The Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

Tel: (617) 573-1600
Fax: (617) 573-1891
www.mass.gov/eohhs

June 8, 2021

Liz Richter
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 314G
Washington, D.C. 20201

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

Dear Acting Administrator Richter:

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

This request to amend the demonstration includes a number of policy changes that support Massachusetts' ongoing progress toward universal health care coverage, promote health equity, and enable flexibility in the delivery of health care services. Specifically, this amendment request includes proposed authorities to:

- implement 12-month continuous post-partum coverage, consistent with the option in the American Rescue Plan (ARP), prior to the April 1, 2022 effective date in the ARP and without regard to immigration status;
- support statewide implementation of a successful pilot program for justice-involved individuals;
- continue and expand upon place-of-service flexibilities implemented during the COVID-19 public health emergency, including the hospital-at-home program and a waiver of outreach limits for clinic services; and
- comply with state law expanding eligibility for Medicare Savings Programs.

EOHHS received comments from 28 organizations in response to the public posting of the draft request, which unanimously supported the proposals included in the request.

Thank you for your consideration of this amendment request. We are also hopeful that CMS will soon approve our pending Serious Mental Illness demonstration amendment request, which will support EOHHS' efforts to expand mental health treatment services and will complement the Commonwealth's existing Substance Use Disorder demonstration.

We appreciate your continued partnership on our 1115 demonstration as we work to advance our shared goals for health care reform.

Sincerely,

[redacted]

Marylou Sudders

cc: Anne Marie Costello, Acting Deputy Administrator, and Director for the Center for Medicaid and CHIP Services
Teresa DeCaro, Acting Director, State Demonstrations Group
Marie DiMartino, CMS, Division of Medicaid Field Operations East

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

MassHealth Section 1115 Demonstration Amendment Request

Revised June 17, 2021

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Introduction

The Massachusetts 1115 demonstration, currently approved through June 30, 2022, has long supported the Commonwealth's commitment to universal health care coverage and, particularly during this most recent demonstration period, has provided federal waiver and expenditure authority to test innovations in payment and care delivery.

Since the initial implementation of the demonstration in 1997, working in partnership with the federal government, the Commonwealth has made significant progress toward the goal of near universal health care coverage for our residents. Over 98 percent of the Commonwealth's children and youth and more than 97 percent of all of its residents have health care insurance, the highest percentages in the country.[1] MassHealth, the Massachusetts Medicaid and Children's Health Insurance Programs, covers approximately 1.9 million individuals, or nearly 30 percent of the Commonwealth's residents.

In 2018 MassHealth launched its Accountable Care Organization (ACO) program across the state to promote integration and coordination of care for members, while holding providers accountable for their quality and cost. MassHealth's ACOs integrate their efforts with community-based health and social service organizations to improve behavioral health, long-term supports and health-related social needs for MassHealth members. While formal evaluation results of this payment and care delivery model are not yet available, early experience indicates the model has resulted in improved care to members and improved fiscal sustainability for the Commonwealth and federal government. For example, early results suggest that primary care utilization is higher for ACO members than non-ACO members, and that primary care utilization increased from CY18 to CY19. Additionally, potentially avoidable admissions decreased from CY18 to CY19, especially for ACO members.

While the Commonwealth is beginning the process to prepare a request to further extend the 1115 demonstration beyond June 30, 2022, there are a small number of flexibilities that require amendment to the demonstration that the Commonwealth wishes to implement prior to July 1, 2022. These flexibilities include responses to recent state law changes and to lessons learned during the COVID-19 pandemic.

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

[1] https://www.chiamass.gov/massachusetts-health-insurance-survey/#:~:text=At%202.9%25%2C%20the%20uninsurance%20rate,Massachusetts%20remained%20low%20in%202019.

Expanding eligibility

1. Updates to Medicare Savings Program language to comply with state law
    A. Increase the income limit for Medicare Savings Program benefits without an asset test from 135% to 165%
    B. Allow Standard members eligible through the State Plan to also be eligible for Qualified Individual Medicare Saving Program benefits

2. Updates to eligibility for postpartum coverage

    A. Extend eligibility for postpartum coverage to 12 months

    B. Authorize postpartum coverage for members not otherwise eligible due to immigration status

Enhancing services for specialized populations

3. Provide Community Support Program benefits with a particularized focus for individuals with justice involvement living in the community

Providing flexibilities related to place of service

4. Permit the state to make payments for clinic services delivered via telehealth and in other non-clinic locations
5. Authorize a Hospital at Home program to reduce cost, improve quality and safety, and improve patient experience

Proposed Changes to the Demonstration

Increase the income limit for Medicare Savings Program (MSP) benefits without an asset test to 165% to comply with state law

The FY2019 State Budget included language to expand the standard income limits for the three Medicare Savings Programs by disregarding 30% of the Federal Poverty Limit (FPL) from an applicant's gross income and doubling the asset limits. In practice, this goal was achieved by raising income limits. The new income limits are therefore 130% FPL for the Qualified Medicare Beneficiary (QMB) program, 150% FPL for the Specified Low-Income Medicare Beneficiary (SLMB) program and 165% FPL for the Qualified Individual (QI) program.

Under the currently approved 1115 demonstration, all MassHealth Standard members with income up to 133% FPL are eligible for QMB benefits without an asset test. The approved 1115 also authorizes the Commonwealth to pay for Medicare Part B premiums for CommonHealth members with income over the Standard limit and up to 135% FPL without an asset test through the QI program. This amendment would increase the income limit for payment of the Medicare Part B premium without an asset test for CommonHealth members, including those 65 and over, and for Standard members of any age that did not have asset test to determine their Standard eligibility to 165% FPL (through SLMB for members over 133% FPL and up to 150% FPL and through QI for members over 150% and up to 165% FPL) to comply with the state budget language requiring the expansion of the income limits for the MSP programs.

This request would also waive the language under Section 1902 of the Social Security Act prohibiting the provision of Qualified Individual benefits to individuals eligible for State Plan Medicaid, including individuals 65 and over. CMS approved an amendment to the state's Medicaid State Plan to allow the provision of QI benefits to individuals with income up to 165% to allow the state to comply with state law. However, the prohibition under Section 1902 means that State Plan Standard members with income over 150% FPL and up to 165% FPL (and therefore over income for SLMB under the expansion) who pay a deductible to spend down to Standard eligibility will not receive assistance with their Part B premium, while individuals without State Plan eligibility in that income range can receive this benefit. Individuals who pay a deductible to be eligible for MassHealth Standard are more likely to need medical care than those with QI only.

