The MassHealth Waiver Extension for State Fiscal Years 2015–2019: FOUNDATION FOR COVERAGE, ENGINE FOR INNOVATION

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MASSACHUSETTS MEDICAID POLICY INSTITUTE

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Center for Health Law and Economics
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Robert W. Seifert
Michael Grenier
Jean C. Sullivan
Center for Health Law and Economics,
University of Massachusetts Medical School

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EXECUTIVE SUMMARY

MassHealth, the Massachusetts Medicaid program, has operated as a "Section 1115 Demonstration Project" since 1997, which has allowed the Commonwealth to experiment with innovative strategies for delivering and financing health care for many of its Medicaid-eligible residents. The demonstration is authorized by a waiver of parts of federal Medicaid law from the Centers for Medicare and Medicaid Services (CMS), the federal Medicaid oversight agency. The waiver must be reauthorized and extended periodically; extensions are often occasions to revise the terms of the waiver to pursue new initiatives or policy goals. CMS granted the most recent extension in October 2014. The extension is for five years (until June 30, 2019), except that a major component—the Safety Net Care Pool—was extended for only three years (until June 30, 2017), with the terms for the remaining two years subject to further negotiation. After reviewing the history of the waiver, this issue brief summarizes the key terms and conditions of the new waiver extension.

HISTORY OF THE MASSHEALTH WAIVER

The MassHealth 1115 waiver was initially granted for a period of five years beginning July 1, 1997. Massachusetts renewed the waiver in 2002, 2005 (with major amendments in 2006), 2008, 2011, and now 2014. The initial waiver period established the foundational goal of the MassHealth demonstration: expanding coverage. Renewal terms expanded coverage further, added goals and features, and became an engine for comprehensive health care reform.

July 1, 1997 – June 30, 2002

The original waiver made about 300,000 Massachusetts residents eligible for MassHealth who were not eligible before, by increasing income eligibility limits for existing categories of members and creating new categories for people not previously eligible. The waiver terms also simplified the application and eligibility process and required most children and families in MassHealth to enroll in a managed care plan. As part of this innovation, the Commonwealth allowed two important safety net hospitals—Boston City Hospital (now Boston Medical Center) and Cambridge Hospital (now Cambridge Health Alliance)—to create their own managed care organizations (MCOs). The waiver also authorized supplemental payments to these new managed care entities to support their transition to managed care, payments that would play an important role in the evolution of the demonstration.

July 1, 2002 – June 30, 2005

The first waiver renewal was an extension for three years of the same terms and conditions as the original five-year waiver. This renewal negotiation focused on demonstrating continued budget neutrality—the requirement that federal spending on a waiver program be no more than it would have been for a traditional Medicaid program—for expenditures under the waiver.

July 1, 2005 – June 30, 2008

In addition to maintaining the basic components of the original waiver, the second waiver extension was the instrument through which Massachusetts established important elements of its 2006 health care reform. To avert the loss of $385 million in federal funds, Massachusetts

agreed to shift the use of these funds from making supplemental payments to the safety net MCOs to expanding the funding available for coverage to low-income previously uninsured people throughout the Commonwealth. A critical innovation in this extension of the waiver was the creation of the Safety Net Care Pool (SNCP), which furnishes additional financial support to providers and programs that deliver services to MassHealth members and other low-income uninsured or otherwise disadvantaged groups. Original SNCP funding combined the funding for the MCO supplemental payments with funding from the state's Medicaid disproportionate share hospital (DSH) program. The SNCP funds were capped and were to be used for supporting providers' delivery of uncompensated care and for expanding insurance coverage, highlighting the trade-off between these two uses.

The commitment to using the SNCP for further coverage expansion was realized in the creation of Commonwealth Care as part of the 2006 health care reform law (known as Chapter 58), which used the SNCP to subsidize the purchase of private health insurance coverage by low- and moderate-income uninsured adults. Chapter 58 also created the Health Connector to administer Commonwealth Care and other new programs. And it extended supplemental payments to providers, though at a lower level than the now-eliminated payments to the safety net MCOs.

July 1, 2008 – June 30, 2011

The next three-year extension maintained the SNCP, with some modifications. It also explicitly focused on cost containment, by setting a savings target of slowing the growth of spending in the demonstration by one percentage point from the budgeted growth rate in each of the state fiscal years 2010 and 2011.

July 1, 2011 – June 30, 2014

The next waiver extension maintained the basic structure of the waiver and introduced two new goals related to system and payment reforms. In support of these goals, this extension introduced a number of new initiatives funded out of the SNCP. The most ambitious was the Delivery System Transformation Initiatives (DSTI), which supports seven safety net hospitals in efforts to enhance access to care, improve quality, and develop payment reform strategies and models. The extension also introduced new programs, including a Pediatric Asthma Bundled Payment pilot, Intensive Early Intervention Services for Children with Autism Spectrum Disorder, and Express Lane Eligibility to streamline eligibility redeterminations for members meeting certain income and family criteria.

The coverage expansion reforms of the federal Affordable Care Act (ACA) went into full effect on January 1, 2014. Massachusetts amended the waiver at that point to comply with ACA requirements. The amendment adjusted MassHealth eligibility levels and eliminated a number of eligibility categories that were no longer needed. It also discontinued Commonwealth Care, as the state subsidies for that program were to be replaced by the federal tax credits and cost-sharing reductions. In its place, the amendment introduced ConnectorCare, which supplements the federal subsidies. Subsequently, because the updated Health Connector website did not function as required and Massachusetts was committed to ensuring coverage through the ACA implementation, CMS extended authority for Commonwealth Care through 2014.

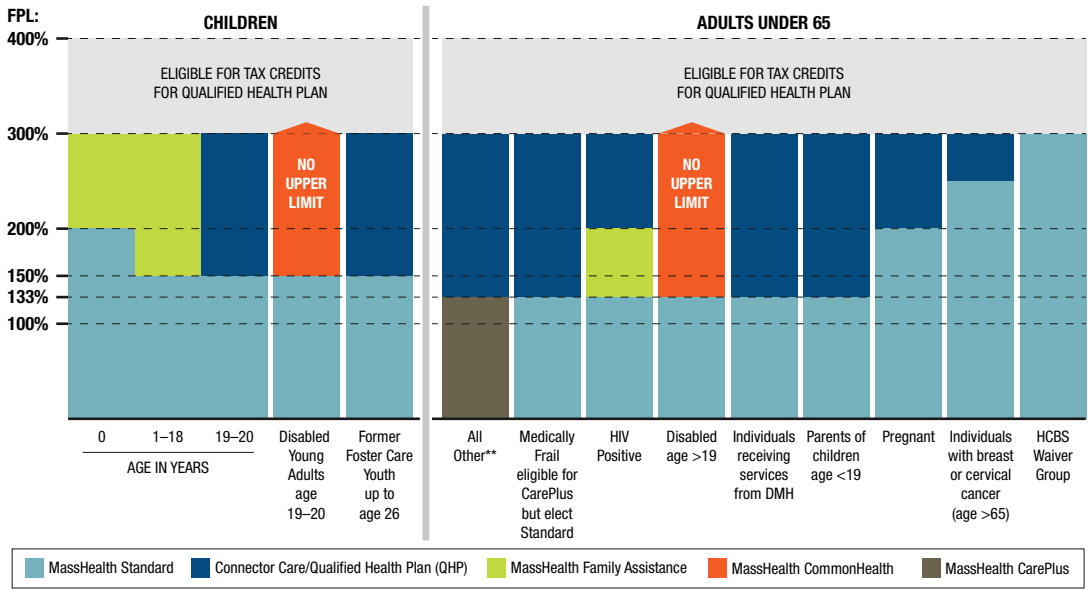
THE NEW WAIVER EXTENSION: STATE FISCAL YEARS 2015–2019

The new extension is structurally similar to the previous one as amended in January 2014 to comply with requirements of the ACA. The Commonwealth estimates the value of the waiver at about $40 billion over five years, slightly more than half of which will come from the federal government. Spending in the SNCP portion of the waiver is authorized at $4.47 billion, but most SNCP programs currently are authorized only for the first three years of the extension. Spending in the waiver is expected to be within the federal "budget neutrality" constraint, which requires that federal spending on a waiver program be no more than it would have been for a traditional Medicaid program over the same time period. The details of the waiver are spelled out in its special terms and conditions (STC), summarized here, organized into five themes.

1. Coverage

The terms of the demonstration include provisions that establish the expansive criteria under which people may be determined eligible for MassHealth. Virtually all residents of Massachusetts under age 65 may qualify for MassHealth if they have an income that is less than 133 percent of the federal poverty level (FPL), and many people qualify with higher incomes.[1] Benefits vary slightly by eligibility category. Figure ES1 shows the maximum income with which various types of people may qualify for MassHealth. The terms and conditions also include provisions that make maintaining eligibility easier for some members.

FIGURE ES1. MASSHEALTH ELIGIBILITY LEVELS AS OF JANUARY 1, 2014



*FPL = federal poverty level

** Includes members previously eligible for MassHealth Basic and Essential with a majority from Essential.

Notes: Several MassHealth programs are no longer available effective 1/1/2014 including MassHealth Basic and Essential, Insurance Partnership, Healthy Start, Prenatal, Commonwealth Care, and the Medical Security Program. Populations previously covered by these programs will now be covered by MassHealth Standard, CarePlus, and Connector Care.

In general, the eligibility level for seniors age 65 and older is 100% of FPL and assets of up to $2,000 for an individual or $4,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs.

Source: *MassHealth, The Basics.* MMPI, April 2014.

1 Immigrants who are undocumented or have been in the U.S. for less than five years are not eligible for MassHealth, except for emergency medical services. Lawfully present immigrants not eligible for Medicaid may be eligible for ConnectorCare subsidies, described below, if they have income below 300 percent of FPL.

2. New/expanded services

The waiver continues to include programs that were first authorized in the SFY 2012–2014 waiver extension. The Pediatric Asthma Bundled Payment pilot will evaluate the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation. Early Intervention Services for Children with Autism Spectrum Disorder provide highly structured and individualized treatment services for children ages 0 to three. Diversionary Behavioral Health Services include home- and community-based services intended to divert admissions to inpatient behavioral health services or to provide support to patients following a discharge from a 24-hour acute placement.

3. Delivery redesign

MassHealth, along with other payers, is working to develop and adopt alternative payment methods and delivery system models that promote greater accountability and integration of primary and behavioral health care.

Delivery System Transformation Initiatives

The DSTI program began with the waiver extension in 2011. It is an incentive-based payment program that supports safety net hospitals to develop, improve, or implement practices that enhance patient access, improve quality of care, and use alternative payment models. The same seven safety net hospitals as were in the prior waiver extension will receive DSTI funds, with an annual allotment for the first three years that is 10 percent higher than the prior extension. Funding for the final two years is subject to further negotiation. A proportion of each hospital's DSTI funding—an average of 10 percent over the three years—is contingent on performance on outcome and quality measures. There is also an aggregate performance target, which attaches an incentive to participating hospitals demonstrating collective improvement over the three years. The specific measures will be included in the hospital-specific and master DSTI plans, which Massachusetts has submitted but CMS has not yet approved.

Public Hospital Transformation and Incentive Initiative

Cambridge Health Alliance will receive funding for this new feature of the waiver, in addition to its continuing DSTI funding. The payments of $220 million per year for three years use funds shifted from supplemental provider payments in previous waiver extensions and now include performance incentives. CHA will use these funds to implement primary care and behavioral health initiatives and other care transformation projects, and an average of 20 percent of the funds will be contingent on achievement of performance metrics.

