MASSACHUSETTS
SECTION 1115 DEMONSTRATION
FACT SHEET
February 21, 2018

Program Name: MassHealth Medicaid Section 1115 Demonstration

Initial Application
Date Proposal Submitted: April 15, 1994
Date Proposal Approved: April 24, 1995
Date of Implementation: July 1, 1997

First Renewal
Date Proposal Submitted: June 28, 2001
Date Approved: December 21, 2001

Second Renewal
Date Proposal Submitted: June 30, 2004
Date Approved: January 26, 2005

Third Renewal
Date Proposal Submitted: June 29, 2007 and December 24, 2007
Date Approved: December 19, 2008
Expiration Date: June 30, 2011 (The demonstration operated under temporary extension until December 20, 2011.)

Fourth Renewal
Date Proposal Submitted: June 30, 2010
Date Approved: December 20, 2011
Expiration Date: June 30, 2014 (The demonstration operated under temporary extension until October 31, 2014.)

Fifth Renewal:
Date Proposal Submitted: January 27, 2014
Date Approved: October 30, 2014
Expiration Date: June 30, 2019

Sixth Renewal:
Date Proposal Submitted: July 22, 2016
Date Approved: November 4, 2016
Expiration Date: June 30, 2022

SUMMARY

The MassHealth demonstration is a statewide multi-faceted health reform effort. The demonstration was initially implemented in July 1997, and has developed over time through

amendments and renewals reflecting new priorities and the enactment of the Affordable Care Act. The demonstration authorizes Medicaid income eligibility for certain categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities, and provides premium and cost sharing subsidies to qualifying individuals who are enrolled in a Qualified Health Plan (QHP) consistent with levels provided under the demonstration prior to the Affordable Care Act. Additionally, the demonstration continues to support a Safety Net Care Pool (SNCP) first created in 2005 for the purpose of reducing the rate of uninsurance in the Commonwealth while also providing funding for uncompensated care. The 2016 renewal implements a separate Uncompensated Care (UC) pool, which compensates hospitals for providing uncompensated charity care to the uninsured. The SNCP currently provides uncompensated care payments to safety net providers for Medicaid and low-income, uninsured individuals. The SNCP also funds delivery system transformation initiatives and infrastructure and capacity-building grants through a Delivery System Reform Incentive Program (DSRIP).

AMENDMENTS

Amendment #14: The demonstration and waiver authorities were amended to revise parameters for individuals who may self-attest to certain eligibility factors at the time of application for a 90 day provisional eligibility period. Children under 21 are not be impacted by this change and will continue to receive provisional eligibility. The following individuals will be able to self-attest to any eligibility factor, except disability, immigration and citizenship:

- Pregnant women with attested MAGI income at or below 200 percent FPL;
- Adults 21 through 64 years of age who are HIV positive and have attested income at or below 200% percent FPL; and
- Individuals with breast and cervical cancer who are under 65 years of age and have attested income at or below 250 percent FPL.

With this demonstration amendment, Massachusetts was also authorized to provide coverage to former foster care youth under age 26 who were in foster care under the responsibility of another state or tribe from any state when they "aged out" of foster care at age 18 (or such higher age as elected by the state) and were enrolled in Medicaid at that time.

Amendment #13: The demonstration and waiver authorities were amended to implement an Affordable Care Organization (ACO) Pilot entities, as well as make a number of programmatic modifications. These included expanding the CommonHealth program to working disabled adults over 65, add a cost sharing and premium subsidy wrap to the state based marketplace for individuals under 300 percent of the poverty level, and enact a substance use disorder (SUD) program to provide enhanced and diversionary services to beneficiaries.

Amendment #12: The demonstration and waiver authorities were amended to comply with the provisions of the Affordable Care Act. The amendment allowed Massachusetts to continue certain programs and realign other programs to comply with the Affordable Care Act provisions that became effective January 1, 2014. For example, the amendment allowed Massachusetts to sunset the Commonwealth Care (CommCare) Program, MassHealth Basic, MassHealth

Essential, the Medical Security Program, and the Insurance Partnership on December 31, 2013. Then, effective January 1, 2014, eligible individuals in these programs with income up to 133 percent of the federal poverty level (FPL) transitioned to the Medicaid state plan and began to receive state plan benefits through the Medicaid state plan Alternative Benefit Plan (ABP).