Extend eligibility for postpartum coverage to 12 months

MassHealth proposes to provide 12 months postpartum coverage, regardless of immigration status, to individuals with income up to 200% FPL. This extension of coverage will significantly improve access to health care and continuity of care, particularly in the vulnerable period after childbirth. Additionally, this will bring Medicaid into alignment with the seamless insurance coverage experienced by postpartum enrollees in commercial insurance plan.

Under the American Rescue Plan, the new state plan option to extend postpartum coverage for 12 months for citizens and lawfully present immigrants goes into effect on April 1, 2022. Therefore, effective upon approval and through 3/31/2022*, MassHealth proposes to provide 12-months uninterrupted postpartum coverage for members who are citizens or lawfully present immigrants and who have attested modified adjusted gross income (MAGI) at or below 200% of the federal poverty level (FPL).

In addition, effective upon approval, MassHealth proposes to provide 12-months uninterrupted postpartum coverage for members not otherwise eligible due to immigration status and who have attested MAGI at or below 200% of the federal poverty level (FPL).[2]

Provide Community Support Program Services (CSP) with a Particularized Focus for Individuals with Justice Involvement Living in the Community

For MassHealth-eligible individuals who have been incarcerated, returning to the community can be fraught with barriers to accessing health care. A significant portion of individuals who have experienced incarceration have diagnosed mental health conditions and/or Substance Use Disorders (SUD). Notably, the risk of opioid-related death for Massachusetts residents returning to the community from incarceration is 120 times greater when compared to the rates for the general population. By far, the risk is greatest during the first month of release.[3] MassHealth members with incarceration history have a much higher risk of opioid overdose than other MassHealth members.[4]

The first months following re-entry into the community are a time of transition for MassHealth-eligible individuals – transition into full MassHealth coverage; enrollment in

[2] MassHealth intends to submit a state plan amendment as authorized under the 2022 American Relief Act to be effective 4/1/2022.

[3] Massachusetts Department of Public Health. An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011 – 2015) (Report to the Massachusetts Legislature), August 2017. Accessed at https://www.mass.gov/doc/legislative-report-chapter-55-opioid-overdose-study-august-2017/download

[4] Center for Health Policy and Research, University of Massachusetts Medical School. Opioid Overdoses Among High-Risk MassHealth Members: An Exploratory Analysis. July 20, 2017.

managed care; and connection with community mental health, SUD treatment, and other providers.

In 2019, MassHealth began a state-funded demonstration to provide Behavioral Health Supports for Individuals who are Justice Involved (BH-JI) in Worcester and Middlesex counties through a partnership among MassHealth and Massachusetts' Executive Office of the Trial Court, Massachusetts Parole Board, the Massachusetts Department of Corrections, and county Sheriffs' Offices. BH-JI includes two primary areas of support provided by navigators trained in supporting individuals with incarceration experience: (1) in-reach activities which take place in correctional facilities prior to a participants' release, and (2) community supports provided to participants after release from incarceration and for individuals on probation or parole.[5] Through this effort, over 725 individuals have been supported with navigation to health care and improved access to resources for health-related social needs as participants return to the community. Typically, these supports are more intensive during the first month of enrollment and/or first month of release from a correctional facility, in which individuals are at higher risk of opioid overdose. Length of engagement is based on medical necessity, but is on average about six months.

MassHealth believes that access to community supports, such as those provided through BH-JI, will be critical to improving and maintaining the health and stability of this population, aiding their transition back to the community and promoting successful community tenure. Preliminary results from the Massachusetts' BH-JI demonstration indicate a decrease in inpatient and emergency room utilization, and increased connection to more appropriate outpatient behavioral health services.

Massachusetts intends to continue its BH-JI demonstration and expand it statewide. A portion of this project (in-reach supports and community supports provided to fee-for-service members) would continue to be funded with state-only dollars. Eligible individuals for whom services cannot be funded through Medicaid under subdivision (A) following paragraph (30) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d) will be covered by state-only funding through the BH-JI program.

This amendment would authorize Medicaid funding for the community supports provided to MassHealth managed care enrolled individuals through the Community Support Program (CSP) already authorized under the Commonwealth's 1115

[5] Press Release: Behavioral Health Initiative Enhances Connection to Community-Based Supports for Individuals Involved with the Criminal Justice System, July 15, 2019. Accessed at https://www.mass.gov/news/behavioral-health-initiative-enhances-connection-to-community-based-supports-for-individuals

demonstration waiver. Like the currently approved CSP services provided to chronically homeless individuals, the CSP service domains for individuals with justice involvement (CSP-JI) would include:

- Assisting Members in enhancing daily living skills
- Providing service coordination and linkages
- Assisting Members with obtaining benefits, housing, and health care
- Developing a crisis plan in the event of a psychiatric crisis
- Providing prevention and intervention
- Fostering empowerment and recovery, including linkages to peer support and self-help groups

Current CSP providers with particularized skills and training will be leveraged to provide this specialized form of CSP to individuals with justice involvement. In anticipation of offering CSP-JI statewide, MassHealth has partnered with the University of Massachusetts to provide specialized training in which over 50 CSP and other MassHealth providers across the Commonwealth have participated to date.

In addition to improving navigation to appropriate levels of care for MassHealth members, CSP-JI will aid in addressing racial and ethnic health disparities. There is growing evidence that the justice system affects Black and Hispanic communities differently than White communities. A September 2020 report issued at the request of the late Massachusetts Supreme Judicial Court Chief Justice Robert Gants notes that "the Commonwealth significantly outpaced national race and ethnicity disparity rates in incarceration, imprisoning Black people at a rate 7.9 times that of White people and Latinx people at 4.9 times that of White people."[6] As Massachusetts continues to address racial and ethnic disparities in its criminal justice system, recognizing the mental health and SUD risks of re-entry, and specifically addressing them through intervention with trained navigators, is an important part of addressing the collateral consequences of incarceration related to access to health care.