Infrastructure and Capacity Building Grants

The waiver extension continues authorization of Infrastructure and Capacity Building (ICB) grants for three years, at the same level as in the previous extension. Hospitals that receive funding for DSTI projects are not eligible for these grants. The goals of the ICB grants mirror those in the DSTI program, including strategies such as development of accountable care organizations (ACO), improving the use of electronic health records and data analytics, and reducing avoidable use of hospital emergency departments.

Primary Care Payment Reform Initiative and Accountable Care Organizations

Though Massachusetts requested approval, CMS did not authorize the payment model for the Primary Care Payment Reform Initiative (PCPRI) and development of an ACO payment model in

this waiver renewal. CMS indicated its support, however, and set a target date for approval of these payment models in 2015, contingent on Massachusetts submitting to CMS a requested actuarial analysis of the PCPRI shared-savings methodology by March 2015.

4. Support for the safety net: SNCP

There are now 12 distinct categories of spending within the SNCP, which fall into three key areas:

- **Provider payments** include payments made directly to providers for services to Medicaid and uninsured patients. This category includes the Health Safety Net, as well as payments to private and public safety net facilities.
- **Delivery system incentive payments** include DSTI, the ICB grants, and the Public Hospital Transformation and Incentive Initiative, described above.
- **Designated State Health Programs (DSHP)** are non-Medicaid state health programs—such as home care services, universal immunization, various mental health programs, and others—that CMS has designated as qualifying for federal Medicaid matching funds; see Appendix A for a complete list. The DSHP category also includes ConnectorCare and two temporary categories (through February 2015) for the closeout of Commonwealth Care and for temporary coverage of individuals who were unable to receive appropriate eligibility determinations during the launch of the new Health Connector website.

For the first three years of the extension, authorized annual funding for most of the components of the SNCP is roughly equal to the final year of the previous extension. Deviations from this level funding include:

- As noted above, the authorized spending for DSTI projects in the seven safety net hospitals is 10 percent higher than the levels for state fiscal year 2014, though a portion of that spending is contingent on achieving specific process and outcome measures.
- Spending for the designated state health programs is scheduled to phase out over the three years, as CMS has intended since these programs were added to the waiver in 2005.
- SNCP funding ends for Commonwealth Care, which Massachusetts is closing out as ACA programs take hold and replacing with ConnectorCare, which is approved for the full five years of the extension. ConnectorCare requires a lower level of SNCP spending to achieve the same end as Commonwealth Care because it is a supplement to the federal premium subsidies under the ACA.

A detailed summary of SNCP funding by category between state fiscal years 2012 and 2019 is given in Appendix B. Over time, the uses of the SNCP have shifted from an emphasis on direct provider payments toward payments to support coverage expansion and, more recently, to help hospitals transform their systems to accommodate changes in how health care is organized and paid for.

5. Looking to the future

The five-year term of the waiver extension gives Massachusetts some running room to pursue the cost containment and system reform initiatives in the demonstration, and it also creates stability for its basic elements: coverage categories, enrollment streamlining, eligibility, and the man-

aged care–based delivery structure. State officials will need to occupy themselves, however, with the part of the waiver that was approved for only three years—the Safety Net Care Pool.[2] In not authorizing SNCP expenditures for the last two years of the extension, CMS is inviting Massachusetts to engage in a dialogue about balancing the expenditure of SNCP funding for newer system transformation investments with the legacy purpose of supporting the safety net providers. This will be a central tension in the negotiation of the future structure of the SNCP.

What Is at Risk?

At risk in the SNCP negotiation is spending authority of close to $1 billion, or nearly $500 million per year over the last two years of the waiver extension. These funds are primarily connected to the system transformation and infrastructure projects, mostly in safety net hospitals. The waiver terms specify an alternative to the SNCP for continuing the direct payments to providers that deliver services to uninsured and low-income patients, including the Health Safety Net, so that spending is protected. Also protected are the ConnectorCare subsidies, which, unlike the rest of the SNCP, are already approved for the full five years. The remaining parts of the SNCP will expire or phase out by design within the currently authorized three-year period.

One indication of the direction in which CMS is likely to try to push Massachusetts is in some of the 1115 waivers it has recently approved in other states. These waivers include "Delivery System Reform Incentive Payment" initiatives that represent an evolution from the type of system transformation projects in the MassHealth waiver by including a broader range of providers, greater accountability for achieving desired outcomes, and a greater emphasis on improving population health. Certain terms of the MassHealth waiver extension suggest an intention by CMS to tip the balance of the SNCP toward supporting system-wide transformation and away from supporting individual providers. Two reports, newly required of MassHealth in the waiver extension, will address this balance and form the basis of the discussions to restructure the SNCP. The challenge—and opportunity—of the upcoming SNCP negotiation will be to promote a broader concept of system change while continuing to sustain a group of providers that are important to geographical regions of the state and, critically, to the populations that rely on their services.

CONCLUSION

The MassHealth waiver continues to be a foundation for coverage and health system innovation. The latest waiver extension affirms the federal government's support for the demonstration by approving a five-year extension and the continuation of many of its elements, modified to comply with the requirements of the Affordable Care Act. As the health care landscape changes, Massachusetts officials are challenged to adapt the demonstration to new priorities while not relinquishing its traditional roles of serving a broad and growing group of members and supporting providers that are critical to serving those members.

2 The exception to the three-year authorization of SNCP programs is ConnectorCare, which was authorized for the full five years of the extension. Also, the Commonwealth Care closeout and Temporary Coverage parts of the SNCP will expire by design in February 2015, and the designated state health programs are scheduled to phase out after three years.

I. INTRODUCTION

On October 30, 2014, the Centers for Medicare and Medicaid Services (CMS) approved the extension of the MassHealth Section 1115 Demonstration Project (also known as an 1115 waiver) for five years, through June 30, 2019.[3] This is the fifth extension of a waiver that was originally approved in 1995 and began with a five-year demonstration period in July 1997. Over the ensuing years, the demonstration established MassHealth as an engine of coverage expansion and continually reinforced this principle. It served as a platform for important health care reforms, most notably Chapter 58 of the Acts of 2006. The waiver has evolved with the health care landscape, incorporating cost containment and delivery system innovations that established MassHealth as both an essential program for people in need and a driver of health policy in the Commonwealth.

Massachusetts has a higher percentage of its population with health insurance than any other state in the nation. This is due in no small part to MassHealth. From the beginning of the demonstration, an intentional policy of coverage expansion has made MassHealth the source of health insurance for more and more groups of people who had no other access to coverage, in addition to the core group of low-income families, elders, and people with disabilities. Over the years, these new groups have included the long-term unemployed, higher-income people with disabilities, low-income employees of small businesses, people with HIV, women with breast or cervical cancer, and more. The state's decision to exercise the Medicaid expansion option in the Affordable Care Act has made even more people eligible. Today, MassHealth covers approximately 1.8 million people—about one of every four people living in Massachusetts.

The new waiver extension builds on this foundation of coverage and on other features that were added in previous extensions. Coverage remains robust, services are maintained, and historical support continues for "safety net" hospitals that provide a large share of the care to low-income, uninsured, or otherwise vulnerable populations. At the same time, the terms of the extension look forward and seek to use the waiver and the federal funds it draws for broader, system-wide transformation. Massachusetts is a site for many innovations in health care delivery reform that aim to improve health care and the health of the population while saving money, and MassHealth, as a major payer, plays an important role. A major event during this extension period will be a negotiation between CMS and the Commonwealth, with significant input from stakeholders in Massachusetts, to reach agreement by June 30, 2017, about the future of the Safety Net Care Pool (SNCP), a key component of the waiver. Unlike the rest of the waiver, the SNCP is initially authorized for three years rather than five, and because of this a large portion of the specific expenditures to be authorized under the SNCP beyond June 30, 2017, are uncertain. The outcome of the deliberations around the SNCP will help determine the future shape and focus of the waiver.

This issue brief begins with a review of the history of the MassHealth waiver, highlighting key features of the original approved waiver and subsequent extensions. Following the history is a

3 A portion of the waiver, the Safety Net Care Pool, was approved for only three years, with the remaining two years dependent on its redesign. This is discussed in detail later in the brief.

summary of the terms of the new waiver extension, organized around five themes: coverage, services, delivery redesign, support for the safety net, and looking to the future.

II. A BRIEF HISTORY OF THE MASSHEALTH WAIVER[4]

Massachusetts began operating the MassHealth program under an approved federal waiver on July 1, 1997. MassHealth is the Massachusetts version of two combined programs: Medicaid, a means-tested public health insurance program administered by states and jointly funded by state and federal governments, and the Children's Health Insurance Program (CHIP), which provides health coverage to children in families whose incomes are too high to qualify for Medicaid but who can't afford private coverage. Medicaid was created by the federal government in 1965 as part of the Social Security Act; Massachusetts began its Medicaid program in 1969.[5] CHIP was signed into federal law and implemented in Massachusetts in 1997. A Section 1115 demonstration waiver allows a state to operate its Medicaid program in a manner that differs from Medicaid rules in Title XIX.[6] The purpose of the waiver is to allow a state to experiment with innovative strategies for delivering and financing health care for some or all of its Medicaid-eligible population which meet the needs of the members, achieve state policy goals, and serve the objectives of the Medicaid program. Federal approval requires an assurance of budget neutrality—that is, the federal government's contribution to a demonstration program may not exceed what that contribution would have been under traditional Medicaid rules (see "Calculating Budget Neutrality" on page 12).[7]

Waivers are typically granted for an initial period of five years, with an opportunity for three-year renewals. A state may request amendments to a waiver at any time. The Affordable Care Act (ACA) included a provision for five-year renewals for waivers with certain features. Following its first five years, the MassHealth waiver was renewed in 2002, 2005 (with major amendments in 2006), 2008, and 2011. The current renewal is for five years. By the end of this period, the MassHealth program will have been operating under the demonstration waiver for 22 years.

The initial waiver period established the foundational goal of the MassHealth demonstration: expanding coverage. While states' use of 1115 waivers to modify their Medicaid programs was not new,[8] MassHealth's focus on coverage expansion was novel. The first renewal (SFY 2002–2004) extended the waiver under the same terms for three years. Subsequent renewals expanded cov-

4 Information in this section draws from material in MMPI summaries of previous waiver renewals: "The MassHealth Waiver" (April 2005); "The MassHealth Waiver: An Update" (September 2006); "The MassHealth Waiver: 2009-2011…and Beyond" (February 2009); and "Summary of Key New Provisions in the 1115 MassHealth Waiver Renewal" (January 2012).

5 Medicaid was enacted as Title XIX of the Social Security Act at the same time as Medicare was enacted as Title XVIII. Medicare is the program for seniors and people with permanent disabilities; it is not means-tested.

6 "Section 1115" and "Title XIX" refer to the Social Security Act.

7 Medicaid is administered by states and jointly funded by the state and federal governments. Federal contributions are determined by a matching rate, or Federal Medical Assistance Percentage (FMAP). In Massachusetts, most MassHealth expenditures are federally reimbursed at a rate of 50 percent. There is a higher matching rate for the CHIP component of MassHealth; for federal fiscal year (FFY) 2015, this rate is 65 percent. Under the Affordable Care Act, the match rate increases to 88 percent from FFY 2016 to FFY 2019. See http://kff.org/other/state-indicator/enhanced-federal-matching-rate-chip/.

8 Arizona, for example has operated its entire Medicaid program under a waiver since its inception in 1982.

erage further, added goals and features, and became an engine for comprehensive health care reform.

