THE FUTURE OF MASSHEALTH: FIVE PRIORITY ISSUES FOR THE NEW ADMINISTRATION

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ABOUT THE MASSACHUSETTS MEDICAID POLICY INSTITUTE

The Massachusetts Medicaid Policy Institute (MMPI)—a program of the Blue Cross Blue Shield of Massachusetts Foundation—is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, MassHealth. MMPI's mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

ABOUT MANATT HEALTH SOLUTIONS

Manatt Health Solutions (MHS) is the interdisciplinary health policy and business strategy advisory division of the law firm of Manatt, Phelps & Phillips, LLP. As an integrated law and consulting firm, Manatt offers a unique combination of legal, policy, and operational expertise drawn from a team of attorneys, policy advisors, business strategists, project managers, and financial analysts with extensive experience working with foundations, federal and state government, providers, health plans, and other industry leaders.

ACKNOWLEDGEMENTS

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The past decade marked an era of seismic change in the Massachusetts health care market and one in which the Commonwealth led the nation in coverage and delivery system reform. In 2006, Massachusetts passed its comprehensive health care reform law (Chapter 58 of the Acts of 2006), and has since achieved near universal coverage through a combination of expanded Medicaid, private market reforms, and individual subsidies to purchase coverage in the nation's first health insurance exchange, the Massachusetts Health Connector (the Connector). The national health care coverage reforms implemented earlier this year, part of the Affordable Care Act of 2010 (ACA), were modeled on the Commonwealth's successful reform road map. Having closed the coverage gap for most residents of the Commonwealth, Massachusetts policy makers turned their attention to reining in health care spending growth across all payers, culminating in landmark legislation, Chapter 224 of the Acts of 2012. In the first full year following enactment of Chapter 224, the Commonwealth appears to be making some progress: total health care costs in the Commonwealth grew by 2.3 percent, well below the 3.6 percent health care cost growth benchmark set for 2013.[1]

As one of the largest health care insurers in the state and the steward of health care coverage and financing for an expected 1.7 million low- and moderate-income individuals, or one in four residents,[2] MassHealth—the state's Medicaid program—is at the center of these reforms. With anticipated expenditures of $13.7 billion in 2015, MassHealth spending represents over 30 percent of the total state budget. This gross figure includes both state and federal Medicaid dollars. The federal government reimburses more than half of this total dollar amount. The MassHealth program is expected to generate $7.7 billion in federal revenues this fiscal year, representing more than 80 percent of all federal revenues to be received by the Commonwealth. As a result of this spending and revenue generation, MassHealth is a major contributor to the Commonwealth's overall economy, supporting health care providers and health plans that employ thousands of people.

While its contribution to the state's economy and its effective stewardship of significant state and federal dollars are important, perhaps MassHealth's most important role is articulated in its mission, which is:

> To improve the health outcomes of our diverse members, their families and their communities, by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.

1 Massachusetts Center for Health Information and Analysis. *Annual Report on the Performance of the Massachusetts Health Care System.* September 2014.

2 Massachusetts Medicaid Policy Institute, MassBudget, and the Massachusetts Law Reform Institute. *The Fiscal Year 2015 Budget for MassHealth and Health Reform Programs.* Budget Brief, September 2014. Available online at http://bluecrossfoundation.org/publication/fiscal-year-2015-budget-masshealth-and-health-reform-programs.

With this mission in mind, over the past decade MassHealth has implemented a sweeping array of initiatives including eligibility expansions for children, single adults, and special-needs populations; alternative payment methods (APM) through its Primary Care Payment Reform Initiative (PCPRI); enhanced access to home- and community-based long-term care services; and One Care, a major delivery system reform for non-elderly adults who are eligible for both MassHealth and Medicare.

As MassHealth has grown in size and scope during the last decade, it has become more administratively complex in terms of its relationship to the rest of state government, its eligibility and delivery system structure, and its day-to-day operations. MassHealth sits alongside 15 other agencies and departments under the Executive Office of Health and Human Services (EOHHS) and shares programmatic and budgeting responsibilities for the Medicaid program with several of these agencies. MassHealth also has interdependencies with other parts of government, including the Executive Office of Administration and Finance and the Connector. The program has over 150 eligibility categories, has payment and delivery mechanisms that span multiple managed-care and fee-for-service programs, and is run by over 800 staff who are dispersed across various agencies and physical locations.

As a new Governor takes office, there is a unique opportunity to take a fresh look at MassHealth and its role in the Commonwealth's health care system. Given the program's size and critical role in providing health coverage to one-quarter of the state's residents, MassHealth will, by necessity, be one of the Governor's top priorities. From July through September of 2014, the Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation, and Manatt Health Solutions (Manatt) conducted over 40 in-person and telephone interviews with a range of individuals regarding the major opportunities and challenges for the MassHealth program that face the next Administration. These stakeholders included representatives of the provider community, the business community, insurers, consumers, and state and federal government, as well as Medicaid policy experts and former Commissioners and Directors. This report identifies the top five MassHealth priorities for the next Governor gleaned from these interviews.

While stakeholders uniformly commend MassHealth for achieving its coverage goals and for initiating major delivery system and payment reforms, they urge the next Governor to clarify the strategic vision and priorities for the program, leverage its size and market clout to lead a transformation of the Commonwealth's broader health care delivery system, and tackle pressing and persistent challenges in the program. A critical assessment of MassHealth management and budgets, including identifying opportunities for administrative and programmatic cost efficiencies, savings reinvestment strategies, and federal revenue enhancement measures, is necessary to protect MassHealth's coverage gains, benefit structure, and provider viability without jeopardizing other state priorities.

Among the issues and concerns raised by stakeholders, the following five priorities emerged as those demanding the urgent attention of the Governor in order to ensure the long-term strength and stability of the MassHealth program:

1. ELEVATE AND CONSOLIDATE MASSHEALTH LEADERSHIP

The beginning of a new Administration is an ideal opportunity to set a clear purpose, vision, and strategy that will drive MassHealth priorities for the next four years and beyond. MassHealth must have empowered leadership with the skills, authority, and accountability to implement the Governor's strategic direction. Many stakeholders suggest that MassHealth's current administrative structure and status within state government impedes effective, accountable program leadership and, ultimately, prevents state leaders from fully harnessing the power of the program to drive system change. A common sentiment is that MassHealth has "lost its voice and power" in the Secretariat and that galvanizing the agency may well require the Governor to restructure MassHealth's place within state government and elevate the role of the Medicaid Director. Stakeholders offer many and diverse opinions about the Governor's options for addressing these structural challenges, including consolidating the full MassHealth budget under the Medicaid Director and elevating the Medicaid Director to at least a Commissioner level.

2. LEVERAGE MASSHEALTH'S PURCHASING POWER TO ACCELERATE DELIVERY SYSTEM REFORM

MassHealth is missing a significant opportunity to more effectively use its clout as a purchaser to accelerate payment reform and delivery system transformation for the benefit of MassHealth enrollees and the Commonwealth overall. Stakeholders urge MassHealth leaders to revamp the program's currently fragmented purchasing approach and develop a comprehensive and cohesive MassHealth purchasing strategy that better leverages the program's size and purchasing power to achieve the program's Triple Aim goals.[3]

To achieve these goals, most stakeholders encourage MassHealth to push care management innovation closer to the roots of care delivery—the provider level—with MassHealth retaining responsibility for purchaser functions, regardless of whether MassHealth purchases care through managed care plans or directly from providers. Many stakeholders feel that community health centers in particular can play a critical role in implementing these reforms because of their deep connections to the communities they serve and their ability to link to efforts that address social determinants of health, such as food sources, housing supports, and other social support resources that can contribute greatly to health, well-being, independence, and quality of life.