[6] Elizabeth Tsai Bishop, Brook Hopkins, Chijindu Obiofuma, and Felix Owusu, Harvard Law School Criminal Justice Policy Program. Racial Disparities in the Massachusetts Criminal System (September 2020). Accessed at http://cjpp.law.harvard.edu/assets/Massachusetts-Racial-Disparity-Report-FINAL.pdf

Expenditure authority for clinic services delivered outside of clinic locations

The COVID-19 public health emergency has exacerbated behavioral health conditions for many individuals and has highlighted, on a national level, both pre-existing barriers to accessing behavioral health treatment, as well as creating new ones.[7] For example, during the pandemic, social distancing and infection control efforts limited the ability of many to seek in-person care, including behavioral health care. In response, during the COVID-19 Public Health Emergency (PHE), CMS offered states the opportunity to request modification of the "facility" requirement in 42 CFR § 440.90 in order to permit the state to temporarily designate a clinic practitioner's location as part of the clinic facility. This flexibility was intended to help ensure continued Medicaid coverage for clinic services during the PHE but also allowed individuals to obtain behavioral health care flexibly, without the added costs or time of traveling to the clinic location.

Through this amendment, MassHealth is seeking to extend and expand on the flexibility granted to the Commonwealth under its approved 1135 waiver, to allow the continued provision of medically necessary clinic services provided outside of the clinic, after federal PHE period ends. With this amendment, the state is requesting authority to cover clinic services delivered via telehealth (when neither the provider nor the member is at the clinic) and in non-clinic locations, including but not limited to the member's home, and other community locations. The flexibility requested will allow providers to continue providing, and members to continue receiving, medically necessary clinic services in non-clinic settings for telehealth and in-person services.

The state predominately provides outpatient behavioral health services as clinic-based services. The state is planning significant improvements to its behavioral health continuum, including the planned introduction of Community Behavioral Health Centers, which will provide a local, centralized, community-based "front door" for individuals seeking behavioral health treatment. Although these new providers will be based in a physical clinic location, the Commonwealth seeks to encourage the clinicians from these clinics to provide services in a mobile, community-focused way, with the flexibility to meet individuals where they are either in a community-based location (e.g. home or mobile site) or via telehealth. The Commonwealth believes this service delivery model will expand member access and improve retention in ongoing behavioral health treatment and is particularly important in ensuring behavioral health treatment reaches vulnerable populations, including older adults and persons with chronic and persistent

[7] Panchal, N., Kamal, R., et. al. Kaiser Family Foundation. The Implications of COVID-19 for Mental Health and Substance Use (August 2020). Accessed at https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

mental illness.[8] Simultaneously, these services and providers remain anchored to behavioral health clinics that provide a robust architecture for clinical oversight and quality assurance. The state believes this continued flexibility, born in the needs of the public health emergency, can play a crucial ongoing role in improving initiation of and engagement in vital behavioral health services for MassHealth members.

Authorization to reimburse qualified acute inpatient hospitals rendering acute inpatient hospital services in a member's home when clinically appropriate

This amendment would authorize a hospital at home program, through which qualified acute inpatient hospital providers would deliver acute inpatient hospital services in a member's home, outside of the institution, to members for whom such services are clinically appropriate.

Acute, brick-and-mortar hospitals have long been the primary venue for treating serious acute illness in the United States. However, hospitalization in inpatient settings can be associated with complications including hospital-acquired delirium,[9] hospital-acquired infections,[10] and functional status loss (sometimes permanently) due to inactivity. Limited hospital capacity can result in prolonged waits in emergency departments and delays in inpatient care.[11] Acute hospitalizations are also expensive, accounting for a substantial and rising proportion of total medical expenditure.[12]

The "hospital at home (HaH)" model of care refers to the home-based delivery of medically necessary acute inpatient hospital services to patients for whom such services are clinically appropriate. The model has been employed for several decades to provide care for patients with both acute and chronic conditions requiring inpatient level of care, both nationally and locally. In the Commonwealth, several health systems have introduced hospital at home programs in recent years. Mass General Brigham (formerly Partners Healthcare) has delivered hospital services at home for several years through Brigham and Women's and Massachusetts General Hospitals with an increase in scale in 2020 to care for patients during the COVID-19 pandemic. Atrius Health in

[8] Reifler, B.V. and Bruce, M.L. Home-Based Mental Health Services for Older Adults: A Review of Ten Model Programs. *American Journal of Geriatric Psychiatry.* Published online February 12, 2013.
[9] Rohatgi N, Weng Y, Ahuja N, et al. Factors Associated with Hospital-Acquired Delirium in Patients 18-65 Years Old. *J Gen Intern Med*. 2021 Jan 8. Doi: 10/1007/s11606-020-06378-w. Online ahead of print.
[10] https://www.cdc.gov/hai/data/portal/progress-report.html
[11] Horwitz LI , Green J , and Bradley EH . US emergency department performance on wait time and length of visit. Ann Emerg Med. 2010;55:133-41.
[12] Centers for Disease Control and Prevention. Health Expenditures. Accessed at: https://www.cdc.gov/nchs/fastats/health-expenditures.htm

recent years has partnered with its subsidiary VNA Care as well as the Medically Home Group to deliver hospital services in the home. Hospital at home programs have demonstrated reduced cost, maintained or improved quality and safety,[13] and improved patient experience for individuals for whom hospital-at-home services are clinically appropriate[14] - with benefits including a reduction in unnecessary laboratory orders and imaging studies, less sedentary time for patients, fewer readmissions,[15] and unchanged or reduced mortality.[16] The need to increase facility capacity and reduce infectious exposures caused by the COVID-19 pandemic has only accelerated interest in hospital-at-home programming.[17]

Indeed, CMS has experience permitting acute inpatient hospitals to render services in nontraditional settings. Through its "*Hospital Without Walls (Temporary Expansion Sites)*" initiative, CMS provided additional flexibilities for hospitals to "create surge capacity by allowing them to provide room and board, nursing, and other hospital services at remote locations or sites not normally considered parts of healthcare facilities, such as hotels or community facilities."[18] More recently, CMS announced the Acute Hospital Care at Home initiative, which provides regulatory flexibility allowing for safe hospital care for eligible patients in their homes during the public health emergency. MassHealth is aligning with CMS to participate in this initiative, recognizing the benefits of this program, as well as the efforts and expertise of two local healthcare systems with extensive experience providing acute hospital care at home, Brigham and Women's Hospital and Massachusetts General Hospital – both of which CMS has approved to participate in this initiative. These flexibilities will help ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients.[19]