CALCULATING BUDGET NEUTRALITY

In general, the state first determines the waiver spending limit (also called the budget neutrality ceiling or cap) by projecting what it would have spent on populations who could have been covered under traditional Medicaid in the absence of the waiver. These calculations are made on a per-member-per-month (PMPM) basis, with different PMPM amounts for categories of families and children, people with disabilities in or out of CommonHealth, and women in the Breast and Cervical Cancer Treatment Program. Spending for most long-term care services is not included in the budget neutrality calculation for the MassHealth waiver. To calculate its projections, the state and CMS identify a base year off of which it will build these "without waiver" spending projections. Then, using a trend rate based either on historical program costs and enrollment or on the underlying Medicaid growth rate in the President's federal budget proposal (whichever is lower), the state projects program spending without a waiver over five years (and then subsequent three- or five-year periods if extending an existing waiver). Typically, the base year remains the same regardless of the number of waiver renewals; the base year for the MassHealth waiver was adjusted to state fiscal year 2009 in the last extension and remains so in this most recent extension. In the 2013 amendment of the demonstration, the ACA's Medicaid expansion population was also added to the without-waiver spending limit.

The state then projects what it expects to spend on the waiver-covered populations, including any new expansion of population groups or services not normally eligible for coverage under Medicaid, with the waiver. These "with waiver" spending projections must be less than or equal to the "without waiver" spending projections to meet the budget neutrality requirement for waiver approval. If they are lower, the state has a budget neutrality "cushion." The state typically creates a cushion by adopting policies or implementing programs under the waiver that deliver care more cost effectively. To be able to cover new populations or services not traditionally authorized by Title XIX, the state must create sufficient savings or a cushion to absorb the expansion costs. While the waiver includes annual amounts for each year of the extension, the budget neutrality limit is enforced on a cumulative basis over the course of the extension period. For enforcement purposes, actual spending per member is compared with the "without waiver" PMPM amounts. The state is at risk only for per capita spending, not for spending resulting from changes in enrollment, because enrollment changes equally affect both sides of the equation. If the state exceeds the budget neutrality limit, it must return the excess federal financial participation (FFP) funds to CMS. The state reports expenditures to CMS quarterly for monitoring purposes.

Budget neutrality often is described as "an art rather than a science." Any budget neutrality calculation is the result of state-specific negotiations with CMS, which can exercise broad discretion in testing and approving a state's demonstration of budget neutrality. This is primarily because of the theoretical nature of the calculation; over time, base year/trend calculations may no longer represent the true "without waiver" scenario, and CMS may, in certain cases, make corresponding adjustments. Additionally, as actual waiver expenditures for both "without waiver" and "with waiver" populations are realized, the cushion varies and the state's projection of the cushion in future years must be updated regularly. In the new MassHealth waiver extension, there is an additional provision for the new adult enrollee population, which is given a separate expenditure cap. If the state underestimates the PMPM costs for this group, for example because people who take up the coverage have greater health care needs than expected, the state can propose an adjustment of the PMPM limit to CMS.

Adapted from S. Anthony et al., "The MassHealth Waiver: 2009-2011…and Beyond." (MMPI 2009)

JULY 1, 1997 – JUNE 30, 2002

The original waiver made about 300,000 Massachusetts residents eligible for MassHealth who had not been not eligible before.[9] This was done in two ways:

- Increasing income eligibility limits for existing categories of eligible people to include more infants, children, parents, pregnant women, and people with disabilities; and
- Creating new eligibility categories for people not previously eligible, including long-term unemployed adults who had exhausted unemployment benefits (MassHealth Basic and Essential), people with HIV (MassHealth Family Assistance – HIV), and low-income employees of certain small businesses (the Insurance Partnership). In addition, the Medical Security Plan (for people on unemployment insurance) and CommonHealth (for people with disabilities with incomes higher than Medicaid limits who may buy into the program), previously funded with state dollars only, were incorporated into the demonstration and began receiving federal matching funds.

The waiver terms also made the application and eligibility process less complicated by eliminating face-to-face interviews and asset test requirements, and simplifying how income was counted, which allowed for the development of an innovative automated eligibility determination system.

Finally, the waiver required most children and families in MassHealth to enroll in a managed care plan—either the state-run Primary Care Clinician (PCC) Plan or a private managed care organization (MCO). This mandate helped the waiver meet its budget neutrality requirements, and it set two important precedents. First, this was an early effort to move MassHealth away from a fee-for-service payment system, a trend that has accelerated more recently, by paying MCOs a monthly capitation fee for its enrollees, rather than paying providers for each service delivered. Second, it built into the financial structure of the waiver supplemental payments to safety net institutions. This happened because the transition to managed care brought with it concerns about the stability of the state's two most important safety net providers: Boston City Hospital (now Boston Medical Center) and Cambridge City Hospital (now Cambridge Health Alliance). The hospitals worried that their patients newly enrolled in a MCO might seek care elsewhere. Further, the hospitals' financial stability might be threatened if MCOs paid rates for services that were significantly lower than the fee-for-service rates MassHealth paid historically, which included enhancements based on the hospitals' significant volume of low-income uninsured patients. The Commonwealth likewise had a key interest to ensure that MassHealth members maintained access to care at these providers. In part to address these concerns, the state allowed the hospitals to create their own managed care plans (BMC HealthNet Plan and Network Health), and the waiver authorized payment of supplemental financial support including additional per-member payments as well as additional lump sum payments. These payments were in addition to the standard MCO capitation payments. These and other supplemental payments played an important role in the evolution of the demonstration.

9 The demonstration waiver applies only to the part of the MassHealth program that serves members under 65 years old who do not reside in institutions. MassHealth also incorporates the Children's Health Insurance Program (CHIP), authorized in Title XXI of the Social Security Act.

JULY 1, 2002 – JUNE 30, 2005

The first waiver renewal was an extension for three years of the same terms and conditions as the original five-year waiver, with new budget neutrality projections.

JULY 1, 2005 – JUNE 30, 2008[10]

In addition to maintaining the basic components of the original waiver, the second waiver extension was the instrument through which Massachusetts established important elements of its 2006 health care reform. In 2004 and 2005, momentum was building for comprehensive reform in the state. The number of uninsured people, after declining from the inception of the waiver through 2000, was rising. Health insurance premiums were growing more unaffordable and the Uncompensated Care Pool, a fund used to pay hospitals and community health centers for providing services to uninsured and underinsured patients, faced annual shortfalls. At the same time, changes in federal rules led CMS, the federal agency responsible for oversight of Medicaid and enforcement of its rules, to decide that the state could no longer make, and the federal government would no longer match, the supplemental payments to the two safety net MCOs. The state was faced with the potential loss of $385 million per year in federal support for the demonstration. Reform plans were already being shaped at this time, so state leaders committed to CMS that they would shift the use of those funds to expand coverage to low-income previously uninsured people throughout the Commonwealth.[11] The tradeoff between supporting providers that deliver care to people with the least ability to pay and funding health insurance coverage for as many people as possible became a central theme of demonstration design and waiver negotiations from this point forward.

The critical innovation of this extension was the creation of the Safety Net Care Pool (SNCP) within the waiver. The SNCP combined the funding for the MCO supplemental payments with funding from the state's Medicaid disproportionate share hospital (DSH) program. DSH consisted of payments to hospitals that serve a relatively high percentage of Medicaid and uninsured patients, as well as the Uncompensated Care Pool, now renamed the Health Safety Net Trust Fund. The original SNCP was $1.34 billion per year, which also served as the cap for waiver spending "for the provision of health care services to uninsured individuals and unreimbursed Medicaid costs, through any type of health care provider or through insurance products,"[12] including the new coverage expansion plans the state had committed to. The shared spending cap for uncompensated care and expanded insurance coverage made the SNCP the embodiment of the tradeoff between these two priorities. As Massachusetts developed its coverage reform, it was allowed a one-year transition to continue making supplemental payments to the safety net MCOs. CMS also agreed to provide federal Medicaid matching dollars to a set of Designated State Health Programs (DSHP), which had been previously financed with state dollars only. DSHP includes such programs as home care services, universal immunization, and various mental health programs;

10 These dates correspond to the state fiscal years in which the waiver or subsequent extensions were in effect. In some cases extensions were approved after the fiscal year so that the terms of the extension did not technically take effect on July 1. For simplicity, this report uses the convention of identifying the extensions by the full fiscal years in which they were in effect.

11 For further details about this episode, see Stephanie Anthony, Robert Seifert, and Jean Sullivan, "The MassHealth Waiver: 2009-2011…and Beyond." MMPI, February 2009.

12 MassHealth Waiver Amendment for Demonstration Period 7/1/2005-6/30/2008, approved July 26, 2006. Special Terms and Conditions (STC) #24. The state is authorized to make SNCP payments only to providers authorized in the waiver.

THE MASSHEALTH WAIVER'S RELATIONSHIP TO STATE AND NATIONAL HEALTH CARE REFORM

The Massachusetts health care reform law (Chapter 58 of the Acts of 2006) sought near-universal coverage by expanding access to insurance in the public and private sectors. The vehicle for expansion on the public sector side was the MassHealth waiver. The waiver extended MassHealth eligibility to children in families with incomes up to 300 percent of FPL and premium assistance eligibility to workers in qualified small businesses up to 300 percent as well (the previous standards for both had been 200 percent). Further, the potential loss of nearly $400 million per year in federal funding, coupled with the recognition that the remaining uninsured fell disproportionately in the income range just above MassHealth eligibility, motivated policy makers to create Commonwealth Care and the Health Connector. Commonwealth Care was private coverage for individuals with incomes up to 300 percent of FPL, subsidized with public funds so that premium outlays were limited to a certain percentage of income. The public funding source was the Safety Net Care Pool, which is part of the MassHealth waiver; Commonwealth Care would likely not have been possible without the federal Medicaid matching funds.

The Affordable Care Act adapted many of the coverage expansion features of Chapter 58, including a Medicaid expansion and subsidized private coverage through an exchange or marketplace. Some of the details in the ACA differ from Chapter 58. For example, Chapter 58 created subsidies to purchase private coverage for low-income adults who were not otherwise eligible for Medicaid and did not have access to employer-sponsored insurance, while the ACA expanded Medicaid eligibility to everyone below 133 percent of FPL. Also, subsidies for purchase of private coverage are available up to 400 percent of FPL in the ACA rather than 300 percent in Chapter 58 and are financed entirely with federal funds, but they are not as generous as the Commonwealth Care (Chapter 58) subsidies. The inspiration for the ACA coverage expansions is unmistakable, however: Massachusetts health care reform and the MassHealth waiver.

see Appendix A for a complete list. State spending on DSHP would replace some of the local funds from the cities of Boston and Cambridge that qualified as the nonfederal share of spending that drew the $385 million federal match.[13]

With the waiver extension approved in 2005, state policy makers turned to completing work on comprehensive coverage reform, culminating in the enactment of the landmark reform law, Chapter 58, on April 12, 2006. Chapter 58 promised near-universal coverage, to be achieved through initiatives in the private and public coverage systems. The centerpiece of the public sector part of the reform was the creation of Commonwealth Care, which used funding from the SNCP in the MassHealth waiver to subsidize the purchase of private health insurance coverage by low- and moderate-income uninsured adults not eligible for MassHealth or employer-sponsored insurance. The four MassHealth MCOs (including the BMC and CHA plans) were the only health plans contracted to offer Commonwealth Care for its first three years. Chapter 58 also created the Health Connector, a new public agency to administer Commonwealth Care, and also to run a commercial insurance exchange for nonsubsidized plans, through Commonwealth Choice. Chapter 58 introduced a number of other features related to the MassHealth waiver. It expanded eligibility for several existing MassHealth coverage programs, so that between the MassHealth expansion

13 These local funds are formally known as intergovernmental transfers (IGTs). IGTs are an option for states to provide the nonfederal share of Medicaid expenditures, by which a local public entity may contribute funds that are then federally matched, rather than using funds from the state budget. Changes in federal Medicaid rules in 2002 and 2003 restricted how states could use IGTs to finance supplemental provider payments, creating this need for a shift in SNCP financing.

and the creation of Commonwealth Care, most people in Massachusetts with incomes up to 300 percent of the federal poverty level (FPL) now had access to affordable coverage. And it created new supplemental payments for BMC and CHA, known as "Section 122 payments," at a lower level than the now-eliminated MCO supplemental payments (most of which were converted to Commonwealth Care subsidies or DSHP). Chapter 58 authorized Section 122 payments for state fiscal years 2007–2009 only, beginning at $200 million in 2007 and declining $20 million each subsequent year. The MassHealth waiver was amended in 2006 to include these new features, with an updated assurance of budget neutrality.