3. LEAD BEHAVIORAL HEALTH DELIVERY AND PAYMENT REFORM

Significant fragmentation and funding and capacity gaps in the Commonwealth's behavioral health system are well documented and urgently require the Governor's attention. Unlike the other priority areas identified by stakeholders, behavioral health reform is acknowledged as "bigger than MassHealth" —meaning that the imperatives for improving the Commonwealth's mental health and substance use disorder delivery system are critical to all residents of the state.

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3 The Triple Aim is a framework developed by the Institute for Healthcare Improvement for optimizing health system performance through "(1) improving the patient experience of care (including quality and satisfaction); (2) improving the health of populations; and, (3) reducing the per capita cost of health care." See http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

But it disproportionately impacts MassHealth, as the single largest payer for behavioral health services. The passionate consensus of stakeholders is that those impacted by mental illness and substance use disorders are unable to access the treatment they need, putting the Commonwealth at ethical, financial, and public health peril. While MassHealth cannot single-handedly solve these problems, it must be a leader in addressing challenges in the state's behavioral health delivery system through enhanced investment in the behavioral health system, particularly by better integrating behavioral health and primary care, and evaluating and expanding access to community-based behavioral health services. Increased investment in the behavioral health care infrastructure also has the potential to reduce acute care medical costs, as untreated behavioral health disorders can lead to physical health issues or functional impairment.

4. TAKE ON COMPREHENSIVE LONG-TERM CARE REFORM

MassHealth's dominant role in paying for long-term services and supports (LTSS) for a large and growing number of seniors and people with disabilities adds up to a looming crisis as we prepare for the changing demographics that the aging of the baby boomers will bring. The greatest opportunity to ensure MassHealth's future sustainability is to take on the complex task of reforming the long-term care delivery and funding systems. While stakeholders laud recent MassHealth efforts to expand access to community-based LTSS and integrate comprehensive services for high-need subpopulations, they express serious concern about the lack of a more comprehensive and deliberate strategy to ensure access to community-based LTSS that are person-centered and in compliance with the Americans with Disabilities Act (ADA) for all enrollees who need these services. They also point to the need for MassHealth leaders to develop focused LTSS cost-containment strategies, to advance a strategic plan for the future role of nursing facilities as more care moves into the community, and to work with the private sector on a long-term LTSS financing plan to help ensure the financial sustainability of the MassHealth program.

5. INVEST IN MASSHEALTH INFRASTRUCTURE

Transformation and innovation require investment in the people and technology needed to implement a new Governor's agenda. Stakeholders across the board question the sufficiency of MassHealth's infrastructure to support the strategic and day-to-day demands of the massive program. Stakeholders identify the need for critical MassHealth infrastructure enhancements in several areas, including staffing covering a wide range of expertise and information technology (IT) systems. Stakeholders particularly single out a need for MassHealth to invest in the subject-matter experts and IT systems necessary to perform high-level, sophisticated, and timely data analytics to support program planning, development, monitoring, and evaluation. MassHealth holds a wealth of data that could better inform basic program metrics, key cost drivers, and reinvestment of any savings MassHealth achieves from implementing program efficiencies. Not only will increasing data analytics capacity improve MassHealth program operations and oversight, but making data and analysis publicly available will enhance MassHealth's relationships with external stakeholders and deepen public understanding and support of the program. Providers, especially those who take on financial risk and accountability under integrated delivery models, need better and more timely MassHealth data. Stakeholders urge the new Governor to review the program's

administrative budget to ensure that it adequately supports these infrastructure needs and is appropriately allocated to drive the Administration's policy agenda.

By addressing these priorities, the new Governor has the opportunity to demonstrate Massachusetts' ongoing commitment to lead in health care reform through innovations aimed at increasing the effectiveness of MassHealth and its ability to sustainably promote the health, well-being, independence, and quality of life of its diverse members, their families, and their communities.

This report first provides a brief overview of MassHealth, including its impact on and contribution to the state budget and the current approaches taken to purchasing services for its many members. The overview is followed by a summary of the key challenges and opportunities for the five priority issue areas and options for addressing each to inform the new Administration's thinking and strategy.

OVERVIEW OF MASSHEALTH

Massachusetts has long been a national leader in health insurance coverage, and its Medicaid program, MassHealth, is an essential source of coverage for residents of the Commonwealth. Over the last 15 years, enrollment in MassHealth has grown steadily to 1.5 million people in 2014, and enrollment is expected to reach 1.7 million in 2015.[4] At the same time, the uninsurance rate in the state has declined to the lowest in the nation at 3 percent (the national average uninsurance rate is 15 percent).[5] Enrollment growth in MassHealth has been largely driven by recession-related job loss and by the state's 2006 health reform law and the ACA, which together expanded eligibility for children whose family incomes were up to 300 percent of the federal poverty level (FPL) and for low-income, single, and childless adults with incomes up to 138 percent of the FPL (the latter of which increased enrollment in MassHealth by more than 200,000 adults.)[6] MassHealth is a critical source of insurance coverage for particularly vulnerable populations in the Commonwealth. MassHealth covers 40 percent of Massachusetts children—including nearly three-quarters of children living below the poverty line and nearly half of children between 100 percent and 300 percent of the FPL—and half of the population with disabilities in the state.

4 Massachusetts Medicaid Policy Institute, MassBudget, and the Massachusetts Law Reform Institute. *The Fiscal Year 2015 Budget for MassHealth and Health Reform Programs.* Budget Brief, September 2014. Available online at http://bluecrossfoundation.org/publication/fiscal-year-2015-budget-masshealth-and-health-reform-programs.

5 Center for Health Information and Analysis. *Massachusetts Health Insurance Coverage 2012 Estimate.* December 2, 2013. Available online at http://www.mass.gov/chia/docs/r/pubs/13/2012-mass-insurance-coverage.pdf.

6 Massachusetts Medicaid Policy Institute and the Center for Health Law and Economics, University of Massachusetts Medical School. *MassHealth: The Basics. Facts, Trends and National Context.* Updated April 2014. Available online at http://bluecrossmafoundation.org/sites/default/files/download/publication/PDF%20National%20comparisons%20chartpack%20june%202012.pdf.

MASSHEALTH BUDGET AND ROLE IN THE STATE'S ECONOMY

MassHealth is a major payer for virtually every type of health care provider, including hospitals, physicians, community health centers, ancillary services such as laboratory and radiology, and nursing facilities. In addition to being the second largest payer of health care services in the state, with spending projected to be $13.7 billion in state fiscal year (SFY) 2015, MassHealth is the primary payer for LTSS, including nursing facility services and home- and community-based support services essential to elderly and disabled Commonwealth residents. In fact, MassHealth represents half of nursing facilities' patient revenues and covers roughly two-thirds of nursing facility residents.[7] At over $3.5 billion in SFY 2015, MassHealth's LTSS budget represents more than one-quarter of the program's total budget. In addition, MassHealth covers a comprehensive range of behavioral health services for most of its members, including many community-based services not traditionally covered by private insurance.

MassHealth is a major driver in the Commonwealth's economy, creating jobs and providing critical coverage for working Massachusetts residents. By one estimate, each dollar spent on MassHealth results in as much as $2.21 in additional economic activity in the state.[8] MassHealth supports employment stability for many residents of the Commonwealth by providing coverage to low-income working individuals who lack access to employer sponsored insurance, subsidizing insurance for low-income workers who do have access to employer based coverage, and enabling people with disabilities, regardless of their income, to access critical LTSS not typically covered by private insurance plans.

Accounting for 35 percent of the state's budget and more than 80 percent of all federal revenue to the state in 2013,[9] MassHealth is also a critical component of any discussion on state fiscal policy. This federal reimbursement—projected to be $7.7 billion in SFY 2015—has a significant impact on the overall burden of the program on the state budget. On a net cost basis, subtracting out the federal reimbursement from the budget total, MassHealth and health reform spending[10] represent 23 percent of the state's net budget dollars.[11] Because Medicaid is an entitlement program, controlling its massive budget is challenging; the state cannot cap MassHealth enrollment, and during times of economic downturn, enrollment skyrockets even as tax revenues to support the program decline. In past years, the Massachusetts Legislature has often needed to appropriate supplemental state funds in excess of budgeted amounts to cover the program's expendi-

7 *Ibid.*

8 Rachel Klein, Kathleen Stoll, and Adele Bruce. *Medicaid: Good Medicine for State Economies, 2004 Update.* Families USA, May 2004.

