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MassHealth 1115 Waiver Approval Overview

Date: October 3, 2022

Executive Summary

On September 28, the Centers for Medicare and Medicaid Services (CMS) approved the extension of the MassHealth Section 1115 Demonstration. The demonstration supports two million beneficiaries, aims to close the gap on health disparities, and sustains Massachusetts' health care access by preserving near-universal health insurance coverage.[i] The $67 billion five-year waiver approval is effective October 1, 2022 through December 31, 2027.[ii]

Coverage, Access, and Quality Improvements

The MassHealth demonstration has five key objectives[iii]:

1. Continue the path of restructuring and reaffirming accountable, value-based care – increasing expectations for how Accountable Care Organizations (ACOs) improve care and trend management, and refining the model:
    - Maintains the same core pillars and requirements while holding ACOs accountable for quality care, with improvements based on previous lessons learned.
    - Refines the Behavioral Health and Long-Term Services and Supports Community Partners program and transitions the program to a more sustainable and accountable financing structure.
    - Transitions approximately 80% of Delivery System Reform Incentive Payment (DSRIP) funding to base funding for members with disabilities, embedded community health workers, and community partners.
    - Expands the Flexible Services Program and Community Supports Programs under a new framework to address and integrate health-related social needs, including support for the homeless and those recently released from jail/prison, and other housing and nutritional supports.

2. Reform and invest in primary care, behavioral health, and pediatric care to expand access and move the delivery system away from fee-for-service health care:
    - Invests $115 million per year in primary care for a new value-based sub-capitation model that requires providers to meet specific standards while also allowing more flexibility in the delivery of care.
    - Invests $43 million over five years in loan repayments and residency training programs to bolster and diversify both the primary care and behavioral health workforce.
    - Expands substance use services and diversionary behavioral health services.
    - Reinforce expectations for ACOs to invest in pediatric care for children with complex health needs in tandem with MassHealth CARES for Kids.

3. Advance health equity, addressing health-related social needs and specific disparities:
    - Allocates more than $2 billion over five years to hold ACOs and ACO-participating hospitals accountable for reducing inequities in health care quality and access.[iv]

    i. Requires providers to improve data collection methods and reporting on demographic factors such as race, ethnicity, language, disability status, sexual orientation, and health-related social needs – ACOs will receive incentive funding for performance.
    ii. Authorizes $400M annually to ACO-participating private acute care hospitals that measure and reduce health care disparities with a focus on pay-for-reporting.
- Addresses racial and ethnic disparities in maternal health, supplementing policies outside of the 1115 waiver including 12-month postpartum eligibility and coverage of doula services.
- Further develops the Flexible Services and Community Supports Programs to address health-related social needs and provides post-release transition supports for justice-involved members.
    i. Pre-release transitional supports for justice-involved members is pending federal guidance, anticipating approval in late 2022 or early 2023.
- Improves coverage for members with disabilities.

4. Sustainably support the Commonwealth's safety net, including increased funding for safety net providers, with a continued linkage to accountable care:
    - Continues and increases Safety Net Provider Payments by $125 million per year and appropriates the bulk of new incentive funding for health equity.
    - Maintains other long-time funding for the state's Health Safety Net.
    - Implements the expanded hospital assessment to fund these initiatives and other hospital programs.

5. Maintain near-universal coverage, including updates to eligibility policies to support coverage and equity:
    - Keeps current coverage expansions, including state subsidies to ensure affordability of the Health Connector plans for individuals with incomes up to 300% FPL.
    - Creates targeted updates for MassHealth eligibility:
        i. Simplified CommonHealth application process for adults with disabilities.
        ii. Three-month retroactive eligibility for pregnant individuals and children.
        iii. 12 months of continuous eligibility for individual experiencing homelessness and individuals recently released from incarceration.
        iv. Expanded access to the Medicare Savings Program.

In addition to these objectives, workgroups of more than 100 various stakeholders met throughout 2020 and 2021 to determine and inform policy design for the newest proposal as submitted to CMS in December 2021. MassHealth has vowed to continue stakeholder engagement throughout implementation of the demonstration.

Financial Components

Of note, the provider incentive payments authorized through the waiver will not count as patient care revenue – service payments – and therefore does not count against the hospital-specific limit (HSL) on disproportionate share hospital (DSH) payments.[1]

[1] See page 83 of the approval letter

The updated MassHealth 1115 waiver also includes the following financial-specific factors:

1. Medicaid to Medicare Provider Rate Ratio
    - As a condition of approval, Massachusetts is required to increase and (at least) maintain Medicaid fee-for-service provider base rates and Medicaid managed care payment rates in primary care, behavioral health, and obstetrics care, if the state's Medicaid to Medicare provider rate ratio is below 80% in any of these categories.[v]

2. Investment in Value-Based Payments:
    - Massachusetts will pilot a new primary care payment model and invest more than $500 million to align with the highest level of CMS's HCP-LAN framework, Category 4.

3. Evaluation of Health-Related Social Needs (HRSN) Initiatives
    - The evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. CMS has also updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration.