JULY 1, 2008 – JUNE 30, 2011

The three-year extension covering state fiscal years 2009–2011 maintained the SNCP to support safety net providers and fund coverage expansion, with some modifications. First, the overall SNCP spending cap applied to the entire three-year period, rather than imposing a separate cap for each year. This gave the state additional flexibility in managing and distributing these funds. The waiver agreement also added complexity by imposing sub-caps within the SNCP. There was a limit to spending on DSHP, which was funded at the full $385 million the first year and scheduled to drop to 75 percent of that in the second year and 50 percent in the third, with the intent of phasing out the DSHP part of the SNCP. The other sub-cap, called the provider cap, was for the provider payments—to safety net hospitals, ongoing Public Service Hospital Safety Net Payments to BMC and CHA,[14] the Health Safety Net, and a final year of the Section 122 supplemental payments. Commonwealth Care subsidies were counted against the overall SNCP cap but did not have their own sub-cap. This structure again emphasized the balance that Massachusetts needed to strike between support for providers on the one hand and for coverage on the other.

This waiver agreement also explicitly focused on cost containment, by setting a savings target of slowing the growth of spending in the demonstration by one percent-

A GLOSSARY OF ABBREVIATIONS

CMS: The Centers for Medicare and Medicaid Services, the federal agency responsible for oversight of state Medicaid programs.

DSH: Disproportionate Share Hospitals are hospitals designated by the state that serve a significantly high proportion of patients who are uninsured or MassHealth members.

DSHP: Designated State Health Programs are non-Medicaid state programs previously funded only by state dollars for which CMS has agreed to contribute federal matching funds. See Appendix A.

DSTI: Delivery System Transformation Initiatives are efforts by seven hospitals to enhance access to health care, improve the quality of care and the health of their patients, and support the development of payment reform strategies and models. Eligible hospitals are hospitals with the highest proportion of Medicaid patients and the lowest proportion of commercial patients. See footnote 15 for a list of the hospitals.

SNCP: The Safety Net Care Pool is a pool of funds authorized in the MassHealth waiver for purposes such as payments for patient services to DSH hospitals and other providers, insurance premium subsidies for low-income individuals, and support for Delivery System Transformation Initiatives in safety net hospitals.

14 These payments had been in place since the beginning of the demonstration in 1997, to offset the two hospitals' draw on the Health Safety Net (originally called the Uncompensated Care Pool).

age point from the budgeted growth rate in SFY 2010 and another one percentage point in SFY 2011. Though the waiver agreement did not include specific cost-containment initiatives, the state's extension proposal noted potential areas for savings, including:

- Ensuring fair and efficient hospital and MCO rates and eliminating earmarks for specific providers;
- Comprehensive care management for high-cost utilizers;
- Expanded pharmacy management; and
- Enhanced quality assurance and payment accuracy efforts.

JULY 1, 2011 – JUNE 30, 2014

The SFY 2012–2014 extension maintained the basic structure of the waiver, including the SNCP with an overall cap and provider and DSHP sub-caps. (Though DSHP appeared to be phasing out in the prior extension, reflecting CMS's view that the state programs were intended as a transitional, not permanent, source of funds for the demonstration, negotiations for this extension restored it, at $360 million in the first year, declining to $130 million in the third.) The agreement also introduced two new goals for the waiver. In addition to maintaining near-universal coverage and continuing to redirect spending from uncompensated care to coverage, the goals now looked ahead to system and payment reforms:

- "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."

In support of these goals, this extension introduced a number of new initiatives, funded out of the SNCP. The most ambitious of them were the Delivery System Transformation Initiatives (DSTI), which shifted funding from supplemental payments to incentive-based payments that required providers to meet specified process and outcome milestones in order to earn some of the funding. DSTI provides funding for projects at the seven hospitals[15] with the highest Medicaid and lowest commercial-payer mix. These projects—defined and approved as part of the waiver agreement—are intended to enhance access to health care, improve the quality of care and the health of patients and families they serve, and support the development of payment reform strategies and models. The agreement designated $628 million over three years for DSTI.

The extension also introduced some new program initiatives, including a Pediatric Asthma Bundled Payment Pilot and Intensive Early Intervention Services for Children with Autism Spectrum Disorder. To help keep eligible members enrolled, Express Lane Eligibility permitted MassHealth to use income information that has already been verified for SNAP (food stamps) eligibility so that

15 Boston Medical Center, Cambridge Health Alliance, Holyoke Medical Center, Lawrence General Hospital, Mercy Medical Center, Signature Healthcare Brockton Hospital, and Steward Carney Hospital.

members who meet certain income and family criteria are not required to complete an annual MassHealth eligibility review form if their circumstances have not changed.

The coverage expansion reforms of the ACA went into full effect on January 1, 2014, six months before the expiration of this extension. To bring MassHealth into conformity with the ACA, Massachusetts proposed an amendment to the waiver in May 2013 and received approval from CMS on October 1. Beginning in 2014, the state had the option of making eligible for MassHealth all residents (except restricted immigrants) with incomes up to 133 percent of FPL. In addition, federal subsidies in the form of premium tax credits and cost-sharing reductions would be available to people purchasing coverage in a state or federal marketplace (the Health Connector in Massachusetts) who were not eligible for Medicaid and had incomes up to 400 percent of FPL. (These subsidies do not use Medicaid dollars and are not part of the MassHealth waiver.)

The waiver amendment primarily adjusted eligibility levels for various types of MassHealth members to reflect the state's adoption of the Medicaid expansion (see Section III below for details) and eliminated a number of waiver categories that are no longer needed, including the Insurance Partnership, MassHealth Basic and Essential, and the Medical Security Plan. In addition, the waiver amendment discontinued Commonwealth Care as of December 31, 2013, as the state subsidies for that program, financed by the SNCP, were to be replaced in part by the federal tax credits and cost-sharing reductions.[16] Subsequently, the updated Health Connector website did not function as required and could not properly determine eligibility for federal subsidies, but because Massachusetts was committed to ensuring coverage through the process, CMS granted extensions for Commonwealth Care, and it remained in place through 2014.

16 While the waiver amendment discontinued Commonwealth Care, federal subsidies under the ACA were not sufficient to entirely replace state subsidies. The state was able to continue to supplement these federal subsidies under the waiver in the October 2014 extension.

III. THE NEW WAIVER EXTENSION FOR STATE FISCAL YEARS 2015–2019

GOALS

CMS approved the extension of the MassHealth waiver from October 30, 2014 (the date of approval) through June 30, 2019. As with the immediately prior agreement, the goals of the waiver are to:

1. Maintain near-universal coverage for all residents 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 transition, 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.

The first goal differs from its counterpart in the previous waiver extension (SFY 2011–2014) by referring to "residents" rather than "citizens." The other three goals are identical to those in the prior extension. These goals reconfirm a vision of the waiver as an instrument for transforming how health care is delivered and paid for in the MassHealth program and, by example and influence, across the broader Massachusetts health care system.

GENERAL TERMS

The new waiver extension is structurally similar to the previous one as it was recently amended to comply with requirements of the ACA. Eligibility categories remain the same, with some provisions added to make it less cumbersome for members to remain enrolled and avoid coverage gaps. The demonstration continues to be a platform for program innovations, as several new programs authorized in past extensions continue here. Financing of the various elements of the waiver are generally comparable to the previous extension, with important exceptions that are discussed below.

Time period

The waiver extension is for five years, rather than the three-year term of every previous extension of the MassHealth waiver. The ACA created the opportunity[17] for a five-year extension for demonstrations that provide medical services for dual eligible individuals—those eligible for both Medicaid and Medicare. Massachusetts' One Care program, which serves dual eligibles, is authorized as a separate demonstration program, but a number of features that are essential to One Care's delivery and payment models are authorized in the MassHealth demonstration waiver. CMS agreed that the two demonstrations are sufficiently intertwined to warrant the five-year extension for MassHealth.

There is an important exception to the five-year term. The Safety Net Care Pool in its current form is authorized only for the first three years of the waiver extension, and its structure beyond that is subject to negotiation. This is discussed further below.

Financing

CMS authorizes spending authority of approximately $40 billion over the five years; the federal government will reimburse more than one-half of the authorized spending.[18] The precise amount of the spending will depend on enrollment in the eligibility categories authorized under the waiver, which represent about 90 percent of all MassHealth members.[19] The trends in per-member-per-month spending assumed for budget neutrality purposes range from 4.6 to 5.2 percent per year, depending on the eligibility group.

Spending in the SNCP portion of the waiver is authorized at $4.47 billion for the first three years of the extension.

MAIN THEMES OF THE WAIVER EXTENSION

The demonstration waiver governs most of the MassHealth program for members under 65 years old, and the details—who is eligible, what services members may receive, what special initiatives are included in the demonstration, how the waiver finances services and specific providers, and how the state is required to report on and account for its activities—are spelled out in the waiver's special terms and conditions (STC). Following is a summary of the terms, organized into five main themes.

1. Coverage

Eligibility

MassHealth has been a linchpin of the Commonwealth's strategy for achieving near-universal health insurance coverage for residents of the Commonwealth, and maintaining that achievement is the first goal for this era of the demonstration. The terms of the demonstration include provisions that establish the expansive criteria under which people may be determined eligible. Virtually all residents of Massachusetts under age 65 may qualify for MassHealth if they have an

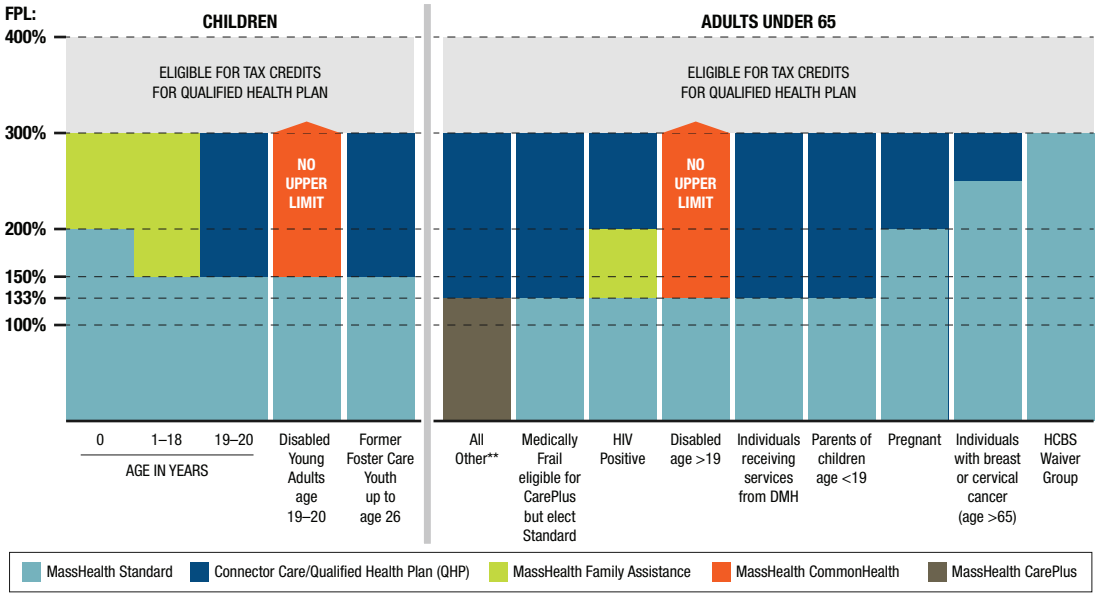
17 Codified in Section 1915(h)(2) of the Social Security Act.