Date Amendment #12 Submitted: June 4, 2013
Date Amendment #12 Approved: October 1, 2013

Amendment #11: An amendment was approved to expand the provision of hospice services to individuals in the MassHealth Basic and Essential programs, specifically: routine home care, continuous home care, inpatient respite care, and general inpatient care. Routine and continuous home care became available in a community setting, as neither the Basic or Essential programs cover long term nursing facility services. These services are subject to the budget neutrality test.

Date Amendment #11 Submitted: November 14, 2012
Date Amendment #11 Approved: May 28, 2013

Amendment #10: An amendment was approved to authorize expenditure authority for a maximum of $125.5 million for state fiscal year (SFY) 2012 for Cambridge Health Alliance through the Safety Net Care Pool for uncompensated care costs. This funding was counted toward the budget neutrality limit approved for SFY 2012 within the renewal award.

Date Amendment #10 Submitted: July 27, 2011
Date Amendment #10 Approved: August 17, 2011

Amendment #9: An amendment was approved to: (1) increase authorization for Designated State Health Programs for State Fiscal Year 2011 to $385 million; (2) count Commonwealth Care adults without dependent children with income up to and including 133 percent of the federal poverty level (FPL) who receive premium assistance for commercial health insurance products as a hypothetical population for purposes of budget neutrality; and (3) allow the following populations to be enrolled into managed care: (a) participants in a Home and Community-Based Services Waiver; (b) Katie Beckett/ Kaileigh Mulligan children; and (c) children receiving title IV-E adoption assistance.

Date Amendment #9 Submitted: March 1, 2010
Date Amendment #9 Approved: January 19, 2011

See the Additional Amendment Section below for more information on amendments.

ELIGIBILITY

MassHealth has multiple eligibility groups:

MassHealth Standard: Children under age 1 and pregnant women with incomes at or below 200 percent of the FPL; children ages 1 through 18 with incomes at or below 150 percent of the FPL; parents with children under age 19 with incomes at or below 133 percent of the FPL; and

adults with disabilities ages 19 through 64 with incomes at or below 133 percent of the FPL. Certain women diagnosed with breast or cervical cancer whose gross family income is at or below 250 percent of the FPL are also covered.

New Adult Group: Adults ages 19-64 with incomes up to 133 percent FPL. Adults ages 19-20 with incomes up to 150 percent FPL.

MassHealth CommonHealth: Disabled children under 1 year old with incomes between 200 and 300 percent FPL. Disabled children through age 18 with incomes between 150 and 300 percent FPL; working disabled adults ages 19 and 20 with income above 150 percent FPL; working disabled adults ages 19 through 64 with incomes above 133 percent FPL; and non-working disabled adults with incomes over 133 percent of the FPL; working disabled adults over 65 with incomes above 100 percent FPL and/or assets greater than $2,000.

MassHealth Family Assistance/Premium Assistance: Children, ages 1 through 18, with incomes between 150 and 300 percent of the FPL who have access to employer sponsored health insurance. Adults, ages 19 through 64, with incomes between 133 and 300 percent of the FPL who have access to employer sponsored health insurance. For these individuals, the Commonwealth pays the employee's share of the employer-sponsored insurance premium minus a small employee contribution.

MassHealth Family Assistance/Direct Purchase of benefits: Children ages 1 through 18 with incomes between 133 and 200 percent of the FPL who do not have access to employer sponsored health insurance or where direct coverage is more cost effective than providing premium assistance. For these children, the Commonwealth provides the MassHealth Standard benefit. Individuals with HIV not otherwise eligible for medical assistance above 133 percent through 200 percent FPL.

MassHealth. Individuals who receive Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled, and Children. Individuals with provisional eligibility.

MassHealth Limited: Emergency services to undocumented individuals who would otherwise be eligible for MassHealth Standard, but for their immigration status.

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

As part of the November 4, 2017 extension of the demonstration, Massachusetts received federal approval to undertake a Delivery System Reform Incentive Payment (DSRIP) program. The objective of the DSRIP program is to further key goals of the 1115 demonstration, including: (1) enacting payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improving integration among physical health, behavioral health, long-term services and supports, and health-related social services; and (3) sustainably supporting safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals.