Given the ample evidence that hospital-at-home programming can improve patient outcomes and reduce costs, and the demonstrated potential for the program to be

[13] Cryer L, Shannon SB, Van Amsterdam M, Leff B. Costs for 'Hospital at Home' Patients Were 19 Percent Lower, With Equal or Better Outcomes Compared to Similar Inpatients. Health Aff (Milwood). 2012; 31(6): 1237-43.
[14] Levine DM, Ouchi K, Blanchfield B, et al. Hospital-Level Care at Home for Acutely Ill Adults: a Pilot Randomized Controlled Trial. *J Gen Intern Med*. 2018 May;33(5):729-736; Shepperd S, Iliffe S, Doll HA, et al. Admission avoidance hospital at home. *Cochrane Database Syst Rev*. 2016;9(9):CD007491.
[15] Levine DM, Ouchi K, Blanchfield B, et al. Hospital-Level Care at Home for Acutely ill Adults: A Randomized Controlled Trial. Ann Int Med. 2019 Dec 17.
[16] Shepperd S, Iliffe S, Doll HA, Clarke MJ, Kalra L, Wilson AD, Gonçalves-Bradley DC. Admission avoidance hospital at home. Cochrane Database Syst Rev. 2016 Sep 1;9(9):CD007491. doi: 10.1002/14651858.CD007491.pub2. PMID: 27583824; PMCID: PMC6457791.
[17] Nundy S, Patel KK. Hospital-at-Home to Support COVID-19 Surge—Time to Bring Down the Walls? *JAMA Health Forum.* Published online May 1, 2020.
[18] https://www.cms.gov/files/document/covid-hospitals.pdf
[19] https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient.

successful in our state as evidenced by active participation in the model of care by at least two institutions during the public health emergency under CMS' Acute Hospital Care at Home initiative, EOHHS is requesting ongoing flexibility for this initiative, not limited to designated public health emergencies, to allow qualified acute inpatient hospitals to bill MassHealth for acute inpatient hospital services rendered in a member's home to members for whom such services are clinically appropriate. EOHHS proposes to model its hospital-at-home program on CMS' Acute Hospital Care at Home initiative, incorporating most of its requirements and limitations, such as requiring appropriate screening protocols for admission, setting clear expectations around clinical team evaluations (both in-person and virtual), ensuring patients can communicate with their clinical team in a timely fashion, and establishing the necessary infrastructure to ensure patient safety.

Summary of waiver and expenditure authorities requested

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

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
Provide Medicare Savings Program benefits to CommonHealth members over 135% FPL and up to 165% FPL and certain Standard members over 133% FPL and up to 165% without an asset test	Waive Medicare Savings Program asset test requirement	Section 1902(a)(10)(E)(i), referencing 1905(p)(1)(C), which includes resource limits
Provide Qualifying Individual benefits for individuals on Standard (including those over 65) otherwise eligible under the State Plan	Waive prohibition of receipt of Qualifying Individual benefits by individuals otherwise eligible for the Medicaid State Plan	Section 1902(a)(10)(E)(iv)
CSP-JI	Existing expenditure authority for Table C services	
Extend postpartum coverage to 12 months	Waive 60-day limit on postpartum coverage to allow for 12 months of continuous postpartum eligibility and to make postpartum coverage available to certain immigrants.	SSA § 1905(n)/42 CFR § 435.4 (Necessary to redefine “qualified pregnant woman or child” (SSA) and “pregnant women” (CFR) to augment the baseline postpartum period from 60 days to 12 months) SSA § 1902(e)(5) and (6)/42 CFR § 435.170(b) and (c) (Necessary to extend both eligibility and continuous eligibility for newly defined “qualified pregnant woman or child”

		and “pregnant woman” from 60 days to 12 months) 42 CFR § 435.916(a) (Necessary to ensure continuity of coverage for newly defined “pregnant woman” until after the augmented postpartum period ends) SSA § 1902(a) last sentence (Necessary to eliminate restriction that only allows assistance to be provided to immigrants subject to restrictions of SSA § 1903(v) SSA § 1903(v) and 42 CFR § 435.406 (Necessary to allow for payments for pregnant women whose immigration status does not otherwise make them eligible for Medicaid)
Clinic Facility Requirement	Expenditure authority to provide clinic services via telehealth (if neither the provider nor the member are at the clinic) and in non-clinic locations.	Section 1905(a)(9) and 42 CFR 440.90
Inpatient Hospital at Home	Expenditure authority to reimburse qualified acute inpatient hospitals rendering acute inpatient hospital services in a member’s home to members for whom such	42 CFR 440.10

	services are clinically appropriate.	

Budget Neutrality

Budget neutrality prior to amendment

The Commonwealth's projected budget neutrality cushion as of the quarterly report for the quarter ending September 30, 2020, [20] is approximately $26 billion total, of which $4 billion is attributable to the SFY 2018-2022 waiver period.[21] This estimate incorporates projected expenditures and member months through SFY 2022 as reported through the quarter ending September 30, 2020. This budget neutrality calculation reflects significant realized and anticipated savings.

Effect of amendment

As reflected in the accompanying budget neutrality workbook, this amendment results in $20.8 million in costs to the MassHealth program and would increase the total populations and expenditures under the demonstration. The combined effect of these two dynamics would decrease the Commonwealth's budget neutrality cushion by approximately $5.6 million for the SFY2018-2022 waiver period. Overall, after integrating the proposed amendments, the Commonwealth and the federal government would continue to realize savings on the demonstration.

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

[20] The budget neutrality cushion as of the quarterly report for the quarter ending September 30, 2020 includes member month and actual expenditure data as reported in the CMS-64 report for the corresponding time period. Safety Net Care Pool spending included in the calculation reflects figures as reported in the budget neutrality agreement approved by CMS on November 4, 2016..

[21] Note, CMS introduced a savings phase-out methodology to the Budget Neutrality calculation so that the Commonwealth may only carry forward 25% of selected population based savings each year between SFY18-22.

