwealth's Duals Demonstration and its integrated care model known as One Care, which provides coverage for individuals under age 65 who are eligible for Medicaid and Medicare. The Duals Demonstration and the 1115 Demonstration are closely interrelated and provide complementary authorities that enable the Commonwealth's efforts to institute a fully integrated and fully capitated delivery model for disabled members. Massachusetts aims to learn from the Duals Demonstration and explore expanding the One Care model to non-dual eligible disabled members through the 1115 Demonstration in future years.

Advancing Alternative Payment Models

MassHealth's new Primary Care Payment Reform Initiative (PCPRI) is the primary vehicle to transition MassHealth members to alternative payment methodologies, as required by Chapter 224, the Commonwealth's pioneering 2012 payment reform and cost containment legislation. To transform health care delivery and payment through the PCPRI, the Commonwealth requests authority to set shared savings / risk targets for providers and to make shared savings payments or, as applicable, recoup payments to providers under alternative payment arrangements involving shared risk. This authority will establish the basis for the Commonwealth to fully implement both the PCPRI and an Accountable Care Organization (ACO) model currently in development. With PCPRI as its foundation, MassHealth would consider making three key changes to the future ACO model: shifting the contracting entity from a Primary Care Clinician (PCC) to an ACO; adjusting the payment model to encourage providers to take on higher levels of risk; and modifying quality metrics and delivery model requirements to extend beyond a medical home to a "medical neighborhood."

Pediatric Asthma Pilot Program

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

Safety Net Care Pool

The Commonwealth requests the following authorities for the Safety Net Care Pool:

1. Elimination of the Provider Sub-Cap;
2. Continued expenditure authority for existing Designated State Health Programs and new authority for additional programs, including:
 - State-supported subsidies for individuals with incomes up to 300 percent of the Federal Poverty Level (FPL) who enroll in health insurance through the Health Connector; and
 - New state health programs associated with Chapter 224 and related efforts to advance Massachusetts' ambitious health care reform and cost containment agenda;
3. Continued authority for the Delivery System Transformation Initiatives;
4. Continued authority for supplemental payments to Cambridge Health Alliance; and
5. Continued authority for the Infrastructure and Capacity Building Grants program.

Express Lane Renewal

The Commonwealth is proposing to continue its current Express Lane renewal process for families, with certain changes to account for implementation of the ACA on January 1, 2014. In addition, the Commonwealth is seeking authority to expand the Express Lane renewal process to childless adults receiving Medicaid benefits with MassHealth-verified income at or below 133 percent FPL and income verified by the Supplemental Nutrition Assistance Program at or below 163 percent FPL.

Medicare Cost Sharing Assistance

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

Early Intervention / Applied Behavioral Analysis for Autism

MassHealth requests continued authority for coverage of enhanced early intervention program services including medically necessary Applied Behavioral Analysis-based treatment services for children with autism spectrum disorders.

From: Kirchgasser, Alison (EHS)

Sent: Friday, August 02, 2013 3:05 PM

To: Cheryl Andrews-Maltais; 'Chris Knowles'; Durwood Vanderhoop; Stephanie White; 'Ryan Malonson'; Cheryl Frye-Cromwell; Wendy Pocknett; 'KFrye@mwtribe.com'; Leslie Jonas; 'Gonsalves, Rita (IHS/NAS)'; Kathleen.Bird@ihs.gov; Reels, Lorraine (IHS/NAS); 'Susan.nal@verizon.net'; hope.nal@live.com

Cc: Wong, Shirley (EHS); Coleman, Michael (EHS); Schmidt, Bill (EHS); Guerino, Robert (EHS); Kemp, Julie (EHS); Chiev, Sokmeakara (EHS); Rudin, Whitney (EHS); Cassel Kraft, Amanda (EHS); Dunbar-Hester, Anna (EHS); Callahan, Robin (EHS); Pitz, Carolyn (EHS); Tierney, Laxmi (EHS); Bennett, Joan (EHS); Theriault, Anne (EHS)

Subject: Notice of 1115 waiver renewal

Good Afternoon,

As we discussed on the Tribal Consultation call on July 31, 2013, The MassHealth Section 1115 Demonstration provides federal authority for Massachusetts to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, offer services that are not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

The current 1115 Demonstration is authorized through June 30, 2014. The Executive Office of Health and Human Services is requesting an Extension to the Demonstration, in order to continue providing the services that are currently offered, as well as creating additional authorities to achieve the goals of health care reform. MassHealth plans to submit our request to extend the 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS) on September 30 of this year.