Massachusetts is making a major commitment to the ACO model with this demonstration. ACOs

can take one of three structures defined by the state, which involve varying levels of provider/payer integration. Two of the three structures involve the ACO taking capitation risk—one sub-contracted to a managed care plan and the other under direct risk contracting with MassHealth—with a third model involving partial upside and downside risk-sharing in a fee-for-service model. Certain individuals who are not eligible for managed care will not be initially eligible for ACOs; with the exception of those individuals, MassHealth enrollees will have the opportunity to choose whether or not to enroll in an ACO. The Commonwealth will attribute MassHealth beneficiaries to a specific ACO once they have decided to enroll in the ACO program. MassHealth beneficiaries will still have the option of receiving Primary Case Management (PCCM) coverage, or other managed care plans.

ACOs will also be required to partner with certified community entities in order to receive funding, with the goal of supporting beneficiary care and addressing social determinants of health. These community partners will also participate with ACOs in care coordination for members with complex behavioral and long-term services and supports (LTSS) needs. Community partners will have their credentials and capacity for participation validated by the Commonwealth prior to being able to participate in DSRIP and the ACO.

While not yet implemented, Massachusetts intends to direct a portion of DSRIP funding to ACOs towards "flexible services" to fund members' social service needs. ACOs will also have the ability to direct the use of flexible spending dollars, within a set of minimum criteria established by the Commonwealth that restrict spending to only interventions likely to improve health outcomes. These services could include but are not limited to care transition assistance, meal preparation and assistance, home modifications, and respite care.

SUBSTANCE USE DISORDER

The Commonwealth will provide enhanced diversionary behavioral health services funding for especially needy and challenging patients. Massachusetts will use DSRIP funding to support investment in new or enhanced diversionary strategies/infrastructure to help place members with behavioral health needs in the least restrictive, clinically most appropriate settings Among the models considered for development and funding are: Urgent care and intensive outpatient program (IOP), Community-based Acute Treatment (CBAT) for adults, ESP/Mobile Crisis Intervention (MCI) Teams, and several others. ACOs, certified CPs, primary care providers, ESPs, community mental health centers, acute care hospitals, community health centers, psychiatric hospitals, vendors, and MCOs may be eligible to apply for funding.

BENEFITS

MassHealth beneficiaries generally receive all services that are currently covered under the Massachusetts Medicaid program. While covered benefits vary slightly across MassHealth components, benefit coverage is comprehensive.

UNCOMPENSATED CARE POOL

Massachusetts will receive $212 million in SFY 2017, and $100 million from SFY 2018 to 2022.

The 2017 amount aids Massachusetts in transitioning to the new uncompensated care pool model from its previous demonstration period. The uncompensated care pool supports safety net hospitals who provide charity care, at cost, to the indigent. CMS and Massachusetts jointly estimated the extent of uncompensated charity care within the Commonwealth over the course of 2017, and decided upon these amounts.

PUBLIC HEALTH TRANSFORMATION AND INNOVATION INCENTIVES

The Public Health Transformation and Innovation Incentives (PHTII) program, which was established in the previous demonstration extension period, focuses on two areas that align with the Commonwealth's plans for a restructured MassHealth delivery system centered around ACOs and emphasizing the integration of care across physical and behavioral health care, long term services and supports, and health related social services.

PHTII is closely aligned with the goals of DSRIP. PHTII has two components: the first component places funding at risk in increasing proportions based on the same ACO performance measures as will operate in the broader statewide DSRIP initiative; such as total cost of care and ACO quality scores. The second component is a continuation of existing initiatives focused on building coordinated community health delivery, such as behavioral health integration, and enhancing services to treat mental health and substance use disorders.

In the first year of the demonstration PHTII will have $204 million allocated towards the program. By year 3 of the demonstration this funding stream will be reduced to $100 million per year, and it will stay at this level until year 5, after which the PHTII will phase out of the demonstration

HEALTH CONNECTOR PREMIUM AND COST SHARING ASSISTANCE SUBSIDIES

Effective November 4, 2016, the MassHealth demonstration provides premium assistance and cost sharing wrap for individuals with under 300 percent FPL who purchase health insurance through the Marketplace to maintain the same level of financial support to this group of demonstration eligibles prior to that date. In addition, individuals who are determined eligible for the Qualified Health Plan (QHP) coverage have up to 100 days to then select, pay the premium and enroll into a plan. During the 100 day gap period the state will cover for expenditures, on a FFS basis, for State Plan services provided to an individual in hospital or CHC setting.

QUALITY AND EVALUATION PLAN

As required under applicable federal laws and regulations, quality of care furnished under MassHealth is subject to internal and external review. The Commonwealth also ensures the effectiveness and quality of care by monitoring access, utilization practices, and client information, as well as through established service standards in contracts with MCOs.