18 In general, Massachusetts receives 50 cents of federal reimbursement for every dollar spent on MassHealth benefits. Certain categories of members qualify for higher reimbursement rates: children who are eligible for CHIP or childless adults newly eligible as a result of the Medicaid expansion in the ACA.

19 The demonstration excludes members age 65 and above, people who are eligible based on a functional status that qualifies them for institutional care, participants in the Program of All-Inclusive Care for the Elderly (PACE), and refugees served through the Refugee Resettlement Program.

income that is less than 133 percent of the federal poverty level (FPL), and many people qualify with higher incomes.[20] Figure 1 shows the maximum income with which various types of people may qualify for MassHealth.

FIGURE 1. MASSHEALTH ELIGIBILITY LEVELS AS OF JANUARY 1, 2014



*FPL = federal poverty level
** Includes members previously eligible for MassHealth Basic and Essential with a majority from Essential.
Notes: Several MassHealth programs are no longer available effective 1/1/2014 including MassHealth Basic and Essential, Insurance Partnership, Healthy Start, Prenatal, Commonwealth Care, and the Medical Security Program. Populations previously covered by these programs will now be covered by MassHealth Standard, CarePlus, and Connector Care.
In general, the eligibility level for seniors age 65 and older is 100% of FPL and assets of up to $2,000 for an individual or $4,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs.

Source: *MassHealth, The Basics*. MMPI, April 2014.

Most MassHealth members are entitled to the Standard benefit package, a comprehensive range of primary care services, hospital services, behavioral health care, and long-term services and supports (LTSS): nursing home care and some community-based services including personal care attendants, adult day health, adult foster care, and day habilitation.[21] Children who qualify for the Standard benefit package receive pediatric services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Adults or children with permanent disabilities who would not qualify for MassHealth using income criteria may be covered by the CommonHealth program and receive Standard benefits.[22] CommonHealth members with family incomes above 150 percent of FPL pay a premium to MassHealth based on their income.

20 Immigrants who are undocumented or have been in the U.S. for less than five years are not eligible for MassHealth, except for emergency medical services. Lawfully present immigrants not eligible for MassHealth may qualify for ConnectorCare if they have incomes under 300 percent of FPL.

21 Additional home- and community-based LTSS are available to a limited number of members as a part of separate waiver programs.

22 Members with Standard or CommonHealth coverage who have access to other health insurance, for example through an employer, may receive Premium Assistance from MassHealth, if MassHealth determines that to be cost-effective. Instead of providing the full benefit directly, MassHealth will contribute toward the employee's share of the premium and then provide the additional MassHealth benefits for which the member is eligible but which are not part of the employer plan. MassHealth also provides premium assistance to people with incomes between 133 and 300 percent of FPL, who work for employers with 50 or fewer employees and have access to employer sponsored insurance, and are ineligible for other subsidized coverage through MassHealth or the Health Connector. Premium assistance is also available for children and HIV-positive individuals in Family Assistance.

MassHealth members who have HIV/AIDS and incomes between 133 and 200 percent of FPL and are not otherwise eligible for MassHealth, and children in families with incomes between 150 and 300 percent of FPL, qualify for the Family Assistance benefit package. Family Assistance differs from Standard benefits because it does not include LTSS, medically necessary non-emergency transportation, and targeted case management services. In addition, children in Family Assistance are not entitled to EPSDT services.

People whose income qualifies them for MassHealth but are not eligible for Standard benefits because they are "non-qualified non-citizens" may receive MassHealth Limited benefits, which cover emergency medical services only.

Retention of coverage

In addition to establishing eligibility standards, the 2013 amendment and the subsequent waiver extension close a coverage gap that had existed since the introduction of Commonwealth Care in 2006. Coverage through the Health Connector begins on the first day of the month following the establishment of eligibility.[23] Formerly, when a MassHealth member's income change made him or her no longer eligible, MassHealth benefits terminated on the date of ineligibility, regardless of when it fell in a month. If that individual was then determined eligible for a federally subsidized Qualified Health Plan (QHP) through the Health Connector (or, previously, for Commonwealth Care), there could still be a gap in coverage lasting as long as six weeks. In this waiver extension, Massachusetts requested authority to extend MassHealth eligibility right up to the end of the month before QHP coverage becomes effective, eliminating the gap. CMS approved the change.

The demonstration also includes administrative measures that simplify the process for eligible members to maintain their MassHealth benefits and not experience gaps in coverage that can impede access to care. The demonstration already authorized streamlined redetermination for families with children under age 19 using Express Lane Eligibility. The new waiver renewal extends this streamlining to families with children up to age 21 and to childless adults. Further, MassHealth has authority to extend eligibility for members who normally would have had their eligibility redetermined between October 2013 and December 2014. This effectively gives Massachusetts until the end of 2015 to process redeterminations and changes in income using a new streamlined strategy.

Affordability of coverage

With the ACA subsidies becoming effective in 2014, Commonwealth Care will be phased out in Massachusetts by February 28, 2015. The federal subsidies, however, require more of a contribution from individuals with incomes between 133 percent and 300 percent of FPL than was required under Commonwealth Care. Acknowledging that the shift from Commonwealth Care to federal subsidy rules should not make anyone worse off, the waiver renewal authorizes Massachusetts to provide additional subsidies to people with incomes between 133 and 300 percent of FPL purchasing coverage through the Health Connector. These subsidies are called ConnectorCare and are funded through the SNCP in the waiver renewal, as was Commonwealth Care previously.

23 If eligibility is established on or before the 15th of a month, coverage begins on the first of the following month; if eligibility is established after the 15th, coverage may not begin until the month after the immediate next month.

2. New/Expanded Services

The waiver extension continues authorization for the Pediatric Asthma Bundled Payment Pilot, which the Commonwealth established to 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. CMS authorized this pilot program in the previous waiver, subject to CMS approval of certain protocols. The Commonwealth submitted these protocols to CMS in January 2013 and received approval from CMS in July 2014. The Commonwealth's goal is to procure as many as six participating practices with up to 200 members enrolled in the pilot. Phase 1 of the Pediatric Asthma Bundled Payment Pilot includes a bundled payment for asthma mitigation services and supplies not currently paid for by MassHealth. These services and supplies include community health worker visits and environmental equipment to mitigate asthma symptoms, such as vacuums and air conditioners. The Commonwealth must evaluate Phase 1 before it can submit protocols for a future phase to CMS.

The extension also continues authorization for Intensive Early Intervention Services for Children with Autism Spectrum Disorder. This program provides highly structured and individualized treatment services for children ages 0 to 3 to address the symptoms of autism spectrum disorder. The waiver extension did not modify the terms of this program from the prior extension period agreement.

Diversionary Behavioral Health Services (DBHS) include home- and community-based services intended to divert admissions to inpatient behavioral health services, or to provide support to patients following a discharge from a 24-hour acute placement. This waiver extension reauthorizes most of these services but only provides a two-year authorization period for DBHS that are provided by Institutions for Mental Disease (IMDs).[24] The extension requires the state to submit data to CMS semiannually on the effectiveness of DBHS services provided by IMDs using evaluation criteria and metrics established by CMS. Upon review of this data at the end of the two-year period, CMS may decide to extend or make changes to the authorization for these services.

3. Delivery Redesign

The Commonwealth's waiver extension request to CMS highlighted the state's progress and continued emphasis on delivery system redesign and reform. The passage of Chapter 224 required MassHealth and other payers to transition away from fee-for-service payments to alternative payment methods (APMs) and to adopt delivery system models that promote greater accountability and integration of primary and behavioral health care. The waiver extension provides substantial funding for these delivery system redesign models, most notably through enhanced funding for the Delivery System Transformation Initiatives (DSTI), continued funding of the Infrastructure and Capacity Building Grants (ICB), and the creation of a new payment category, the Public Hospital Transformation and Incentive Initiative.

Primary Care Payment Reform Initiative and Accountable Care Organizations

As part of its extension request, the Commonwealth requested CMS's approval of the Primary Care Payment Reform Initiative's (PCPRI) payment model and the future development of an

24 CMS defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services" (42 CFR 435.1009). Certain community-based residential treatment facilities are considered IMDs under this definition. CMS is undertaking a nationwide evaluation of the effectiveness of IMDs providing diversionary behavioral health services and will decide within two years whether and how best to alter this policy.

Accountable Care Organization (ACO) payment model. However, CMS authorization for these initiatives was not included in the final waiver extension. In its approval letter, CMS indicated its support for these initiatives and set a target date for approval of the PCPRI and ACO payment models in 2015. To meet this timetable, the Commonwealth is required to submit to CMS an actuarial analysis of the PCPRI shared savings methodology by March of 2015.

Delivery System Transformation Initiatives

As described earlier, the DSTI program began with the waiver extension in 2011. The DSTI program earmarks SNCP funding for safety net hospitals to develop, improve, or implement programs that enhance patient access, improve quality of care, and use alternative payment models. Under the prior waiver extension, seven safety net hospitals, which have a higher reliance on public payers than other hospitals, established DSTI programs. There are four categories of DSTI funding available to hospitals: the development of an integrated delivery system, improved health outcomes and quality, movement toward value-based purchasing and alternative payment methods, and population-focused improvements. A portion of DSTI payments are incentive-based.

In this waiver extension, DSTI funding for the same seven hospitals increased 10 percent, from an annual allotment of $209.3 million for SFY 2012 through SFY 2014, to an annual allotment of $230.3 million for SFY 2015 through SFY 2017. Funding for the last two years of the waiver extension was not determined and is subject to further negotiation.

The waiver extension places a proportion of each hospital's DSTI funding at risk based on performance on outcome and quality metrics, with the portion of funding tied to these metrics increasing from 0 percent in SFY 2015 to 10 percent in SFY 2016 and to 20 percent in SFY 2017. While the exact performance metrics were not specified in the waiver extension, examples of such metrics noted in the extension document include quality of care process measures, cost of care measures, and patient experience measures. There is also an aggregate performance withhold, requiring the participating hospitals to demonstrate collective improvement over the three-year period of SFY 2015 to 2017. The aggregate performance measures have also not yet been defined, but the measures will be distinct from the hospital-specific measures. If the aggregate performance is not achieved, there will be a 5 percent withhold from the entire pool of funding in SFY 2017.

While the waiver extension establishes these performance standards, many of the details of the DSTI program have not been finalized. The Commonwealth is required to obtain CMS approval for a Master DSTI Plan that will establish specific requirements of the DSTI program. The Master DSTI Plan will identify the projects that will be funded, establish the performance metrics, and set forth reporting requirements. The Master DSTI plan must also incorporate a DSTI Payment and Funding Protocol that describes the incentive payment methodology and identifies hospital-specific budgets. Hospitals must also receive approval from the Commonwealth and CMS for hospital-specific DSTI plans that will describe their DSTI projects, objectives, and performance metrics, within the parameters of the Master DSTI Plan. The target date of approval for the Master DSTI Plan, the Payment Protocol, and the hospital-specific plans is 90 days from the approval of the waiver extension. This date may be extended at CMS's discretion.