The Extension request will build on the Amendment request that was recently submitted to CMS, which proposes significant changes to programs in conjunction with implementation of the Affordable Care Act. The Extension request will propose to continue many of the changes established in the Amendment. It will also include requests for authority to expand the use of alternative payment models

rather than fee-for-service payment models, requests to further streamline some of MassHealth's eligibility processes, and requests related to certain payments to hospitals and community health centers that are authorized through the Demonstration.

As our 1115 Demonstration grants the state the authority for a variety of programs and policies, it impacts nearly all MassHealth members, including Tribal members. We therefore want to be sure you have the opportunity to share any concerns or any ideas with us of items you would like to see included in the Demonstration. MassHealth plans to submit the Extension request to CMS on September 30, 2013. We are providing 60 days notice of our intent to extend the Demonstration, and you also will have at least 30 days to review the 1115 Demonstration Extension request documents and share with us any questions, concerns, feedback or advice before we submit the request to CMS.

The Extension request documents will be posted online and available in paper format for comment. As we prepare to submit our completed 1115 Demonstration Extension request, we will send out information to you about where the renewal request documents will be found online or in paper form and the exact time period for comments and questions. We will also send additional information regarding the two public hearings held in Boston and Worcester.

While we encourage you to take advantage of the regular public comment process, you also are welcome to reach out directly to Carolyn Pitzi by email (carolyn.pitzi@state.ma.us) or phone (617-573-1776) with any comments or questions. Also, as noted on the call, Tribal governments may request that MassHealth meet in-person with tribal representatives to discuss any issues related to the proposed renewal. Please let Carolyn know if you would be interested in such a meeting.

Sincerely,

Alison Kirchgasser
Massachusetts Office of Medicaid
617-573-1741

Appendix F: Summary of Proposed Demonstration Changes

Proposed Change	Impact	Hypothesis
5 year renewal and One Care Model	The One Care program will provide a fully capitated integrated care model for dual-eligibles under the age of 65. The five-year renewal period will allow for full implementation of One Care and learning from initial outcomes.	The One Care model will provide MassHealth with substantial information on the value of an integrated care model and its potential success with Medicaid-only members.
Alternative Payment Models	Payments to providers will move away from the standard fee-for-service model to alternative payment models.	Providers will be able to share in savings and take on financial risk while being held accountable for quality of care.
Pediatric Asthma Pilot Program	Providers participating in the Primary Care Clinician Plan (PCCP) will receive a bundled payment for care provided to high-risk pediatric asthma patients.	Children with high-risk asthma who participate in the pilot program will experience better coordination of care, higher quality of care, improved health outcomes and possibly lower health care costs.
Removal of Provider Sub-cap	The Safety Net Care Pool provider payments will be de-linked from the state's Disproportionate Share Hospital (DSH) allotment.	Budget neutrality savings will be sufficient to support provider payments under the Safety Net Care Pool.
Designated State Health Programs	The Commonwealth will be able to support critical state initiatives that directly impact MassHealth members.	DHSP funding will allow the Commonwealth to maintain near universal health coverage while implementing critical delivery system reforms.
Delivery System Transformation Initiatives (DSTI)	Hospitals with a higher than average Medicaid payer mix and lower than average commercial payer mix will be able to implement transformative delivery system reforms.	DSTI providers will continue and build upon their work from the previous waiver period and implement transformative delivery system reforms, increase their participation in alternative payment models, and maintain and improve quality of care.
Safety Net Care Pool Payments for Cambridge Health Alliance (CHA)	MassHealth will continue to support CHA, the only public acute hospital system in Massachusetts.	CHA will provide essential services for the MassHealth population while implementing innovative care models. MassHealth's SNCP payments will continue to shift from supplemental payments to incentive or performance-based payments.

Infrastructure and Capacity Building Grants (ICB)	Eligible hospitals and community health centers (CHCs) will receive support to implement infrastructure and capacity building projects.	Hospitals and CHCs that receive ICB grant funding will develop projects that enhance services and provide high-quality care for MassHealth members.
Express Lane Renewal	MassHealth will implement a streamlined application and renewal process for members.	Eligible MassHealth members will experience greater continuity in their health care coverage.
Medicare Cost-Sharing Assistance	MassHealth will utilize a single income methodology to determine eligibility for MassHealth CommonHealth and Medicare Cost-Sharing Assistance.	The use of a single income methodology will promote administrative simplification and make benefits easier for members to understand.
Intensive Early Intervention/Applied Behavioral Analysis (IEI)	MassHealth will implement early intervention services, including Applied Behavioral Analysis, for children with Autism Spectrum Disorders.	Children with autism-spectrum disorders will have improved access to evidence-based, person-centered care that meets their needs.