9 Massachusetts Medicaid Policy Institute and the Center for Health Law and Economics, University of Massachusetts Medical School. *MassHealth: The Basics. Facts, Trends and National Context.* Updated April 2014. Available online at http://bluecrossmafoundation.org/sites/default/files/download/publication/PDF%20National%20comparisons%20chartpack%20june%202012.pdf.

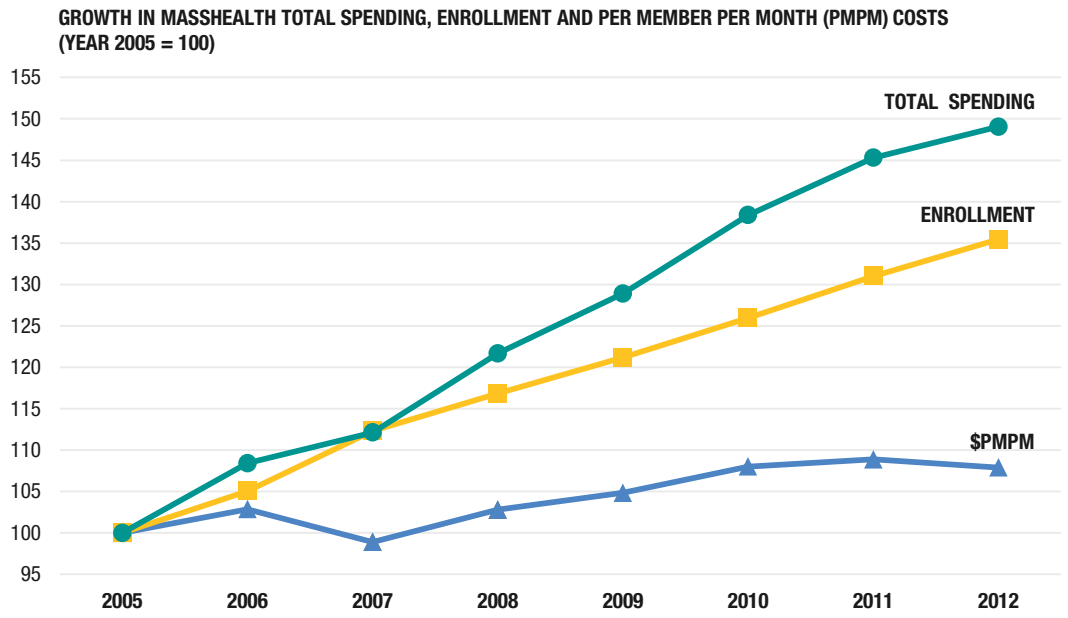
10 MassHealth and health reform spending includes funding for MassHealth program and administration; Executive Office of Health and Human Services administration; funding for the Prescription Advantage pharmacy program; funding for health planning, research and finance, and health information and technology; and funding transferred into several special trusts established to support the state's publicly funded health care programs.

11 Massachusetts Medicaid Policy Institute and MassBudget and Policy Center. *Understanding the Actual Cost of MassHealth to the State.* November 18, 2014. Available online at http://bluecrossfoundation.org/publication/understanding-actual-cost-masshealth-state.

tures. Further, as Medicaid consumes an increasing portion of the state budget, it competes with spending on other priorities.[12]

For all of these reasons, MassHealth is a crucial engine of the state's economy, a major source of revenue for the Commonwealth's health care system, a perennial source of budget debate in the state Legislature—and, as such, a major priority for every gubernatorial Administration.

ENROLLMENT HAS DRIVEN GROWTH IN MASSHEALTH SPENDING IN RECENT YEARS



Source: Massachusetts Medicaid Policy Institute and the Center for Health Law and Economics, University of Massachusetts Medical School. *MassHealth: The Basics. Facts, Trends and National Context.* Updated April 2014.

ADMINISTRATIVE INFRASTRUCTURE

As MassHealth has grown in size and scope during the last decade, it has become more administratively complex in terms of its relationship to the rest of state government, its eligibility and delivery system structure, and its day-to-day operations. MassHealth sits alongside 15 other agencies and departments under EOHHS and shares programmatic and budgeting responsibilities for the Medicaid program with several of these agencies. MassHealth also has interdependencies with other parts of government, including the Executive Office of Administration and Finance with respect to budget oversight, and the Connector around eligibility systems. The program is run on a day-to-day basis by over 800 staff who are dispersed across various agencies and physical locations.

12 Beth Waldman, Robert Seifert, and Kate Nordahl. *Stabilizing MassHealth Funding: Options to Break the Recurring Cycle of Expansion and Contraction.* Massachusetts Medicaid Policy Institute, February 10, 2012. Available online at http://bluecrossmafoundation.org/sites/default/files/Stabilizing%20MassHealth%20report%20Feb2012v5_1.pdf.

MassHealth also has an extremely complex eligibility structure. Enrollees fall into one of 150 aid categories based on their eligibility pathway (age, parental status, disability status, income), benefit package (full benefits, partial benefits wrapping around other primary coverage, limited benefits), and care delivery and service payment method. Covered individuals are eligible for one of four major coverage types: MassHealth Standard (children from low-income families, parents, pregnant women, people who are medically frail, people who are over age 64, and people with disabilities), MassHealth CarePlus (childless adults), MassHealth CommonHealth (higher-income people with disabilities), and MassHealth Family Assistance (children from moderate-income families and individuals with HIV/AIDS not qualifying for MassHealth Standard). Each eligibility group receives a different package of MassHealth benefits, with different levels of cost sharing and premiums.[13]

DELIVERY SYSTEM

The delivery system through which MassHealth beneficiaries receive services is a hybrid of managed care and fee-for-service programs. Most enrollees under age 65 who lack access to other insurance coverage must enroll in one of MassHealth's managed care programs—either the Primary Care Clinician (PCC) Plan or a Medicaid managed care organization (MMCO). Some populations are required to enroll in an MMCO, some populations can choose between an MMCO and the PCC Plan, and some special populations, such as women enrolled in the Breast and Cervical Cancer Treatment program, can enroll only in the PCC Plan.

The PCC Plan is co-administered by MassHealth and its behavioral health vendor, the Massachusetts Behavioral Health Partnership (MBHP), a subsidiary of ValueOptions. The MBHP is contracted on a per member per month (PMPM) basis to provide and manage behavioral health care services for PCC Plan enrolled members and to provide network, quality, and care management for the PCC Plan overall, extending beyond behavioral health. MassHealth contracts directly with primary care clinicians and pays them an enhanced fee-for-service rate. Acute hospital services provided on both an inpatient and an outpatient basis are paid for under a direct contract between a hospital and MassHealth. Specialty physician and all other non-behavioral health services are paid for on a fee-for-service basis according to rates set by regulation. Roughly 383,000 MassHealth members are served through the PCC Plan, representing 28 percent of all members.[14]

MassHealth administers its MMCO program, one of the nation's oldest, through contracts with six MMCOs: Boston Medical Center HealthNet Plan, Celticare, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Network Health. The National Committee for Quality Assurance (NCQA) ranked four of these six plans as the top four in the nation among Medicaid

13 Beth Waldman, Robert Seifert, and Kate Nordahl. *Stabilizing MassHealth Funding: Options to Break the Recurring Cycle of Expansion and Contraction.* Massachusetts Medicaid Policy Institute, February 10, 2012. Available online at http://bluecrossmafoundation.org/sites/default/files/Stabilizing%20MassHealth%20report%20Feb2012v5_1.pdf.