Evaluation

The currently approved demonstration seeks to advance seven goals:

- Goal 1: Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care
- Goal 2: Improve integration of physical, behavioral and long-term services
- Goal 3: Maintain near-universal coverage
- Goal 4: Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals
- Goal 5: Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services
- Goal 6: Ensure access to Medicaid services for former foster care individuals aged 18 through 26 who previously resided in another state; and
- Goal 7: Ensure the long-term financial sustainability of the MassHealth program through refinement of provisional eligibility and authorization for SHIP Premium Assistance.

The amendment's impact on the current demonstration's evaluation will increase the number of goals to be evaluated and is described below:

Amendment request #1 seeks to advance Goal #3, to maintain near-universal coverage and support Hypothesis H4, which posits that "enrollment in new and select ongoing programs funded with demonstration investments supports near-universal coverage in Massachusetts".

Providing MSP benefits to additional individuals to comply with the expansion under state law supports the state's goal of maintaining near-universal coverage. The MSP amendment would also help to ensure the long-term financial sustainability of the state's health coverage programs by requiring enrollment in Medicare as the Medicare coverage would no longer come at a cost to the member.

Amendment request #2 seeks to advance Goal # 3, to maintain near-universal coverage. This amendment would increase Medicaid members' access to needed services and improve continuity of care through continuous, comprehensive Medicaid coverage in the postpartum period.

Amendment request #3 would create a new evaluation goal “Goal 8: Enhance services for Individuals with Justice Involvement Living in the Community”. The amendment enhances community supports to help these individuals transition back to the community and promotes successful community tenures. The outcomes of this amendment are beyond what is covered under Goal 3. The hypotheses to be tested through the evaluation will examine expanded access to health care services and social determinants, lengthened community tenure, and improved health outcomes for justice involved population.

Amendment requests #4 and #5 will be evaluated under a new goal “Goal 9: Expand payment of services delivered in non-traditional places of services”. Both amendments allow Medicaid to pay for services in non-traditional settings, although amendment request #4 applies to behavioral health services and amendment request #5 applies to acute hospital care. The common hypotheses to be evaluated relate to Medicaid members’ increased access to needed services (especially among subpopulations who were known to have underutilization of services in traditional settings), increased member satisfaction, and improved health outcomes due to easier access to services. Successes of and barriers to delivering services outside traditional settings will also be evaluated through interviews/surveys with providers, the findings of which will help assess whether the impact of payment flexibility is obscured by operational challenges or barriers.

Public Process

The public process for submitting this amendment conforms with the requirements of STC 15, including State Notice Procedures in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements as outlined in the Commonwealth’s approved State Plan. In addition, the Commonwealth has implemented certain of the transparency and public notice requirements outlined in 42 CFR § 431.408, although the regulations are not specifically applicable to demonstration amendments. The Commonwealth is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Notice

The Commonwealth released the amendment for public comment starting on March 23, 2021. The public notice, the Amendment Request, which included the Budget Neutrality Impact section, and a Summary of the Amendment (including the instructions for submitting comments) were posted on the MassHealth website (https://www.mass.gov/service-details/amendment-of-1115-masshealth-demonstration-waiver-march-2021), and the public notice with a link to the MassHealth website was published in the Boston Globe, Worcester Telegram & Gazette and the Springfield Republican on March 26, 2021.

Tribal Consultation

MassHealth provided a summary of the Amendment through an email to all Tribal leaders or their designees and additional Tribal health contacts on March 23, 2021. The summary included links to the documents and instructions for providing comment.

Public Meeting

The Commonwealth hosted a virtual listening session on March 31, 2021 to seek input regarding the amendment. The session included a conference line, as well as Communication Access Realtime Translation (CART) services.

The session included a presentation on the proposed changes and an opportunity for public testimony.

61 people attended the session. During the public testimony portion of the meeting, one speaker expressed support for the items in the amendment, particularly the MSP and post-partum items, noting that these policies will help advance a lot of our health equity goals, and asked whether the 12- month continuous eligibility for post-partum members would continue if their income fluctuates over 200% FPL. We took that question back and updated the listening session slides posted on the website with confirmation that the 12-month continuous eligibility would continue.

Another speaker expressed strong support for the post-partum extension and noted that maternal mortality in the Commonwealth, in particular. is driven by postpartum mortality and most of that is after 42 days postpartum.

One speaker asked that we clarify that the authority related to relief from the limit on clinic outreach services will pertain to all clinics, not just Community Behavioral Health Centers. We confirmed that the authority would pertain to all clinics.

One speaker expressed strong support for the amendment and asked about whether it would be possible to assign incarcerated individuals to MassHealth Accountable Care or Managed Care Organizations prior to their release so that there is continuity of care before they started leaving the institution. We responded that currently we do have a process to reinstate individuals or to help them apply for MassHealth prior to their release, as well as connecting them with a managed care plan.

This speaker also asked about the Hospital at Home item and how we would ensure that it's a consumer choice, about the definition of a home based hospital setting and what kind of services would be provided in the home to ensure that they're getting adequate or equivalent care at home. We responded that patient choice and consent is essential to home hospital programs. For patients who have common chronic conditions and are experiencing acute exacerbations, treatment at home may be a very appropriate replacement service. The providers that offer this tend to be quite experienced in essentially setting up all the infrastructure that's needed to deliver all the same things that would be delivered in a hospital, in the home. And they do so by carefully targeting it towards patients with the most appropriate conditions and the most appropriate home settings.

A speaker asked if we could clarify whether the hospital in the home authority will include provision of inpatient psychiatric hospital or inpatient SUD services that are delivered in both acute general hospital and freestanding hospital settings. We clarified that Hospital at Home is currently limited to acute inpatient hospital services but noted that we would continue to explore is whether this would be appropriate for other, non-acute inpatient services as well.

A speaker expressed support for the additional benefits that these proposals are extending to people who need them so much.

<u>Public Comment letters</u>

The Commonwealth received fourteen comment letters from consumer and legal advocates, health care provider organizations, social service providers and individuals on or before April 25, 2021, including one letter submitted on behalf of fifteen other organizations. All of the comment letters expressed overall support for the amendment.

Twelve* of the commenters expressed particular support for the proposal to extend post-partum coverage for 12 months to individuals up to 200% FPL, regardless of immigration status, noting that this extension would contribute to improved health outcomes for the covered individuals and would be a key tool in addressing maternal health disparities.

Five* commenters expressed particular support for the proposal to allow the provision of clinic services outside of the clinic, noting that this flexibility will enhance access to clinically appropriate behavioral healthcare and to community based care.