Public Hospital Transformation and Incentive Initiative

This waiver extension includes a new category of available SNCP funding for Cambridge Health Alliance (CHA), called the Public Hospital Transformation and Incentive Initiative (PHTII). This initia-

tive is in addition to CHA's DSTI funding. CHA, which is the Commonwealth's only public acute hospital, will use these funds to implement primary care and behavioral health initiatives, as well as other care transformation projects. The waiver provides for $220 million annual allotments for the PHTII from SFY 2015 to 2017. Part of the funding for this initiative is the redirection of some of CHA's existing Public Service Hospital (PSH) supplemental payments.

The PHTII funding is subject in part to CHA's achievement of performance metrics, at a slightly higher level of risk than the DSTI program. The portion of the total payment that is at risk ranges from 0 percent in SFY 2015 to 15 percent in SFY 2016 and 30 percent in SFY 2017. The specific metrics and evaluation of the initiative were not finalized in the waiver documents and are targeted to be completed on the same timeline as the DSTI Master Plan, 90 days from the approval of the waiver extension.

Infrastructure and Capacity Building Grants

The waiver extension continues and provides level spending authorization for the Infrastructure and Capacity Building (ICB) category within the SNCP. This funding is provided to hospitals and community health centers (CHCs) to enable them to invest in projects that benefit MassHealth enrollees as well as uninsured and underinsured individuals. Safety net hospitals that are eligible for DSTI projects are not eligible for ICB funding. The waiver extension provides for federal matching funds for ICB grant spending up to $30 million annually for SFY 2015 through SFY 2017.

4. Support for the Safety Net: SNCP

The SNCP includes payments to providers to support the provision of care to Medicaid and uninsured populations, as well as payments to support delivery system transformation that will improve access to cost-effective quality care—as discussed above. There are twelve distinct categories of spending within the SNCP, which can be summarized in three key areas:

- ***Provider payments*** include payments made directly to providers for services to Medicaid and uninsured patients. This includes the Public Service Hospital payment to Boston Medical Center and Cambridge Health Alliance, payments made to hospitals operated by the Departments of Public Health and Mental Health, Health Safety Net Trust Fund payments made to hospitals,[25] and payments made to Institutions for Mental Disease (IMDs). During the three-year period of SFY 2015 – SFY 2017, these four categories account for approximately $1.4 billion in payments, or 30 percent of SNCP funding. Compared with the prior waiver period of SFY 2012 – SFY 2014, funding for this category of spending declined by $547 million, nearly 30 percent, but this decline is due to the shift of funds from CHA's Public Service Hospital payment to the Public Hospital Transformation and Incentive Initiative. Estimated spending for the Health Safety Net increased by 1 percent, while other provider payments are estimated to increase by about 6 percent on average.
- ***Delivery System Incentive*** payments include the DSTI program, the Infrastructure and Capacity Building (ICB) grant program, and the Public Hospital Transformation and Incentive Initiative (PHTII). These categories are not direct payment for service but are payments that support hospital efforts to improve and transform their delivery systems, improve quality,

25 While the Health Safety Net makes payments to acute hospitals and community health centers (CHCs), the expenditure authority for HSN payments to CHCs is included as a DSHP payment, not under the provider payment sub-cap.

and reduce the cost of care. During the three-year period of SFY 2015 – SFY 2017, these three categories account for approximately $1.4 billion in payments, or about a third of SNCP funding. The total allocated to incentive payments doubled compared with the SFY 2012 – SFY 2014 extension, from $718 million to $1.44 billion, $660 million of which is attributable to the creation of the PHTII. Funding for DSTI increased by 10 percent, or $63 million annually, over the prior waiver period.

- ***Designated State Health Programs (DSHP)*** is a category that was authorized in the prior renewal and includes payments made to support separately identified health care programs operated by the Commonwealth. DSHP includes many health care programs operated by agencies other than MassHealth; see Appendix A for a complete list. In the prior waiver extension, funding for DSHP was phased down from $360 million in 2012 to $139 million in 2014. However, CMS and the Commonwealth agreed to reinstate funding for these programs with a similar phase-down, from $385 million in 2015 to $129 million in 2017. In addition, this waiver extension creates a new DSHP category to authorize funding for Health Connector

MASSHEALTH TEMPORARY COVERAGE

In October 2013, the Massachusetts Health Connector launched a new website and eligibility system to conform to the requirements of the Affordable Care Act (ACA). This revamped system had numerous technical glitches, and the Connector was unable to determine MassHealth or ConnectorCare eligibility for many consumers who applied for coverage. To ensure that no one was denied coverage due to these glitches, CMS authorized the Commonwealth to extend the Commonwealth Care program until February 28, 2015, and enrolled approximately 240,000 consumers into temporary MassHealth coverage.*

Under the waiver extension, the state is authorized to claim federal matching funds for expenditures in the Commonwealth Care extension and temporary MassHealth programs made between January 1, 2014, and February 28, 2015. The gross cost, consisting of both federal and state shares, is estimated to be $175.4 million for the Commonwealth Care extension and $560.2 million for the temporary MassHealth coverage.

There are a few limitations on the federal match for the MassHealth temporary coverage. First, the state cannot claim spending for individuals whose incomes are ultimately determined to exceed 400 percent of FPL. Second, the state cannot count spending for people whose enrollment in other coverage has become effective. Third, because this funding is authorized under the Safety Net Care Pool, the federal match rate is limited to the Commonwealth's regular 50 percent match rate.

These limitations have both upsides and downsides. The Commonwealth will pay 100 percent of the costs for those individuals with incomes over 400 percent of FPL who were enrolled in temporary coverage. However, the costs for individuals with incomes below 400 percent of FPL who were not enrolled in another program are matchable, even if they are ultimately determined to be ineligible for ConnectorCare or MassHealth. An additional potential loss is that the Commonwealth may have missed out on a higher match rate for some individuals. For example, under the ACA, there is an enhanced match rate for the new adult population whose incomes are below 133 percent of FPL. Because the Commonwealth was unable to determine eligibility for some of these applicants, their enrollment in temporary coverage means that the federal government will pay just 50 percent of the costs during the temporary enrollment period, less than it would have otherwise.

*Connector Board Meeting, HIX Project Update, December 11, 2014.

subsidies—ConnectorCare—for individuals with incomes between 133 and 300 percent of FPL, who are ineligible for MassHealth, and who are eligible for the advance premium tax credit under the ACA. There are also two new temporary DSHP categories for the closeout of the Commonwealth Care program and for temporary coverage for individuals who were unable to receive appropriate eligibility determinations during the launch of the new Health Connector website. CMS will not provide matching funds for services provided to people in these categories with incomes over 400 percent of FPL or once a person's coverage in another program has become effective. Authorization for these two temporary categories expires at the end of February of 2015. During the three-year period of SFY 2015 – SFY 2017, these four categories account for approximately $1.7 billion in payments, or about 38 percent of SNCP funding. Of this amount, $930 million is attributable to Connector subsidies, the Commonwealth Care closeout, and MassHealth temporary coverage. While these are new categories, the extension that ended in state fiscal year 2014 allocated $1 billion to fund Commonwealth Care, so these new categories are nearly equivalent to the prior Commonwealth Care allocation. Funding for other DSHP programs declined by $29 million, or 4 percent, compared with the prior extension period.

Table 1 lists the SNCP categories, the affected providers, and the change in spending authorization compared with the previous waiver extension. A detailed summary of SNCP funding by category between state fiscal years 2012 and 2019 is provided in Appendix B.

TABLE 1. SAFETY NET CARE POOL FUNDING BY TYPE AND CHANGE FROM PREVIOUS WAIVER EXTENSION, STATE FISCAL YEARS 2015-2017 ($MILLIONS)

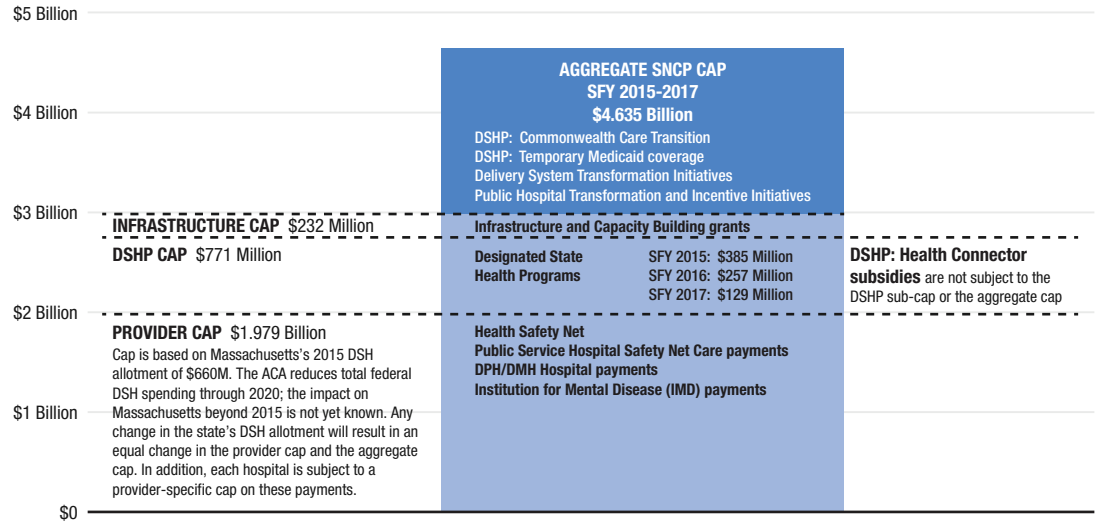
	TYPE	AFFECTED PROVIDERS
SPENDING AUTHORIZATION UNCHANGED FROM PREVIOUS EXTENSION	Public Service Hospital	Boston Medical Center (BMC)
	Health Safety Net Trust Fund	Acute Hospitals & Community Health Centers (CHCs)
	Institutions for Mental Disease	Psychiatric Hospitals and Community-Based Detoxification Centers
	Department of Public Health (DPH) Hospitals	DPH Hospitals (5)
	Department of Mental Health (DMH) Hospitals	DMH Hospitals (6)
	Infrastructure and Capacity Building Grants	Hospitals, CHCs, Primary Care Practices
SPENDING AUTHORIZATION INCREASED 10% FROM PREVIOUS EXTENSION	Public Service Hospital AND Public Hospital Transformation & Incentive Initiative	Cambridge Health Alliance (CHA)
	Delivery System Transformation Initiatives	BMC, CHA, Holyoke, Lawrence General, Mercy, Signature Brockton, Steward Carney
NEW COMPONENT OF SNCP	ConnectorCare Subsidies	N/A
COMPONENTS OF SNCP PHASING OUT	Designated State Health Programs (DSHP)	See Appendix A
	Commonwealth Care and Commonwealth Care Transitional Coverage	N/A
	MassHealth Temporary Coverage	N/A

All SNCP expenditures are reimbursable only at the Commonwealth's regular match rate. Consistent with prior waiver extensions, the SNCP is also subject to its own cap distinct from the budget neutrality provisions. The aggregate cap increased over the prior extension period, from $4.4 billion for the three-year period ending in SFY 2014 to $4.64 billion for the three-year period end-

ing in SFY 2017. While funding for ConnectorCare subsidies was authorized for the full five-year period, other SNCP funding for the last two years of the waiver renewal was not authorized and is subject to further negotiation; this is discussed below.