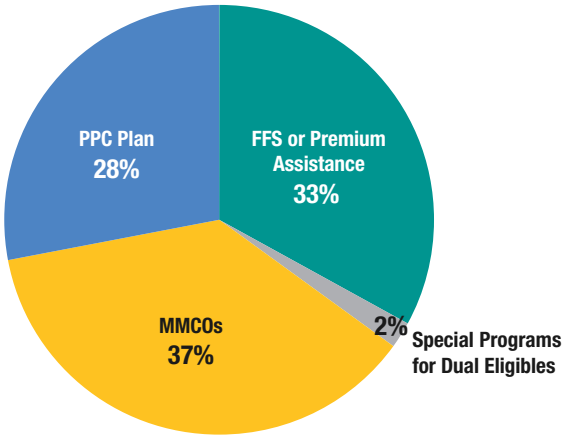
14 Massachusetts Medicaid Policy Institute and the Center for Health Law and Economics, University of Massachusetts Medical School. *MassHealth: The Basics. Facts, Trends and National Context.* Updated April 2014. Available online at http://bluecrossmafoundation.org/sites/default/files/download/publication/PDF%20National%20comparisons%20chartpack%20june%202012.pdf.

managed care plans. This ranking is based on clinical performance and member satisfaction.[15] These plans are at full financial risk to arrange health care for their enrollees through contracted provider networks. MMCOs are responsible for all physical health, behavioral health, and pharmacy services their members require, with the exception of long-term services and supports (LTSS) and dental care, which MassHealth covers on a fee-for-service basis. Four MMCOs subcontract behavioral health services to a single behavioral health vendor, Beacon Health Strategies, which recently announced its planned acquisition of ValueOptions. Roughly 522,000 MassHealth members are served through the MMCOs, representing 37 percent of all members.[16]

While MassHealth's roughly 270,000 dual eligibles[17]—MassHealth enrollees also eligible for Medicare—are not eligible to enroll in either the PCC Plan or an MMCO, roughly 20 percent of dual eligibles are enrolled in several small, but growing, managed care programs: Senior Care Options (SCO), Programs of All-Inclusive Care for the Elderly (PACE), and One Care. These programs integrate the full set of Medicaid and Medicare services and financing with the goal of providing coordinated, integrated care that better meets the needs of these members. The remaining dual eligibles receive MassHealth on a fee-for-service (FFS) basis, where behavioral health services in particular are limited both in terms of benefits covered and providers participating, and care often is fragmented since there is no mechanism for coordination and providers must follow the rules of the two different payers, Medicare and MassHealth.

In addition, there are other MassHealth members who are not enrolled in managed care because MassHealth coverage is secondary to private coverage; these are referred to as "premium assistance" members. In such cases, MassHealth's role is limited to assisting with coverage of premiums and cost sharing and, in some cases, paying for a limited set of services not covered under those plans. Care for these members is paid for on a fee-for-service (FFS) basis.

MASSHEALTH ENROLLMENT BY PAYER TYPE (DECEMBER 2013)



Source: Massachusetts Medicaid Policy Institute and the Center for Health Law and Economics, University of Massachusetts Medical School. *MassHealth: The Basics. Facts, Trends and National Context.* Updated April 2014.

15 National Committee for Quality Assurance. *Medicare/Medicaid Health Plan Rankings 2014–2015.* Available online at http://www.ncqa.org/ReportCards/HealthPlans/HealthInsurancePlanRankings/MedicareMedicaidHealthPlanRankings20142015.aspx.

16 *Ibid.*

17 Kaiser State Health Facts, 2010. Available online at http://kff.org/medicare/state-indicator/dual-eligible-beneficiaries/.

PAYMENT RATES

Massachusetts providers frequently call attention to the inadequacy of MassHealth rates to cover the cost of delivering services under the program. Stakeholders frequently cite provider underpayment as a barrier to access and quality for MassHealth enrollees. Recognizing these concerns, Massachusetts created a Public Payer Commission under Chapter 224 to examine both the adequacy of MassHealth rates and the methodology through which rates are determined.[18]

The Commission is also charged with analyzing cost shifting in the health care market, meaning the extent to which providers offset shortfalls in MassHealth rates by increasing the prices charged to commercial payers (therefore increasing commercial insurance premiums). In a recent presentation to the Commission, the Commissioner of the Center for Health Information and Analysis (CHIA) testified that cost shifting from MassHealth is modest or potentially nonexistent.[19] The Commission has not yet filed a report with the Legislature but is expected to later this month.

Recently, the MMCOs that contract with MassHealth have raised the alarm regarding their reported $140 million in losses since the start of the year due to the inadequacy of MassHealth capitation payments. The plans point to losses as a result of costly pharmaceuticals for which MassHealth has failed to adjust rates, including Sovaldi, a new treatment for hepatitis C. Plans also have flagged cost concerns related to the more than 300,000[20] new members who were temporarily assigned to MassHealth when the state's Health Connector enrollment website failed at the start of the 2014 open enrollment period.[21]

ALTERNATIVE PAYMENT METHODOLOGIES

Massachusetts is pursuing a number of strategies to improve quality of care while reducing health care costs. Chapter 224 of the Acts of 2012 is a major impetus for many of these initiatives, including alternative payment methodologies (APMs), which the law requires MassHealth (and the Connector and the Group Insurance Commission) to implement to the "maximum extent possible." The law defines APMs as methods that do not rely solely on traditional fee-for-service arrangements, including shared savings arrangements, bundled payments, and global payments, and it sets an aggressive schedule for MassHealth to implement APMs for 80 percent of its members by July 1, 2015.

MassHealth is pursuing APM implementation for its general membership through both its PCC and MMCO delivery systems. In 2014, MassHealth implemented the Primary Care Payment Reform Initiative (PCPRI), a three-year program targeted to transitioning PCC Plan providers to APM arrangements, accelerating their transformation into primary care medical homes, and promoting integration of behavioral health and primary care services. Among its participation standards,

18 Massachusetts Executive Office of Health and Human Services. *Public Payer Commission Presentation.* January 6, 2014. Available online at http://www.mass.gov/eohhs/docs/eohhs/public-payer/presentation-20140106.pdf.

19 Aron Boros. *Cost Shifting: A Look at Provider Behavior When Public Payer Rates Aren't Enough.* Presentation to the Public Payer Commission, June 26, 2014. Available online at http://www.mass.gov/eohhs/docs/eohhs/public-payer/ppcguestpres062614.pdf.

20 Health Connector Board of Directors Meeting, October 9, 2014. Available online at https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2014/2014-10-09/HIX_Project_Update_100914.pdf.

21 *Boston Globe.* August 20, 2014. Available online at http://www.bostonglobe.com/business/2014/08/19/medicaid-insurers-losing-tens-millions-from-high-cost-drug-influx-new-enrollees/iRTX3ucMaX2N3AMccv55jM/story.html.

PCPRI requires providers to achieve NCQA medical home certification, meaningful use of health information technology, and robust reporting standards for access, care management and quality. MassHealth pays providers participating in PCPRI a risk-adjusted capitation rate for primary care services for MassHealth enrollees in their practices, which varies based on the Comprehensive Primary Care Payment (CPCP) Tier or the level of behavioral health covered services provided by the practice. CPCP payments are supplemented by annual primary care performance quality incentives. Participating providers self-select into a shared savings track, through which they have the opportunity to share in savings—and, for some providers, risk—on their MassHealth patients' total health expenditures. MassHealth is requiring shared downside risk in year two for all PCPRI participating providers.

Building on its experience with PCPRI, MassHealth is also developing an accountable care organization (ACO) initiative. In June 2014, MassHealth, with the support of the Massachusetts Medicaid Policy Institute (MMPI), held a series of stakeholder engagement sessions with providers, health plans, and consumers, and in October, MassHealth issued a Request for Information and formed a Technical Advisory Group to inform their development of Medicaid ACO specifications.