Five* commenters expressed particular support for the proposal to provide Community Support Program services to Justice Involved Individuals, noting that the services will improve the health and stability of the members and support a successful transition to the community.

Three* commenters expressed particular support for the proposed flexibilities that would allow further expansion of eligibility for the Medicare Savings Programs, noting that this would improve the affordability of health care and strengthen economic security for the newly eligible members.

Finally, four* commenters expressed particular support for the proposal to authorize the Hospital at Home program beyond the COVID-19 public health emergency, noting this program improves health outcomes while reducing costs.

Two* commenters, while expressing support for the amendment, also requested that MassHealth discontinue its waiver of the three month retroactive eligibility requirement and to continue the policy, temporarily in place during the COVID-19 public health emergency, to grant all applicants three months of retroactive eligibility. MassHealth is reviewing and considering this issue as part of its upcoming request to extend the 1115 demonstration.

After reviewing and considering the comments received, the Commonwealth does not propose any changes to the proposal as originally posted for public comment.

* including the comment letter written on behalf of fifteen additional organizations

Given the supportive comments at the public hearing and in the comment letters, we have not made any changes to the request as posted for public comment.

Conclusion

The proposed flexibilities described in the demonstration amendment request build on the Commonwealth's current efforts to maintain near universal health care coverage through coverage expansion and would authorize the provision of services in non-traditional locations. These flexibilities will allow us to comply with state law by increasing the number of individuals receiving Medicare Savings Program benefits and will provide crucial support to the vulnerable justice-involved population upon returning to the community in order to address behavioral health and substance use disorder needs, while also addressing racial and ethnic health disparities. Finally, the flexibility will also allow the state to test the efficacy of providing services outside traditional settings of care. The Commonwealth appreciates this opportunity to amend our 1115 demonstration and to continue to work with CMS to improve health care outcomes for the people of the Commonwealth.

State Contact

Daniel Tsai
Assistant Secretary for MassHealth and Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place
Boston, MA 02108
617-573-1770

Medicare Part B Premium		
CY 20	CY 21	CY 22 (Projected)
$ 144.60	$ 148.50	$ 152.51

1115 Amendment for MSP Expansion

9/1/2021 Projected Start Date

			FY 2022		
	Member Months	PMPM			Total
MSP Expansion	14,060	$	151.17	$	2,125,497

1/1/2022 Projected Start Date

			FY 2022		
	Member Months	PMPM			Total
CommonHealth	60,096	$	152.51	$	9,165,241
1902 (r) 2 Children	6	$	152.51	$	915
MSP Expansion	24,540	$	152.51	$	3,742,595
Total				**$**	**15,034,248**

Provide Community Support Program Services (CSP) to Justice Involved Individuals

10/1/2021 Projected Start Date

			FY 2022		
	Member Months	PMPM			Total
New Adult Group	2,965,139	$	0.84	$	2,495,366
Base Disabled/MCB	817,208	$	0.30	$	247,214
Base Families	2,159,147	$	0.30	$	653,165
CommonHealth	20,319	$	0.30	$	6,147
e-HIV/FA	5,039	$	0.30	$	1,524
1902 (r) 2 Children	152,509	$	0.30	$	46,136
1902 (r) 2 Disabled	16,024	$	0.30	$	4,847
1902 (r) 2 BCCDP	8,856	$	0.30	$	2,679
Total				**$**	**3,457,079**

Postpartum Expansion

9/1/2021 Projected Start Date - Subject to CMS Approval

			FY 2022		
	Member Months	PMPM			Total
Base Families	4,333		444.45		1,925,580
1902 (r) 2 Children	893		444.45		396,672
Total				**$**	**2,322,251**

Waiver of place of service requirements for clinic services

This waiver amendment will have no net fiscal impact. Services provided under this waiver amendment will be reimbured at the same rate as in clinic visits.

Waiver to allow for Hospital services at home

This waiver amendment will have no net fiscal impact. MassHealth will pay 100% DRG for home hospitalizations. Home hospitalizations are intended to replace facility hospitalizations, not augment them.

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	**21**
Budget Neutrality Reporting End DY	**25**

Actuals + Projected

Without-Waiver Total Expenditures

			21	22	23	24	25	Total
Medicaid Per Capita								
Base Families	1	**Total**	$ 7,319,238,826	$ 7,294,350,293	$ 7,587,681,600	$ 8,140,826,784	$ 8,690,615,636	
		PMPM	$753.10	$781.72	$811.42	$842.25	$874.26	
		Mem-Mon	9,718,814	9,331,155	9,351,115	9,665,571	9,940,539	
Base Disabled/MCB	2	**Total**	$ 4,716,788,922	$ 4,788,093,200	$ 4,856,973,961	$ 5,153,100,223	$ 5,509,287,084	
		PMPM	$1,647.49	$1,713.39	$1,781.93	$1,853.21	$1,927.34	
		Mem-Mon	2,863,015	2,794,515	2,725,682	2,780,635	2,858,493	
1902 (r) 2 Children	3	**Total**	$ 125,228,384	$ 115,622,257	$ 94,372,809	$ 111,145,725	$ 118,985,144	
		PMPM	$597.02	$618.51	$640.78	$663.85	$687.75	
		Mem-Mon	209,756	186,937	147,278	167,426	173,006	
1902 (r) 2 Disabled	4	**Total**	$ 292,900,324	$ 283,261,369	$ 294,337,900	$ 310,483,922	$ 330,668,576	
		PMPM	$1,284.97	$1,331.23	$1,379.15	$1,428.80	$1,480.24	
		Mem-Mon	227,943	212,782	213,420	217,304	223,388	
1902 (r) 2 BCCDP	5	**Total**	$ 73,317,328	$ 69,793,429	$ 70,595,122	$ 74,984,042	$ 79,858,624	
		PMPM	$4,928.56	$5,105.99	$5,289.81	$5,480.24	$5,677.53	
		Mem-Mon	14,876	13,669	13,345	13,683	14,066	
Base Families 21 RO	6	**Total**	$ -	$ -	$ -	$ -	$ -	
		PMPM	$753.10	$781.72	$811.42	$842.25	$874.26	
		Mem-Mon						
1902 (r) 2 RO	7	**Total**	$ -	$ -	$ -	$ -	$ -	
		PMPM	$597.02	$618.51	$640.78	$663.85	$687.75	
		Mem-Mon						
Medicaid Aggregate - WOW only								
DSH	1	**Total**	$ 680,109,699	$ 695,930,159	$ 710,007,363	$ 720,822,506	$ -	
TOTAL			**$ 13,207,583,483**	**$ 13,247,050,706**	**$ 13,613,968,755**	**$ 14,511,363,202**	**$ 14,729,415,064**	**$ 69,309,381,209**