Within the SNCP, there are subordinate caps on the amount of funding available for specific categories of payment. There are three types of SNCP sub-caps: Infrastructure, Provider, and DSHP (see Figure 2). As with the aggregate SNCP cap, if the Commonwealth's spending exceeds these sub-caps, no federal financial participation will be available for the excess amounts.

FIGURE 2. SAFETY NET CARE POOL AGGREGATE CAP AND SUB-CAPS



Infrastructure Cap applies to payments made under the ICB payment category. This cap is set at 5 percent of the aggregate SNCP cap, which is the same level as in the previous demonstration period extension.

Provider Cap applies to payments made to providers to support uncompensated care delivered to Medicaid-eligible and uninsured individuals. Essentially, these are the payments tied to Massachusetts's Disproportionate Share Hospital (DSH) federal allotment, and the cap on this portion of SNCP expenditures is equal to that allotment. If the allotment changes over the course of the renewal period, the Provider Cap will be automatically revised to match the new allotment amount.[26] The Provider Cap for the renewal is based on the SFY 2015 allotment of $659.6 million for Massachusetts. The Provider Cap in the prior extension was based on the SFY 2012 annual allotment of $624.7 million.

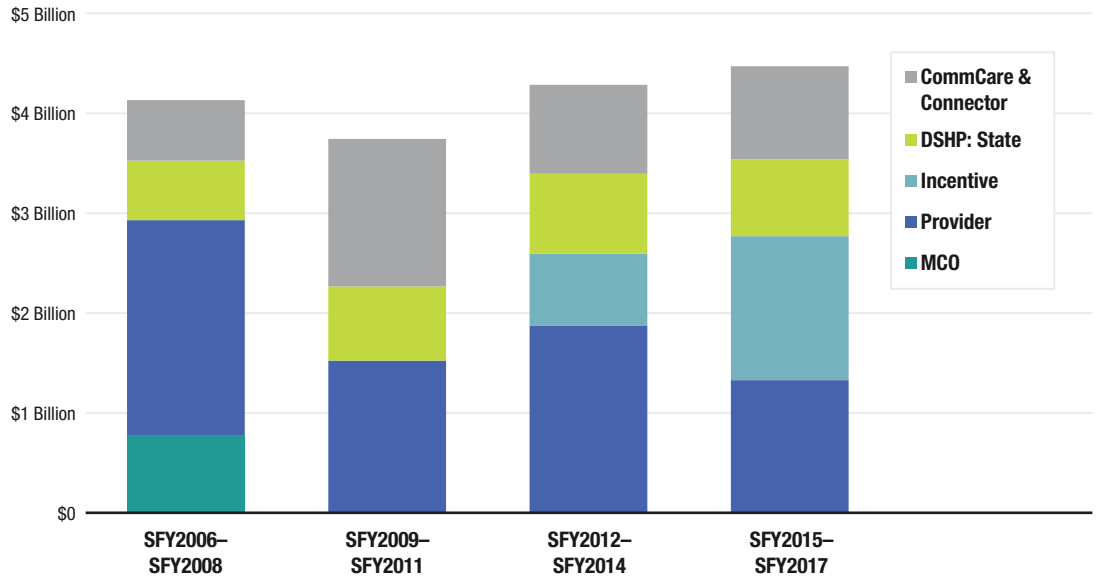
SNCP payments made under the Provider Cap are also subject to hospital-specific payment limits. Pursuant to terms required during the last renewal period, CMS and the Commonwealth agreed

26 DSH allotments to all states are scheduled to decline, as more people gain coverage. While the ACA initially reduced DSH funding beginning in federal fiscal year 2014, Congress delayed these cuts until 2017. The reductions nationally are $1.8 billion in federal fiscal year 2017, and $4.7 billion per year in 2018, 2019, and 2020. The federal government has not yet proposed a methodology for distributing the reductions among states. For context, federal DSH spending totaled $17.4 billion in FY 2011.

to limit SNCP provider payments based on the hospital-specific costs of providing services to Medicaid-eligible and uninsured individuals. The cost limit protocol went into effect on July 1, 2014.

DSHP Cap applies to payments made under the DSHP category, except for Connector Care Subsidies, Commonwealth Care Transitional Coverage, and Temporary Coverage. The DSHP Cap is an annual cap that varies over the course of the renewal period: $385 million in SFY 2015, $257 million in SFY 2016, and $129 million in SFY 2017. Notably, the prior waiver period also included a similarly declining DSHP cap trajectory, beginning with $360 million in SFY 2012 and ending with $130 million for SFY 2014.

FIGURE 3. SNCP SPENDING BY CATEGORY



Note: Commonwealth Care values are actual amounts claimed. All other values in this chart are the authorized amounts specified in the waiver documents.

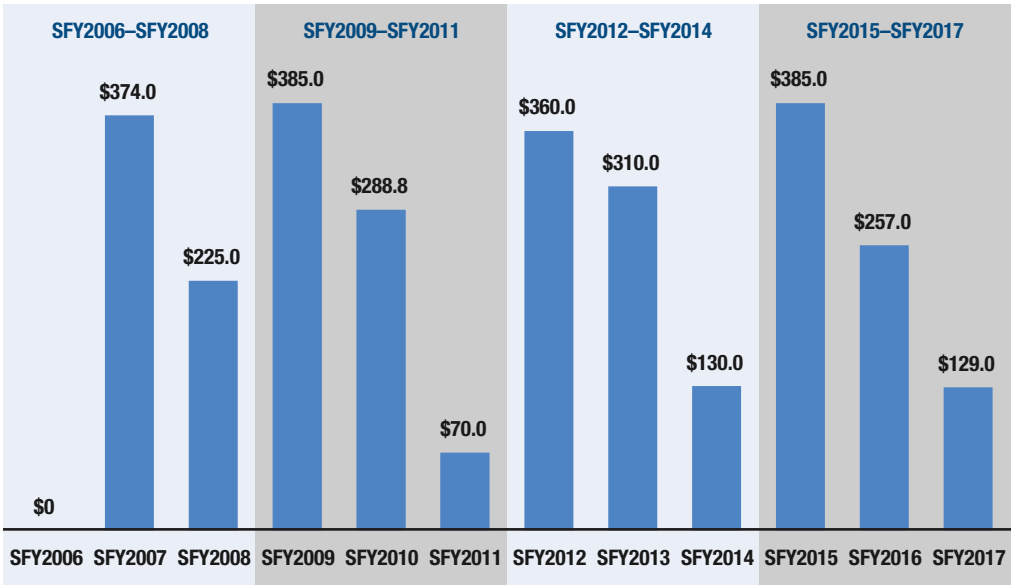
Figure 3 shows the authorized spending for various categories in the SNCP in the waiver extension periods since its inception in state fiscal year 2006. The categories in the chart are as follows:

- ***Commonwealth Care and ConnectorCare:*** Premium subsidies for Commonwealth Care and, beginning in 2015, the ConnectorCare program.
- ***DSHP State:*** The non-Medicaid state health programs that CMS has designated as qualifying for federal Medicaid matching funds.
- ***Incentive:*** Payments for hospital Delivery System Transformation Initiatives and Infrastructure and Capacity Building grants, portions of which are contingent on quality and outcome performance.
- ***Provider:*** Payments authorized under the Provider Cap, described above.
- ***MCO:*** The supplemental payments to the managed care organizations created by Boston Medical Center and Cambridge Health Alliance.

The chart shows the dynamics over time in the uses of the SNCP, from an emphasis on direct provider payments in the early years (Provider segment), shifting more toward payments to support coverage expansion (Commonwealth Care and ConnectorCare segment) and, more recently, to help hospitals transform their systems to accommodate changes in how health care is organized and paid for (Incentive segment).

Figure 4 looks at a detail of SNCP spending, namely the annual changes in the DSHP spending cap. DSHP is an important source of federal funds for the demonstration, and the yo-yo nature of its funding suggests an ongoing conversation about the tension between CMS's original desire that DSHP be a temporary means of securing federal funds and the budget implications of Massachusetts losing this funding.

FIGURE 4. CHANGES IN DSHP FUNDING BY YEAR (millions of $)



5. Looking to the Future

The five-year term of the waiver extension gives Massachusetts some running room to pursue the cost-containment and system reform initiatives in the demonstration, which have taken several years to plan and will likely take several more to fully implement and for the effects of transformation to be assessed. Those initiatives include the pediatric asthma bundled payment pilot program, which is in its early stages, and the delivery system transformation initiatives. In addition, CMS has agreed to a target for reaching agreement to add PCPRI and an ACO payment model to the waiver in calendar year 2015, contingent on receiving an actuarial analysis for the PCPRI shared savings methodology from Massachusetts by March 2, 2015.

The five-year term also creates stability for basic elements of the demonstration. Coverage categories, enrollment streamlining, eligibility standards and the managed care–based delivery structure are all in place, approved, and eligible for federal reimbursement through June 2019. This assures program consistency for MassHealth members for several years and relieves MassHealth administrators from the need to start planning for the *next* waiver extension soon after the current

extension has been approved (CMS requires that a state submit its waiver extension proposal at least 12 months before its effective end date). However, if the Baker Administration should want to alter some of the elements of the demonstration to reflect its policy priorities, the state may propose amendments to the waiver at any time.

Future of the Safety Net Care Pool

State officials will need to occupy themselves, however, with the part of the waiver that was approved for only three years—the Safety Net Care Pool. The terms of the waiver point out that "as the Commonwealth has achieved significant progress in increasing access to health coverage, the SNCP has evolved to support delivery system transformation and infrastructure expenditures, both aimed at improving health care delivery systems and thereby improving access to effective, quality care."[27] In not authorizing SNCP expenditures for the last two years of the extension, CMS is inviting Massachusetts to engage in a dialogue about balancing this newer system transformation function with the legacy purpose of supporting the safety net providers that serve people who have low incomes, have little or no insurance, or are otherwise disenfranchised. This will be a central tension in the discussions to restructure the SNCP for the final two years of this extension. The stated objective is for Massachusetts and CMS to "collaborate to reach agreement on a redesigned SNCP structure for DYs 21 and 22[28] that ensures the Commonwealth can sustainably support delivery of care to low-income populations and align with system-wide transformation."[29]

Because the waiver includes a shorter term for most important features of the SNCP—provider payments and the Health Safety Net, and DSTI and other capacity building projects[30]—there is an imperative to reach agreement for restructuring the SNCP for the last two years of the waiver. This presents both a risk for the state and an opportunity to use the waiver for broad, system-wide reform.

In play are hundreds of millions of federal dollars that currently support system reform efforts, primarily in safety net hospitals. These include the Delivery System Transformation Initiatives (authorized at $230.3 million per year for years 1-3), the Public Hospital Transformation and Incentive Initiative ($220 million per year), and the Infrastructure and Capacity Building grants ($30 million per year). Amounts for these expenditures in years 4 and 5 are subject to negotiation but, using these levels as a guide, the process to restructure the SNCP will determine spending authority in the demonstration for perhaps $960 million ($480 per year), one-half of which are federal dollars.

The payments to providers that directly support services delivered to uninsured and low-income patients, including the Health Safety Net, do not appear to be at risk, even if they do not remain part of the SNCP. If a restructured SNCP agreement does not include these funds, Massachusetts will revert to paying these providers traditional Medicaid Disproportionate Share Hospital (DSH) payments. The state's annual DSH allotment is the source for this part of the SNCP, and the provider cap described earlier is tied directly to the DSH allotment. The payments therefore would not

27 MassHealth Waiver Extension for Demonstration Period 10/30/2014–6/30/2019, approved October 30, 2014 (Waiver Extension). Special Terms and Conditions (STC) #48.