FIVE MASSHEALTH PRIORITIES FOR THE NEW GOVERNOR

The findings of this policy paper are based on primary research through stakeholder interviews, supplemented by secondary research and the authors' subject-matter expertise in Medicaid generally, and MassHealth specifically. From July through September of 2014, MMPI and Manatt conducted over 40 in-person and telephone interviews with a range of individuals regarding the major opportunities and challenges in the MassHealth program that face the new Administration. (See Appendix for a list of those interviewed.) Stakeholders included representatives of the provider community, the business community, insurers, consumers, and state and federal government as well as Medicaid policy experts and former Commissioners and Directors. These individuals brought diverse perspectives both politically and with regard to how they relate to the MassHealth program. For example, some relate to MassHealth as a payer, service provider, or consumer advocate, while others have had a role in administering the program. Still others view MassHealth from the perspective of the program's impact on the state budget and economy. Stakeholders identified and framed priority issues for the new Administration and raised potential options for resolving those issues, and the authors identified the highest priorities based on issue magnitude, frequency, and urgency with which issues were raised by stakeholders. Based on secondary research and the authors' expertise in Medicaid and MassHealth, the authors expanded on and enhanced the discussion of issues and solutions, and in some cases added solutions for consideration.

Overall, stakeholders express a sense of urgency for the next Administration to take a fresh look at MassHealth and its role in the Commonwealth's health care system. Given the program's size, complexity, and critical role in the state economy and in providing health coverage to one-quarter of the state's residents, MassHealth, by necessity, must be one of the Governor's top priorities. Stakeholders speak to the pressing need for a renewed MassHealth vision and strategic direction

to accelerate delivery system change and tackle program challenges—namely, ensuring its long-term financial sustainability and making the best use of public dollars to avoid crowding out other state spending priorities. To do this, stakeholders call for a critical assessment of the MassHealth administrative and program budgets, including a review of administrative and programmatic cost efficiencies, savings reinvestment strategies, and revenue enhancement measures. This is necessary to protect MassHealth coverage levels, provider viability, and, ultimately, enrollees' access to care.

Among the issues and concerns raised by stakeholders, the following five priorities emerged as those demanding the urgent attention of the Governor in order to ensure the long-term strength and stability of the MassHealth program:

- **Elevate and Consolidate MassHealth Leadership**. The beginning of a new Administration is an ideal opportunity to set a clear purpose, vision, and strategy that will drive MassHealth priorities for at least the next four years. MassHealth must have empowered leadership with the skills, authority, and accountability to implement the Governor's strategic direction.
- **Leverage MassHealth's Purchasing Power to Accelerate Delivery System Reform.** There is significant opportunity for MassHealth to more effectively use its clout as a purchaser to accelerate payment reform and delivery system transformation for the benefit of MassHealth enrollees and the Commonwealth overall.
- **Lead Behavioral Health Delivery and Payment Reform.** Significant fragmentation and funding and capacity gaps in the Commonwealth's behavioral health system are well documented and urgently require the Governor's attention. The passionate consensus of stakeholders is that Commonwealth residents impacted by mental illness and substance use disorders are unable to access the treatment they need. While this concern is "bigger than MassHealth," MassHealth must lead the Commonwealth in addressing these issues because of its role as a major payer for behavioral health services and programs, and because its membership disproportionately relies on these services.
- **Take on Comprehensive Long-Term Care Reform.** MassHealth's dominant role in paying for long-term services and supports (LTSS) for a large and growing number of seniors and people with disabilities adds up to a looming budget crisis. The greatest opportunity for ensuring MassHealth's future sustainability is to take on the complex task of reforming the long-term care delivery and funding systems.
- **Invest in MassHealth Infrastructure.** Transformation and innovation require investment in the people and technology that MassHealth needs to implement a new Governor's agenda.

For each of these priority issues, we identify the challenges and opportunities, and present options for addressing each, to inform the new Administration's thinking and strategy.

MAINTAINING MASSHEALTH COVERAGE GAINS

An ongoing priority for the MassHealth program, and an important foundation for the reforms discussed throughout this report, will be to maintain its coverage gains. Over the last two decades, Massachusetts has led the nation in access to insurance coverage for its residents, and maintaining those gains will be crucial to ensuring that care delivery and payment in the state is both effective and sustainable. The Commonwealth faces unique challenges in this regard given the failure last year of its new eligibility and enrollment system and its use of temporary Medicaid coverage as a key strategy in getting and keeping Commonwealth residents covered during the 2014 open enrollment period. Stakeholders urge the Governor to continue to devote both resources and leadership to ensure that eligibility and enrollment systems are functional and any remaining issues are resolved quickly. Maintaining coverage levels will require the smooth transition of those with temporary Medicaid to permanent coverage. The state must also ensure that new applicants receive timely eligibility determinations and have access to a seamless enrollment process. Maintaining coverage includes, wherever possible, administrative renewal procedures that MassHealth implements to retain enrollees with minimal burden, and procedures to effectively transition consumers across the Commonwealth's continuum of insurance programs while minimizing gaps in and loss of coverage.

PRIORITY AREA #1: ELEVATE AND CONSOLIDATE MASSHEALTH LEADERSHIP

Given MassHealth's size, breadth, and importance in providing health coverage to the state's residents, stakeholders agree that MassHealth must play a central role in advancing delivery system and payment reform in the Commonwealth, while managing the budget and day-to-day operations of the nearly $14 billion program. According to stakeholders, MassHealth is struggling on these fronts, because of a lack of clear organizational priorities and the decentralized administration and management of the program. Stakeholders urge a new Governor to establish a clear vision and realistic set of strategic priorities for MassHealth from the outset of his Administration, and then empower MassHealth with the authority and tools it needs to execute the vision and effectively oversee the core mission, staff, and functions of the program. Many stakeholders suggest that MassHealth's current administrative structure and status within state government impedes effective, accountable program leadership and, ultimately, prevents state leaders from fully harnessing the power of the program to drive system change. A common sentiment is that MassHealth has "lost its voice and power" in the Secretariat and that empowering the agency may well require the Governor to restructure MassHealth's place within state government and elevate the role of the Medicaid Director.

OVERVIEW OF MASSHEALTH'S CURRENT ADMINISTRATIVE STRUCTURE

The Executive Office of Health and Human Services (EOHHS) is the single state agency in the Commonwealth charged with administering the Massachusetts Medicaid program.[22] This structure recognizes that MassHealth enrollees, dollars, and programs are dispersed across several of EOHHS's 16 health and human service agencies, including the Executive Office of Elder Affairs, Department of Developmental Services, Department of Mental Health, Department of Public Health, and Department of Children and Families. Unlike many other states, Massachusetts has not consolidated its Medicaid program under a single leader, division, or agency. Key MassHealth program responsibilities, functions, and leadership, and MassHealth's 800 staff members, are located in multiple EOHHS offices, agencies, and physical locations. This structure has been in place since 2003, when state leaders undertook a major restructuring of the MassHealth program.

The Office of Medicaid, the state's medical assistance unit, sits within EOHHS and is led by a Medicaid Director who reports to the EOHHS Secretary. MassHealth is one of the few divisions within EOHHS that is not led by a Commissioner or Secretary. Under the direction of the EOHHS Secretary, the Medicaid Director oversees key functions of the MassHealth program (e.g., budget development, eligibility determinations, program integrity, federal relations), administers key program areas (e.g., managed care and behavioral health delivery systems), participates in its program development and evaluation, and coordinates the overall program administration across the EOHHS agencies. While the Medicaid Director manages the bulk of the program's $13.7 billion budget, he or she shares responsibility for the program's budget of over $3.5 billion for long-term care and responsibility for long-term care policy development with other EOHHS leaders. The Secretary of Elder Affairs has primary responsibility for the MassHealth long-term care budget and long-term services and supports (LTSS) programs for enrollees age 65 and older, and the Assistant Secretary for Disabilities and Community Services leads LTSS policy development for enrollees under age 65 with disabilities. These officials, who also report to the EOHHS Secretary, have significant influence on MassHealth spending and policy direction.