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Medicaid Per Capita								
Base Families	1		$ 2,676,663,390	$ 2,726,201,355	$ 2,770,839,209	$ 3,038,434,484	$ 3,135,204,698	$43,736,003,544
Base Disabled/MCB	2		$ 2,446,111,317	$ 2,617,746,590	$ 2,666,468,455	$ 2,839,998,714	$ 2,928,285,888	$38,606,142,800
1902 (r) 2 Children	3		$ 96,124,870	$ 78,740,273	$ 73,411,564	$ 75,063,626	$ 77,834,321	$1,152,223,389
1902 (r) 2 Disabled	4		$ 55,836,760	$ 60,198,685	$ 62,724,513	$ 71,497,753	$ 73,719,031	$960,101,429
1902 (r) 2 BCCDP	5		$ 9,791,399	$ 13,492,920	$ 14,032,126	$ 15,411,564	$ 15,892,001	$126,115,217
Base Families 21 RO	6		$ -	$ -	$ -	$ -	$ -	
1902 (r) 2 RO	7		$ -	$ -	$ -	$ -	$ -	
Medicaid Aggregate - WW only								
e-Family Assistance	1		$ -	$ -	$ -	$ -	$ -	$45,231,794
e-HIV/FA	2		$ 9,630,164	$ 11,725,819	$ 11,205,798	$ 12,016,651	$ 12,390,691	$268,238,395
SBE	3		$ 22,687	$ 9,182	$ -	$ -	$ -	$842,117
SNCP-DSRIP	4		$ 425,000,000	$ 425,000,000	$ 400,000,000	$ 325,000,000	$ 225,000,000	$1,800,000,000
SNCP-DSRIP-ACO	5		$ -	$ -	$ -	$ -	$ -	
SNCP-DSRIP-CP	6		$ -	$ -	$ -	$ -	$ -	
SNCP-DSRIP-SWI	7		$ -	$ -	$ -	$ -	$ -	
SNCP-DSRIP-Operations	8		$ -	$ -	$ -	$ -	$ -	
SNCP-PHTII	9		$ 309,000,000	$ 243,000,000	$ 120,000,000	$ 100,000,000	$ 100,000,000	$1,166,389,329
SNCP-DSH-HSNTF	10		$ 287,000,000	$ 287,000,000	$ 288,000,000	$ 288,000,000	$ -	$2,017,523,364
SNCP-DSH-IMD	11		$ 28,954,675	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ -	$167,575,543
SNCP-DSH-CPE	12		$ 155,000,217	$ 157,999,250	$ 69,000,000	$ 159,000,000	$ -	$677,987,683
SNCP-UCC	13		$ -	$ -	$ 100,000,000	$ -	$ -	$100,000,000
SNCP-OTHER	14		$ 200,210,000	$ 197,410,000	$ 286,110,000	$ 196,000,000	$ -	$1,256,053,848
DSHP-Health Connector Subsidies	15		$ 108,917,689	$ 132,579,163	$ 144,480,079	$ 142,156,945	$ 144,480,079	$913,669,799
DSHP-CSR	16		$ 101,287,543	$ 134,790,876	$ 134,033,016	$ 126,690,724	$ 134,033,016	$692,889,261
Provisional Eligibility	17		$ -	$ -	$ -	$ -	$ -	
TANF/EAEDC	18		$ 252,770,827	$ 258,160,403	$ 297,223,400	$ 298,197,364	$ 307,441,482	$1,413,793,475
End of Month Coverage	19		$ -	$ -	$ -	$ -	$ -	$640,917,799
Continuous Eligibility	20		$ -	$ -	$ -	$ -	$ -	
SUD	21		$ -	$ -	$ -	$ -	$ -	
MSP Expansion							$ 5,868,092	
TOTAL			**$ 7,162,321,538**	**$ 7,374,054,515**	**$ 7,467,528,160**	**$ 7,717,467,824**	**$ 7,160,149,299**	**$ 36,881,521,337**

Savings Phase-Down

Medicaid Per Capita			21	22	23	24	25	TOTAL
		Savings Phase-Down						
Base Families	1	**Without Waiver**	$ 7,319,238,826	$ 7,294,350,293	$ 7,587,681,600	$ 8,140,826,784	$ 8,690,615,636	
		With Waiver	$ 2,676,663,390	$ 2,726,201,355	$ 2,770,839,209	$ 3,038,434,484	$ 3,135,204,698	
Difference			$ 4,642,575,436	$ 4,568,148,938	$ 4,816,842,391	$ 5,102,392,300	$ 5,555,410,938	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 3,481,931,577	$ 3,426,111,704	$ 3,612,631,793	$ 3,826,794,225	$ 4,166,558,204	
		Savings Phase-Down						
Base Disabled/MCB	2	**Without Waiver**	$ 4,716,788,922	$ 4,788,093,200	$ 4,856,973,961	$ 5,153,100,223	$ 5,509,287,084	
		With Waiver	$ 2,446,111,317	$ 2,617,746,590	$ 2,666,468,455	$ 2,839,998,714	$ 2,928,285,888	
Difference			$ 2,270,677,605	$ 2,170,346,610	$ 2,190,505,506	$ 2,313,101,509	$ 2,581,001,196	

Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 1,703,008,204	$ 1,627,759,958	$ 1,642,879,130	$ 1,734,826,132	$ 1,935,750,897	
		Savings Phase-Down						
1902 (r) 2 Children	3	**Without Waiver**	$ 125,228,384	$ 115,622,257	$ 94,372,809	$ 111,145,725	$ 118,985,144	
		With Waiver	$ 96,124,870	$ 78,740,273	$ 73,411,564	$ 75,063,626	$ 77,834,321	
Difference			$ 29,103,514	$ 36,881,984	$ 20,961,245	$ 36,082,099	$ 41,150,823	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 21,827,636	$ 27,661,488	$ 15,720,934	$ 27,061,574	$ 30,863,117	
		Savings Phase-Down						
1902 (r) 2 Disabled	4	**Without Waiver**	$ 292,900,324	$ 283,261,369	$ 294,337,900	$ 310,483,922	$ 330,668,576	
		With Waiver	$ 55,836,760	$ 60,198,685	$ 62,724,513	$ 71,497,753	$ 73,719,031	
Difference			$ 237,063,564	$ 223,062,684	$ 231,613,387	$ 238,986,169	$ 256,949,545	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 177,797,673	$ 167,297,013	$ 173,710,040	$ 179,239,627	$ 192,712,159	
		Savings Phase-Down						
1902 (r) 2 BCCDP	5	**Without Waiver**	$ 73,317,328	$ 69,793,429	$ 70,595,122	$ 74,984,042	$ 79,858,624	
		With Waiver	$ 9,791,399	$ 13,492,920	$ 14,032,126	$ 15,411,564	$ 15,892,001	
Difference			$ 63,525,929	$ 56,300,509	$ 56,562,996	$ 59,572,479	$ 63,966,623	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 47,644,447	$ 42,225,381	$ 42,422,247	$ 44,679,359	$ 47,974,967	
		Savings Phase-Down						
Base Families 21 RO	6	**Without Waiver**	$ -	$ -	$ -	$ -	$ -	
		With Waiver	$ -	$ -	$ -	$ -	$ -	
Difference			$ -	$ -	$ -	$ -	$ -	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ -	$ -	$ -	$ -	$ -	
		Savings Phase-Down						
1902 (r) 2 RO	7	**Without Waiver**	$ -	$ -	$ -	$ -	$ -	
		With Waiver	$ -	$ -	$ -	$ -	$ -	
Difference			$ -	$ -	$ -	$ -	$ -	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ -	$ -	$ -	$ -	$ -	
Total Reduction			**$ 5,432,209,536**	**$ 5,291,055,543**	**$ 5,487,364,144**	**$ 5,812,600,917**	**$ 6,373,859,344**	**$ 28,397,089,484**

BASE VARIANCE			**$ 613,052,409**	**$ 581,940,647**	**$ 659,076,451**	**$ 981,294,461**	**$ 1,195,406,421**	**$ 4,030,770,389**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 4,030,770,389**

Cumulative Target Limit

			21	22	23	24	25	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 7,775,373,947	$ 15,731,369,109	$ 23,857,973,720	$ 32,556,736,005	$ 40,912,291,725	
Allowed Cumulative Variance (= CTP X CBNL)			$ 155,507,479	$ 235,970,537	$ 238,579,737	$ 162,783,680	$ -	

Actual Cumulative Variance (Positive = Overspending)			$ (613,052,409)	$ (1,194,993,056)	$ (1,854,069,507)	$ (2,835,363,968)	$ (4,030,770,389)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 1 Per Capita								
CommonHealth	1	**Total**	$ 257,830,255	$ 296,157,012	$ 329,228,225	$ 353,013,237	$ 380,317,733	
		PMPM	$776.08	$813.33	$852.37	$893.28	$936.16	
		Mem-Mon	332,221	364,129	386,250	395,188	406,253	
CommonHealth XXI	2	**Total**	$ -	$ -	$ -	$ -	$ -	
		PMPM	$776.08	$813.33	$852.37	$893.28	$936.16	
		Mem-Mon						
TOTAL			**$257,830,255**	**$296,157,012**	**$329,228,225**	**$353,013,237**	**$380,317,733**	**$1,616,546,462**

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 1 Per Capita								
CommonHealth	1		$117,679,728	$131,711,215	$139,405,901	$150,231,545	$164,060,110	
CommonHealth XXI	2							
TOTAL			**$ 117,679,728**	**$ 131,711,215**	**$ 139,405,901**	**$ 150,231,545**	**$ 164,060,110**	**$ 703,088,499**
HYPOTHETICALS VARIANCE 1			**$ 140,150,527**	**$ 164,445,797**	**$ 189,822,324**	**$ 202,781,692**	**$ 216,257,622**	**$ 913,457,962**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 2 Per Capita								
Out-of-state Former Foster Care Youth	1	**Total**	$ 173,453	$ 390,698	$ 399,106	$ 419,939	$ 450,264	
		PMPM	$350.41	$365.48	$381.19	$397.58	$414.68	
		Mem-Mon	495	1,069	1,047	1,056	1,086	
TOTAL			**$ 173,453**	**$ 390,698**	**$ 399,106**	**$ 419,939**	**$ 450,264**	**$ 1,833,460**

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL

Hypothetical 2 Per Capita								
Out-of-state Former Foster Care Youth	1		$ 128,577	$ 376,448	$ 425,545	$ 379,612	$ 391,380	
TOTAL			**$ 128,577**	**$ 376,448**	**$ 425,545**	**$ 379,612**	**$ 391,380**	**$ 1,701,561**
HYPOTHETICALS VARIANCE 2			**$ 44,876**	**$ 14,251**	**$ (26,439)**	**$ 40,327**	**$ 58,885**	**$ 131,899**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 3 Per Capita								
New Adult Group	1	**Total**	$ 2,291,798,158	$ 2,235,054,169	$ 2,363,884,134	$ 2,581,992,716	$ 2,768,450,115	
		PMPM	$561.68	$585.83	$611.02	$637.29	$664.70	
		Mem-Mon	4,080,256	3,815,192	3,868,751	4,051,519	4,164,962	
TOTAL			**$ 2,291,798,158**	**$ 2,235,054,169**	**$ 2,363,884,134**	**$ 2,581,992,716**	**$ 2,768,450,115**	**$ 12,241,179,291**

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 3 Per Capita								
New Adult Group	1		$ 2,193,495,553	$ 2,192,312,327	$ 2,185,770,422	$ 2,441,776,403	$ 2,519,966,837	
TOTAL			**$ 2,193,495,553**	**$ 2,192,312,327**	**$ 2,185,770,422**	**$ 2,441,776,403**	**$ 2,519,966,837**	**$ 11,533,321,542**
HYPOTHETICALS VARIANCE 3			**$ 98,302,605**	**$ 42,741,842**	**$ 178,113,712**	**$ 140,216,313**	**$ 248,483,278**	**Excluded**