The Commonwealth's evaluation plan focuses on objectives such as:

- Maintain near-universal health care coverage for all citizens of the Commonwealth and

reduce barriers to coverage;

- 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
- 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.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

1. The formation of new partnerships and collaborations within the delivery system
2. The increased acceptance of TCOC risk-based payments among MassHealth providers
3. Improvements in the member experience of care, particularly through increased member engagement in the primary care setting or closer coordination among providers
4. Reductions in the growth of avoidable inpatient utilization
5. Reductions in the growth of TCOC for MassHealth's managed care-eligible population
6. More robust EHR and other infrastructure capabilities and interconnectivity among providers
7. Increased coordination across silos of care (e.g., physical health, behavioral health, LTSS, social supports)
8. Maintenance or improvement of clinical quality
9. The enhancement of safety net providers' capacity to serve Medicaid and uninsured patients in the Commonwealth
10. The strength of aggregate provider networks in the ACO and MCO programs (excluding Primary Care ACOs) relative to the PCC Plan, in first three years of demonstration, including:
    i. Types of providers
    ii. Breadth of providers
    iii. Quality of services
    iv. Outcomes of services

COST-SHARING

Cost-sharing requirements vary across the MassHealth programs. However, in general, no copayments are charged for any benefits rendered to children under 19 or pregnant women. Additionally, no premiums are charged for any individual enrolled in the demonstration whose gross income is less than 133 percent of the FPL. For individuals who would be eligible for title XIX absent the demonstration the requirements for premiums and copayments are nominal. Where cost-sharing is required, it is on a sliding-scale based on income.

ADDITIONAL AMENDMENTS

Amendment #8: An amendment was approved to allow Massachusetts to (1) increase the MassHealth pharmacy co-payment from $2 to $3 for generic prescription drugs; (2) provide relief payments to Cambridge Health Alliance totaling approximately $216 million; and (3) provide relief payments to private acute hospitals in the Commonwealth totaling approximately $270 million.

Date Amendment #8 Submitted: March 1, 2010
Date Amendment #8 Approved: September 30, 2010

Amendment #7: An amendment was approved to allow Massachusetts to add independent foster care adolescents as a base demonstration population and to authorize expenditures for behavioral health services for this population.

Date Amendment #7 Submitted: December 29, 2006
Date Amendment #7 Approved: June 19, 2007
Date of Technical Corrections Letter: October 19, 2007

Amendment #6: An amendment was approved to allow the Massachusetts to add non-emergency medical transportation (NEMT) benefits for expansion populations.

Date Amendment #6 Submitted: November 30, 2006
Date Amendment #6 Approved: June 19, 2007

Amendment #5: An amendment was approved to allow Massachusetts to (1) increase its enrollment caps for beneficiaries with HIV receiving coverage under the Family Assistance program and for long-term chronically unemployed beneficiaries receiving services under the Essential program; (2) implement program modifications enacted by the Health Care Reform Act to the current IP program; and (3) expend funds from the SNCP based on approved payment methodologies.

Date Amendment #5 Submitted: May 1, 2006
Date Amendment #5 Approved: July 26, 2006

Amendment #4: Massachusetts submitted an amendment request to allow the Commonwealth to modify the standards utilized in its disability determination process in determining eligibility for the MassHealth Program to ensure that only adults who are truly incapable of substantial gainful activity are found "disabled." CMS disapproved this amendment request.

Date Amendment #4 Submitted: August 29, 2003
Date Amendment #4 Approved: Disapproved

Amendment #3: An amendment was approved to allow Massachusetts to impose an enrollment cap on non-state plan demonstration eligibles.
Date Amendment #3 Submitted: June 5, 2003
Date Amendment #3 Approved: January 29, 2004

Amendment #2: Massachusetts submitted an amendment request to allow the Commonwealth to cover prescription drug expenditures for low- income elderly and disabled individuals not otherwise eligible for MassHealth. Massachusetts withdrew this amendment request on August 29, 2003.

Date Amendment #2 Submitted: March 14, 2003

Date Amendment #2 Withdrawn: August 29, 2003

Amendment #1: An amendment was approved to allow Massachusetts to provide coverage for certain uninsured women with breast and cervical cancer.

Date Amendment #1 Submitted: July 16, 2002
Date Amendment #1 Approved: December 4, 2002