> "MassHealth is the biggest muscle in the state, as it has the dollars coursing through it, and should be the connective tissue across the EOHHS agencies."
>
> — *Health Plan Representative*

The current structure of the MassHealth program has some benefits. With the EOHHS Secretary as head of the MassHealth program, he or she can influence parts of the program or budget that are managed across the Secretariat. For example, the structure enables the Secretary to align Public Health and MassHealth provider regulations to advance integrated care delivery initiatives or require uniform payment and service definitions across the agencies to appropriately maximize federal Medicaid revenue. According to several interviewees, however, these cross-Secretariat efforts often are hindered by competing Secretariat and agency priorities. The structure also enables the EOHHS

22 Massachusetts General Laws, Chapter 118E, Section 1, accessed October 1, 2014. Available online at https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter118E/Section1. And MassHealth State Plan Amendment (SPA) #: 14-0010-MM4, approved June 11, 2014, accessed October 1, 2014. Available online at http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MA/MA-14-0010-MM4.pdf.

"mission agencies," which serve population-specific constituencies, to more effectively advocate for Medicaid dollars, command high-level attention to their priority issues, and ensure that MassHealth addresses the needs of the vulnerable populations they serve. These state agencies have played a critical role in developing and implementing major MassHealth policy initiatives, including the state's Community First LTSS agenda and the One Care program.

ISSUES AND CHALLENGES RELATED TO MASSHEALTH ADMINISTRATION

Despite these benefits, stakeholders suggest that the current fragmented MassHealth administrative structure impedes program leaders' ability to effectively execute strategic direction and manage program operations and costs. Most stakeholders believe that some change in structure is necessary to strengthen the authority and accountability of the Medicaid Director and deploy the full power of the MassHealth program. While a minority of stakeholders suggest that strong leadership can overcome real or perceived structural deficiencies, ignoring structural impediments leaves success of the MassHealth program too dependent on personalities and relationships among agency leadership.

> "MassHealth both consumes too much and too little of the Secretary's time."
>
> — *Business Leader*

According to many stakeholders, the job of leading MassHealth is too big for an already busy Secretary. The Secretary's scope of responsibility for 16 agencies is enormous, and a public health or child welfare crisis can divert the Secretary's attention for long periods of time. But MassHealth does not stop running. On a daily basis, program leaders make complex and highly political decisions. It is not uncommon for MassHealth leaders to navigate hospital, MMCO, and nursing facility rate negotiations, Affordable Care Act (ACA) compliance issues, and 1115 Waiver program negotiations with the federal government, while simultaneously addressing operational, member services, legal, and clinical crises. MassHealth can dominate the bulk of a Secretary's time and attention, but in reality cannot be the Secretary's only focus. Many stakeholders suggest that the Commonwealth needs a leader at a very high level in state government focused exclusively on Medicaid.

In the current construct, the Medicaid Director does not have the authority to make critical decisions about program services, policies, and budgets without negotiating with agency colleagues (often more senior-ranking Secretaries, Assistant Secretaries, and Commissioners) and "going up the ladder" to the Secretary for both strategic and more mundane decisions. This dynamic inhibits responsive and decisive program leadership, creates decision-making bottlenecks, and strains interagency relationships. Numerous stakeholders suggest that the MassHealth administrative structure adversely impacts the state's ability to recruit for a Medicaid Director. It also may impact the talent a Medicaid Director can recruit to fill key programmatic and strategic positions in the agency. Given the program's importance and public visibility, many stakeholders argue that the Medicaid Director's role should be more robust and its status elevated.

> "The Medicaid Director lacks direct authority over functions needed to manage a complex program effectively."
>
> — *Policy Expert*

A new Administration has a unique and likely time-limited opportunity to review MassHealth's administrative and management structure and consider redefining the status, role, and responsibilities of the Medicaid Director. Many stakeholders liken MassHealth to a large business that requires strong and centralized leadership to achieve its core mission and strategic goals; for MassHealth, these include serving the comprehensive care needs of a diverse population and responsible stewardship of public dollars. Stakeholders assert that a Medicaid Director armed with clear strategic direction from the Governor and empowered with complete authority and accountability over the MassHealth program along with a more prominent status within state government can more effectively:

- Drive the Governor's Medicaid policy agenda
- Advocate for MassHealth infrastructure support needs
- Recruit MassHealth talent and ensure staff stability
- Develop trusting and committed relationships with consumers, providers, and health plan partners
- Foster collaborative relationships with other state agencies
- Strengthen understanding of and support for the MassHealth program from state budget leaders, federal officials, and the public
- Manage the entirety of the program's budget

OPTIONS FOR CONSIDERATION

Stakeholders uniformly agree that the next Administration should recruit a Medicaid Director with a solid understanding of the health care system, a strong business, financial, and/or strategic background, the practical experience to manage the daily operations and staff of the program, and the skills to navigate the program through major emerging health care system changes. The new Medicaid Director should make a first-term commitment to promote program stability and long-term program planning. Historically, Massachusetts' Medicaid Directors have had tenures of four or more years; recently, tenures have declined to roughly two years. While these more recent tenures are in line with the historical national median Medicaid Director tenure of two years (which rose to three years this year),[23] stakeholders believe that a longer commitment is critical for a Medicaid Director to be able to develop strong relationships with key stakeholders and effectively shepherd the program and its staff through a period of substantial change and reform.

While there also is near unanimity among stakeholders that the Medicaid Director position should be elevated to at least a Commissioner position, stakeholders have many and diverse opinions about the Governor's options for addressing the structural issues and challenges discussed above. Some call for a wholesale restructuring of MassHealth and its place in state government.

23 National Association of Medicaid Directors. *State Medicaid Operations Survey, Second Annual Survey of Medicaid Directors.* February 2014. Available online at http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/ops_survey.pdf.

Others caution that major restructuring will be unnecessarily distracting, time-consuming, and politically difficult, and that even bringing about more limited structural and management changes could be challenging.

Among the options, the Governor should consider a new structure within the existing Secretariat to ensure that the Medicaid Director has sufficient authority and accountability to efficiently run the entire program. Ways to achieve this could include:

- Transferring oversight of the MassHealth LTSS budget and program staff from the Secretary of Elder Affairs to the Medicaid Director and giving the Medicaid Director primary oversight of MassHealth's full budget and key staff and programs. This option, which could be accomplished without any other structural changes to the program, is not one on which all stakeholders agree, although it is strongly supported by former MassHealth leaders.
- Elevating the Medicaid Director to a Deputy Secretary or Assistant Secretary position, making the Medicaid Director's authority more in line with or even above his or her peers. This option would strengthen the Medicaid Director's decision-making power and enable the Medicaid Director to more effectively collaborate on program policy development with his or her peers. It would also make the stature of the position more commensurate with the size and responsibilities of the MassHealth program and could help with recruiting and retaining talent for key senior positions in the program.
- Alternatively, reestablishing the MassHealth program and its staff under a single EOHHS agency (similar to the Division of Medical Assistance, which existed until 2003, when the single state agency designation was transferred to the Secretariat) and elevating the Medicaid Director to a Commissioner position. This option would achieve the structural benefits of enhancing the voice of the Medicaid Director and power of the program, as well as improving the Medicaid Director's ability to coalesce program staff around a unified sense of purpose and ensure that all MassHealth staff are "marching in the same direction."

Some stakeholders suggest the next Administration consider a new stand-alone structure, through which the Medicaid Director is elevated to a cabinet-level position reporting directly to the Governor. In 11 states the Medicaid program is a stand-alone agency, with all but two of the Medicaid Directors in those programs reporting directly to the Governor.[24] Some stakeholders suggest this could be accomplished by bifurcating EOHHS into an Executive Office of Health (with MassHealth at its core) and an Executive Office of Human Services. However, some stakeholders strongly recommend against separating MassHealth from the current EOHHS "mission" agencies that serve a significant number of MassHealth enrollees, as doing so could potentially adversely impact cross-agency care coordination and care management activities and opportunities to maximize revenue.