4. Changes to the Budget Neutrality Approach
    - CMS is moving away from its 2018 budget neutrality policy to provide states with expanded flexibilities and budgets to implement innovative programs with a focus on advancing health equity and addressing disproportionate HRSNs.
    - CMS signaled that it will consistently apply the approach to Massachusetts budget neutrality to all similarly situated states going forward.[vi]
    - CMS is making several changes to give states greater access to funding while maintaining fiscal integrity. *See these changes in the table on the following page.*[vii]

Area of Focus	2018 SMD Guidance	Changes approved through MA waiver	Anticipated Impact
Without Waiver (WOW) Baseline	Adjusted WOW per-member-per-month (PMPM) cost estimates to reflect only the recent actual PMPM costs	Uses a weighted average of MA's historical WOW PMPM baseline and its actual PMPM costs	Expected to result in a slightly higher WOW baseline
Trend rate for Expected Expenditures	Used the lower of the state's historical trend rate or the President's Budget trend rate	Projected demonstration expenditures associated with each Medicaid Eligibility Group in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period	Increases budget room and aligns the demonstration trend rate with federal budgeting principles and assumptions
Demonstration "Savings" Rollover	CMS explained that it expected to permit states to roll over "savings" to a demonstration extension from only the most recent five years of prior approvals, and that there would be a transitional phase-down of accrued "savings"	The "savings" amount available for the extension approval period has been limited to the lower of: (1) The "savings" available in the current extension approval period plus net savings from up to 10 years of the immediately prior demonstration approval period(s); or (2) 15% of the state's projected total Medicaid expenditures in aggregate for the demonstration extension period	With less narrow limitations on savings rollover, states can access more "savings" from prior approval periods to fund program innovations
"Hypothetical" Expenditures for HRSN Infrastructure and Services	No explicit categorization of HRSN expenditures as hypothetical expenditures	CMS is treating certain HRSN expenditures as "hypothetical" expenditures. There is an additional sub-cap to HRSN infrastructure expenditures, referring to these expenditures as "capped hypothetical expenditures" in the Special Terms and Conditions (STCs) Unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year	States do not have to find demonstration "savings" to offset hypothetical expenditures, thereby freeing up funds/adding flexibility

Evaluation

The approved waiver STCs require the Commonwealth's waiver evaluation design to include the following:

- Substance Use Disorder (SUD) Treatments
    - Must assess the objectives of the SUD component of the demonstration, which may include initiation and engagement with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes, such as deaths due to overdose.
- Serious Mental Illness (SMI) Services
    - Must assess the objectives of the SMI component of the demonstration, which may include utilization and length of stay in emergency departments, reductions in

preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination.

- Hospital Quality and Equity Initiatives
    - Must assess the effectiveness of the Hospital Quality and Equity Initiative in ensuring provision of consistent high-quality care to all beneficiaries, and must provide evidence of the Commonwealth's efforts to collect stratified data for selected performance measures.
- Workforce Development
    - Must evaluate whether the targeted loan repayment and residency grant programs, and any other authorized workforce initiatives under the demonstration, improve access to covered services for Medicaid beneficiaries.
    - Must investigate the effects of the workforce initiatives on beneficiary access to care, as compared to what may be achieved through direct interventions such as rate increases.
- HRSN
    - Must assess the effectiveness of the HRSN services in mitigating identified needs of beneficiaries.
    - Must include analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes.
    - Must include research questions and hypotheses focused on understanding the impact of HRSN initiatives on advancing health quality, including through the reduction of health disparities.
    - Must assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives.
    - Must examine whether and how local investments in housing, nutrition, and any other type of allowable HRSN services change over time in concert with new Medicaid funding toward those services.
    - Must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services.
- Continuous Eligibility
    - Must evaluate the impact of the program on all relevant populations appropriately tailored for the specific time span of eligibility.
    - Must evaluate the effectiveness of the continuous eligibility authority.
    - May conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.
- Premiums and Premium Assistance
    - Evaluation of beneficiary access to and utilization of preventive, primary, specialist, and emergency services; enrollment continuity, number and frequency of coverage gaps, and disenrollment rates; and beneficiary experiences with care.

- Waiver Retroactive Eligibility
    - Assessment of the outcomes of the retroactive eligibility component of the demonstration, such as likelihood of enrollment and enrollment continuity, health status, and beneficiary medical debt.
- Delivery System Reform
    - Evaluation of formation of new partnerships and collaborations within the delivery system.
    - Evaluation of increased acceptance of total cost of care risk-based payments among MassHealth providers.
    - Evaluation of improvements in the member experience of care.
    - Evaluation of maintenance or improvement of clinical quality.
    - Evaluation of enhancement of safety net providers' capacity to serve Medicaid and uninsured patients in the Commonwealth.

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[i] Baker-Polito Administration, Centers for Medicare and Medicaid Services Announce Five Year, $67.2 Billion Agreement for MassHealth Reforms | Mass.gov
[ii] MassHealth Extension Approval(mass.gov)
[iii] MassHealth 1115 Waiver Extension Fact Sheet (mass.gov)
[iv] MassHealth Extension Approval(mass.gov)
[v] Ibid.
[vi] Ibid.
[vii] Ibid.