28 Demonstration Years 21 and 22, equivalent to state fiscal years 2018 and 2019.

29 Waiver Extension, STC #48.

30 As explained earlier, the Health Connector subsidies part of DSHP is approved for all five years of the waiver extension. The Commonwealth Care closeout and Temporary Coverage parts of the SNCP's Designated State Health Programs (DSHP) will expire by design in February 2015. The Other State Programs part of DSHP is scheduled to phase out after three years.

necessarily have to change from what they are now if they are not continued through the SNCP. However, because federal DSH audit rules would apply, the specific types of allowable payments might be affected.

One indication of the direction in which CMS is likely to try to push Massachusetts in restructuring the SNCP is in the Delivery System Reform Incentive Payment (DSRIP) initiatives that are part of Section 1115 waivers that CMS has recently approved in other states. The DSTI part of the SNCP is actually an early example of DSRIP—programs intended to support the "transformation of the Medicaid payment and delivery system in an effort to achieve measurable improvement in quality of care and overall population health."[31] More recent DSRIP waivers, for example those granted to Texas and New York, differ from Massachusetts's DSTI in some significant ways:[32]

- While early DSRIP waivers focused only on safety net hospitals, the later ones have included a broader range of providers, with a safety net hospital at the center of a collaborative provider network ("Regional Healthcare Partnerships" in Texas; "Performing Provider Systems" in New York) that includes clinics and other providers.
- The recent DSRIP waivers require a greater level of accountability, putting payment to providers at risk if they fail to meet a specific set of process and outcome measures. The waiver extension in Massachusetts moves the MassHealth DSTI projects in this direction, with a new provision that puts an average of 10 percent of the funds at risk for outcome and quality measures over the three years. For the new Cambridge Health Alliance Public Hospital Transformation and Incentive Initiative, an average of 15 percent of payments per year is at risk for outcomes and quality performance.
- Emphasizing the goal of improving population health, New York's DSRIP waiver makes aggregate funding to the state contingent on meeting statewide performance metrics, in addition to the individual provider incentives. Again, the MassHealth waiver extension reflects this development with a new DSTI provision that makes 5 percent of third-year funding contingent on aggregate performance improvements, based on measures still to be determined.

The DSTI program in Massachusetts has had a dual purpose: giving financial support to important hospitals that struggle financially because of a high MassHealth/low commercial insurance patient base, and giving those hospitals the capacity to undertake necessary work to transform their care in a way that improves health care and health and responds to the statewide shifts to value-based purchasing that promote cost containment. The function of a restructured SNCP as described in the waiver extension—that it "sustainably support delivery of care to low-income populations and align with system-wide transformation"—identifies the tension that will likely be at the heart of the discussions about the SNCP.

Two reports, newly required of MassHealth in this waiver extension, will address this balance and form the basis of the discussions to restructure the SNCP. The first, the Safety Net Care Pool Financing Report, will provide an analysis of payments to providers under the SNCP between

31 Alexandra Gates, Robin Rudowitz and Jocelyn Guyer, "An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers." Kaiser Commission on Medicaid and the Uninsured, October 2014.

32 *Ibid.*

July 1, 2012, and June 30, 2015 (state fiscal years 2013–2015). The report must detail how the state funds its share of the payments and note any gaps in payment or overages in the current funding structure. Much of the report is to be devoted to various analyses of uncompensated care payments to providers, including:

- Payments that are attributable to uninsured individuals and MassHealth members (due to managed care or fee-for-service shortfalls in MassHealth payments);
- Payments to "unqualified aliens" and "qualified aliens" subject to a five-year ban; and
- An analysis of the factors contributing to the necessity of uncompensated care payments (e.g., the number of people without insurance, the number of MassHealth members, and demographic factors).

In addition, the report calls for an accounting of the amount of DSTI payments made to participating providers and an analysis of measurable project outcomes achieved by participating providers.

The report will focus on "the effect, adequacy, and accountability of SNCP payments on provider financing."[33] The state must commission a nongovernmental entity that is independent of provider interests to produce the report. A draft report is due to CMS by October 1, 2015, and the final report is due February 1, 2016.

The second report, the Sustainability and Delivery System Transformation Report, will be more broadly focused. The report will address payment and delivery system reforms and propose "alternative pathways toward a sustainable and equitable Massachusetts Medicaid financing system based on a coordinated and integrated care delivery system."[34] The report must further "assess the appropriate role of the SNCP relative to conventional Medicaid payments, other revenue sources and provider costs."[35] A draft report is due March 1, 2016, one month after the final SNCP Financing Report. The final report is due June 30, 2016.

These two reports will set the stage for redesigning the SNCP, which, according to the terms of the extension, must be completed by June 30, 2017. The descriptions of the reports and the context in which they appear suggest an intention by CMS to tip the balance of the SNCP toward supporting system-wide transformation and away from supporting individual providers. The challenge—and opportunity—will be to achieve this while sustaining a group of providers that are important to geographical regions of the state and, critically, to certain populations that rely on their services.

33 Waiver Extension, STC #54.

34 Waiver Extension, STC #55.

35 *Ibid.*

IV. CONCLUSION

The MassHealth demonstration waiver continues to be the foundation of coverage and health system innovation that it has been since it began over 17 years ago. It is a vital program for nearly one-quarter of the state's residents. The latest waiver extension affirms the federal government's support for the demonstration by approving a five-year extension and the continuation of many of its elements, modified to comply with the requirements of the Affordable Care Act. As the health care landscape changes, Massachusetts officials are challenged to adapt the demonstration to new priorities while not relinquishing its traditional roles of serving a broad and growing group of members and supporting providers that are critical to serving those members. The next several years will be a dynamic time for the Massachusetts health care system, and the terms of the new waiver extension mean that MassHealth will be a key participant in directing the change.

APPENDIX A: LIST OF DESIGNATED STATE HEALTH PROGRAMS, STATE FISCAL YEARS 2015–2017

PROGRAMS AUTHORIZED IN PREVIOUS WAIVER EXTENSIONS

AGENCY	PROGRAM NAME
DMH	Homeless Support Services
DMH	Individual and Family Flexible Support
DMH	Comprehensive Psychiatric Services
DMH	Day Services
DMH	Child/Adolescent Respite Care Services
DMH	Community Rehabilitative Support
DMH	Adult Respite Care Services
DMH	Department of Corrections — DPH/Shattuck Hospital Services
DPH	SANE Program
DPH	Growth and Nutrition Program
DPH	Multiple Sclerosis
DPH	Universal Immunization Program
DPH	Pediatric Palliative Care
EHS	Children's Medical Security Plan
ELD	Prescription Advantage
ELD	Enhanced Community Options
ELD	Home Care Services
ELD	Home Care Case Management and Administration
ELD	Grants to Councils on Aging
HCF	Community Health Center Uncompensated Care Payments
HCF	Fisherman's Partnership
MCB	Turning 22 Program — respite
MCB	Turning 22 Program — training
MCB	Turning 22 Program — co-op funding
MCB	Turning 22 Program — mobility
MCB	Turning 22 Program — homemaker
MCB	Turning 22 Program — client supplies
MCB	Turning 22 Program — vision aids
MRC	Turning 22 Services
MRC	Head Injured Programs
VET	Veteran's Benefits

NEWLY AUTHORIZED PROGRAMS

AGENCY	PROGRAM NAME
DMH	Prescription Monitoring Program
DMH	Substance Abuse Trust Fund
DMH	Naloxone Project
DMH	MA Child Psychiatric Access Project
DMH	Clubhouse Services
DMH	Program of Assertive Community Treatment
DPH	Domestic Violence Prevention
DPH	Suicide Prevention and Intervention Program
DPH	Prevention and Wellness Grant Program
DPH	Postpartum CHW Pilot Program
DCF	Domestic Violence Prevention — residential
DCF	Family Resource Centers
DESE	Substance Abuse Counselors
DDS	Oral Healthcare for Developmentally Disabled

APPENDIX B: SAFETY NET CARE POOL FUNDING BY CATEGORY: STATE FISCAL YEARS (SFYs) 2012–2019 (millions of $)

TYPE	PROVIDERS	SFY2012	SFY2013	SFY2014	SFY2015	SFY2016	SFY2017	SFY2018*	SFY2019*
PUBLIC SERVICE HOSPITAL	Boston Medical Center (BMC)	$52.0	$52.0	$52.0	$52.0	$52.0	$52.0	TBD	TBD
	Cambridge Health Alliance (CHA)	$280.0	$280.0	$280.0	$88.0	$88.0	$88.0	TBD	TBD
HEALTH SAFETY NET TRUST FUND	Acute Hospitals	$147.4	$159.4	$156.3	$156.3	$156.3	$156.3	TBD	TBD
INSTITUTIONS FOR MENTAL DISEASE	Psychiatric Hospitals and Community-Based Detoxification Centers	$20.0	$22.0	$24.0	$24.0	$24.0	$24.0	TBD	TBD
DEPARTMENT OF PUBLIC HEALTH (DPH) HOSPITALS	DPH Hospitals (5)	$40.0	$43.0	$45.0	$45.0	$45.0	$45.0	TBD	TBD
DEPARTMENT OF MENTAL HEALTH (DMH) HOSPITALS	DMH Hospitals (6)	$70.0	$74.0	$77.0	$77.0	$77.0	$77.0	TBD	TBD
DELIVERY SYSTEM TRANSFORMATION INITIATIVES	BMC, CHA, Holyoke, Lawrence General, Mercy, Signature Brockton, Steward Carney	$209.3	$209.3	$209.3	$230.3	$230.3	$230.3	TBD	TBD
PUBLIC HOSPITAL TRANSFORMATION & INCENTIVE INITIATIVE	CHA	$0.0	$0.0	$0.0	$220.0	$220.0	$220.0	TBD	TBD
DESIGNATED STATE HEALTH PROGRAMS (DSHP)	See Appendix A	$360.0	$310.0	$130.0	$385.0	$257.0	$129.0	TBD	TBD
COMMONWEALTH CARE†	N/A	$305.1	$303.3	$283.5	$0.0	$0.0	$0.0	$0.0	$0.0
DSHP: CONNECTORCARE SUBSIDIES	N/A	$0.0	$0.0	$0.0	$41.8	$75.2	$78.3	$81.2	$84.2
DSHP: COMMONWEALTH CARE TRANSITIONAL COVERAGE	N/A	$0.0	$0.0	$0.0	$175.4	$0.0	$0.0	$0.0	$0.0
DSHP: MASSHEALTH TEMPORARY COVERAGE	N/A	$0.0	$0.0	$0.0	$560.2	$0.0	$0.0	$0.0	$0.0
INFRASTRUCTURE AND CAPACITY BUILDING GRANTS	Hospitals, CHCs, Primary Care Practices	$30.0	$30.0	$30.0	$30.0	$30.0	$30.0	TBD	TBD
TOTAL		**$1,513.8**	**$1,483.0**	**$1,287.1**	**$2,085.0**	**$1,254.8**	**$1,129.9**	**$81.2**	**$84.2**

* For State Fiscal Years (SFYs) 2018 and 2019, final approved amounts for most categories were not determined and are subject to further negotiation.
† Commonwealth Care values are actual amounts claimed. All other values in this chart are the authorized amounts specified in the waiver documents.

Source: MassHealth Medicaid Section 1115 Demonstration approval documents (11-W-00030/1), December 20, 2011 & October 30, 2014, Attachment E.