24 National Association of Medicaid Directors. *State Medicaid Operations Survey, Second Annual Survey of Medicaid Directors.* February 2014. Available online at http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/ops_survey.pdf.

PRIORITY AREA #2: LEVERAGE MASSHEALTH'S PURCHASING POWER TO ACCELERATE DELIVERY SYSTEM REFORM

> "Medicaid should be able to throw its weight around. It doesn't seem to know its own strength."
>
> — *Provider*

Among the highest MassHealth priorities for the next Governor is the need to develop a comprehensive and cohesive MassHealth purchasing strategy—an approach to contracting for and measuring the performance of the health plans and providers that serve MassHealth enrollees. Stakeholders are emphatic that the Commonwealth should revamp its MassHealth purchasing approach, better leveraging MassHealth's size and purchasing power to achieve its Triple Aim-based programmatic goals[25]:

- "Deliver a seamless, streamlined, and accessible member experience
- Promote integrated care systems that share accountability for better health, better care, and lower costs
- Shift the balance toward preventive, patient-centered primary care, and community-based services and supports"[26]

The benefits of MassHealth making optimal use of its market power extend beyond transforming care for MassHealth enrollees. Stakeholders agree that MassHealth has a critical role to play in reforming the delivery system in the state overall by using substantial Medicaid funding to change incentives and behavior among health plans, providers, consumers, and employers to improve outcomes, efficiency, and affordability.

> "MassHealth can be a deliberate vehicle for using the state's clout to influence the practice of providers that serve everyone in the Commonwealth."
>
> — *State Official*

ISSUES AND CHALLENGES RELATED TO MASSHEALTH PURCHASING

MassHealth currently contracts with a variety of health plans and providers to manage and deliver care for its members, including the Massachusetts Behavioral Health Partnership (MBHP) for the PCC Plan and six capitated MMCOs to serve most enrollees under age 65; five SCO capitated health plans for dual eligible members age 65 and older; six PACE elder service programs, which are direct provider contracts serving dual eligible members over age 55; and three One

25 The Triple Aim is a framework developed by the Institute for Healthcare Improvement for optimizing health system performance through "(1) improving the patient experience of care (including quality and satisfaction); (2) improving the health of populations; and, (3) reducing the per capita cost of health care." See http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.

26 Massachusetts Executive Office of Health and Human Services. *MassHealth Managed Care Quality Strategy.* December 2013. Available online at http://www.mass.gov/eohhs/docs/masshealth/research/qualitystrategy-05.pdf.

Care capitated health plans for dual eligibles under the age of 65.[27] MassHealth also administers fee-for-service arrangements with providers for long-term services and supports, physical health services provided to PCC Plan members, and services to enrollees for whom MassHealth is a secondary payer. Stakeholders characterize MassHealth's purchasing approach as a fragmented array of contracts and payment arrangements that is confusing to providers charged with delivering and managing care under these diverse arrangements, and that dilutes MassHealth oversight of its programs. In addition, many stakeholders observe that too little has been done to evaluate the effectiveness of the different purchasing models. Many argue that MassHealth needs a more streamlined and nimble approach to contracting.

More troubling to those interviewed, MassHealth's purchasing approaches do not reflect a cohesive strategy for ensuring that the Commonwealth is getting value out of its contractor relationships by holding vendors accountable for performance on access, quality, and health outcomes and for containing spending. Stakeholders note that low MassHealth payment rates and the prevalence of fee-for-service payment in MassHealth hamper the Commonwealth's ability to effectuate its programmatic goals, and that both of these barriers could be addressed through a new value-driven purchasing approach. Stakeholders generally agree that models in which providers assume financial responsibility and performance accountability for managing care for MassHealth enrollees are central to achieving innovation in transforming care delivery, integration, quality improvement, and reallocating the health care dollar from inpatient acute care to preventive community-based care.

But while the transition to alternative payment models (APMs) that vest financial responsibility and performance accountability with providers is a high and statutorily mandated priority for MassHealth, the program has not used all of the levers at its disposal to accelerate APM implementation.

> "Hospitals have a hard time coming up with APMs absent a vision and direction from MassHealth. The reforms need to go beyond primary care and PCPRI."
>
> — *Provider*

Many stakeholders argue that providers in the market are prepared to accept financial risk, including global risk, for MassHealth enrollees, and are already doing so successfully for their commercial and Medicare patients. Health plan representatives and several larger provider systems share the view that MassHealth is moving cautiously, focusing narrowly on risk sharing with primary care providers through PCPRI. Hospital system representatives express concern that MassHealth has excluded hospitals from its APM vision to date, despite the fact that hospitals can be reform drivers, including assuming global contracting risk. Nonetheless, in October 2014 MassHealth initiated a technical advisory group that includes hospitals and health systems to advise on its development of an ACO program.

The entities charged with overseeing and evaluating implementation of Chapter 224 share the view that MassHealth is moving slowly with regard to APMs. CHIA reports that 19 percent of

27 *Ibid.*, pages 4–5.

MassHealth members were covered under APMs in 2012, as compared with 34 percent of members in the commercial market and 24 percent in Medicare.[28] The Health Policy Commission notes that the transition to APMs in MassHealth and in the market overall continues to be hampered by implementation challenges, including APM models that vary widely across payers and models that are based on historic payment levels, perpetuating disparities in payment among provider organizations. The Health Policy Commission also notes that when services such as behavioral health are paid for through separate funding arrangements, this can lead to misaligned incentives in APMs.[29]

Other interviewees take the view that most providers are not ready for sharing losses in MassHealth, much less global risk arrangements. One interviewee notes that the slow uptake of PCPRI among providers has occurred because they were being asked to assume too much risk too soon. Among the concerns expressed by providers is the lack of timely, accurate data on their patients to successfully manage care and risk. A PCPRI participating provider observes that a "steep learning curve" is associated with financial analysis and risk sharing. Another provider suggests that there is a need for multi-year partnerships to provide a glide path to enable providers to transition to risk.

> "MassHealth went a step too far in the PCC program with PCPRI. Providers aren't prepared to assume risk on services they can't really manage."
>
> — *Policy Expert*

> "Neither model [PCC or Medicaid managed care] uses redesigned clinical systems as a means to improve care.… These models have outlived their usefulness in a world that is rapidly moving to global payment and new models of accountable care."
>
> — *Provider*

Stakeholders express equally diverse opinions regarding the vehicle through which MassHealth should purchase services. Some urge the Commonwealth to move beyond the "PCC Plan versus MMCO" debate that frequently dominates discussion about the best purchasing model for MassHealth, noting that either model can work well depending on the contractors and how the state oversees them. Other interviewees express the strong view that the PPC Plan and/or the MMCO program are outmoded and should not be central to MassHealth purchasing in the future. Several observers caution that whatever purchasing model it pursues, MassHealth should maintain a market share balance among contractors, lest it lose leverage with "too big to fail" vendors.

Despite their differences, stakeholders are unanimous in the view that MassHealth is missing an opportunity to set quality, payment, and cost-containment requirements designed to meet its Triple Aim goals, and should contract only with those providers and vendors who commit to achieving them.

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28 Massachusetts Health Policy Commission. *Chartbook for Cost Trends Report: July 2014 Supplement*, Figure B-10. July 2014. Available online at http://www.mass.gov/anf/docs/hpc/cost-trends-july-2014-chartbook.pdf.

29 Massachusetts Health Policy Commission. *2013 Cost Trends Report*. January 2014. Available online at http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf.

OPTIONS FOR CONSIDERATION

At the heart of stakeholder recommendations with regard to MassHealth purchasing is the strong consensus that MassHealth should push care management innovation closer to the roots of care delivery—the provider level—with MassHealth retaining responsibility for purchaser functions. Stakeholders are aligned in the view that MassHealth should set purchasing requirements designed to promote its programmatic goals, including clear performance measures with regard to management of and payment for care to its members; contract with organizations that can meet its requirements; and hold contractors accountable through rigorous oversight and evaluation. There are a variety of mechanisms MassHealth could use to overhaul its approach to purchasing, both by building on the Commonwealth's existing purchasing structure and by pursuing new purchasing models.

Insurer and managed care plan representatives highlight the opportunity for MassHealth to advance quality, cost, and payment goals through contracts with insurers/MMCOs. For example, MassHealth could set forth a specific timeline and requirements for plans to transition providers to APMs along a continuum of options, including pay for performance, shared risk/reward, and global risk contracts with ACOs. Proponents of this model believe that MassHealth does not have the infrastructure to administer direct provider risk arrangements and that insurers/MMCOs are better able to meet providers where they are with respect to risk sharing. This approach aligns with the direction of the commercial market, where plans like Blue Cross Blue Shield of Massachusetts through its Alternative Quality Contract and Tufts Health Plan through its Medicare risk contracts have developed nationally recognized provider risk-sharing models that can extend to providers' MassHealth panels.

> "MassHealth doesn't have the bandwidth or expertise to design delivery system transformation. Providers do."
>
> — *Provider*

Other stakeholders tend to be more supportive of a direct provider purchasing model, through which MassHealth contracts directly with ACOs on a full-risk basis to provide and manage care for MassHealth members. Proponents of this model argue that providers have the expertise and resources to change the way care is delivered "on the ground," while MassHealth and insurers/MMCOs do not. Others point to drawbacks of this model—most notably that many providers are not able to take financial risk, so that direct provider contracting cannot be MassHealth's only approach to purchasing at any time in the near future.

Recognizing the strengths and potential pitfalls of purchasing exclusively from either insurers/MMCOs or ACOs, MassHealth likely should pursue a hybrid purchasing model, through which it contracts with any organization, whether ACO- or insurer/MMCO-based, that can deliver on its delivery system transformation and payment reform goals.[30] In the hybrid approach, MassHealth

30 The authors note that even in pursuing this purchasing model, MassHealth likely will maintain a limited fee-for-service program as the most efficient mechanism for providing "wraparound" services for certain populations, including those in premium assistance, as well as transitional coverage for enrollees before their health plan enrollment becomes effective.

would focus on its role as purchaser, defining standards, requirements, and performance measures for its contractors including:

- Investment in PCMH infrastructure
- Reduction of avoidable hospital admissions and ED visits
- Implementation of APMs
- Redistribution of health care dollars from inpatient acute to community-based services
- Improved quality outcomes
- Elimination of excess inpatient and long-term care bed capacity
- Expansion of primary care and community-based behavioral health and LTSS capacity

Regardless of the approach taken, many stakeholders feel that community health centers in particular can play a critical role in implementing these reforms because of their deep connections to the communities they serve and their ability to link to efforts that address social determinants of health, such as food sources, housing supports, and other social support resources that can contribute greatly to health, well-being, independence, and quality of life.

> "MassHealth shouldn't design the system it thinks is best—it should let the market innovate and propose models."
>
> — *Policy Expert*

MassHealth would also need to develop a rigorous, data-driven performance measurement system to evaluate its contractors. Those supporting adoption of this approach point to the benefits of MassHealth leveraging market competition to drive innovation and accelerate APMs. The concern raised most frequently about this approach is the need for MassHealth to develop the infrastructure and expertise to support "letting the market innovate." Stakeholders caution that it would take time and investment to be able to execute this approach to purchasing, particularly the capacity to use a rigorous and data-driven approach to select contractors and to monitor and evaluate their performance.

PRIORITY AREA #3: LEAD BEHAVIORAL HEALTH DELIVERY AND PAYMENT REFORM

Among the issues raised by interviewees, none elicited a greater sense of urgency than the need to "fix" the behavioral health delivery system to deal with issues related to capacity, access, funding, and delivery system fragmentation in the Commonwealth. Unlike the other issue areas identified by stakeholders, behavioral health is generally acknowledged to be "bigger than MassHealth"—meaning that the imperatives for improving the Commonwealth's behavioral health delivery system are critical to all residents of the state. Indeed, more than half of Massa-

chusetts residents with a mental health condition and in need of treatment do not receive treatment, and this problem is particularly acute among adolescents and children.[31]

However, the problems plaguing the behavioral health system disproportionately impact MassHealth as the single largest payer of behavioral health services in the Commonwealth. MassHealth covered 48 percent of total behavioral health expenditures in the state in 2013,[32] with total MassHealth spending of $1.8 billion, excluding pharmacy costs.[33] More than one in five MassHealth members used a mental health service in 2012; roughly one in 20 used a substance use disorder service.[34] National data indicates that Medicaid enrollees with behavioral health conditions and comorbid chronic conditions have health care costs that are up to three times higher than enrollees with chronic conditions who do not have behavioral health diagnoses.[35]

The passionate consensus of stakeholders is that MassHealth members with mental illness and substance use disorders are not able to access treatment they need—putting the Commonwealth at ethical, financial and public health peril. While MassHealth alone cannot solve these problems, it can be a leader in addressing challenges in the state's behavioral health delivery system.

ISSUES AND CHALLENGES IN MASSHEALTH'S BEHAVIORAL HEALTH DELIVERY SYSTEM

Numerous reports have been published in the last several years regarding the behavioral health care system in the Commonwealth, including a June 2014 report of the Mental Health Advisory Committee of the Massachusetts General Court and a July 2013 report of the Behavioral Health Integration Task Force established by Chapter 224. These reports provide in-depth analysis of the state's mental health and substance use disorder delivery systems, identify the problems and pitfalls in behavioral health delivery, and make numerous recommendations to address these challenges. Those interviewed for this report underscore the main themes of these studies:

- Lack of integration across physical and behavioral health services is a major barrier to quality care, positive health outcomes, and cost containment
- Significant gaps in community-based behavioral health capacity prevent residents from accessing services they need
- Low provider payment rates in both the commercial insurance market and MassHealth create capacity issues and impede development of new behavioral health services

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31 Abt Associates. *Massachusetts General Court Mental Health Advisory Committee Report*. June 2014. Available online at https://malegislature.gov/content/documents/newsitems/Mental%20Health%20Advisory%20Committee%20Appendix%20C%20-%20Final%20Consultant%20Report%206-30-2014.pdf.

32 Office of Attorney General Martha Coakley. *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D, § 8*. 2014. Available online at http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2014/proceedings-and-presentations/office-of-the-attorney-general.pdf.

33 *Ibid*.

34 Massachusetts Executive Office of Health and Human Services. *Presentation to the Public Payer Commission*. September 18, 2014. Available online at http://www.mass.gov/eohhs/docs/eohhs/public-payer/ppcpres091814.pdf.

35 C. Boyd, B. Leff, C. Weiss, *et al*. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies, Inc. December 2010. Available online at http://www.chcs.org/media/clarifying_multimorbidity_patterns.pdf.

- The most seriously ill residents of the Commonwealth bear the brunt of these access, capacity, and integration gaps

Lack of integration across the physical and behavioral health delivery systems in Massachusetts is a significant and well-documented impediment to quality of care, cost containment, and advancement of APMs across the continuum of public and private insurance programs in the state.

In MassHealth, members enrolled in the MMCO program have an integrated physical and behavioral health benefit for which their health plan assumes full financial risk and responsibility for these services. Most of these plans contract with a behavioral health vendor, Beacon Health Strategies, which manages behavioral health services in close collaboration with the plans' care management teams. In the PCC Plan, behavioral health benefits are managed by the MBHP under a full-risk contract. As noted above, the MBHP provides overall care management services for PCC Plan members and has some (though, many argue, limited) ability to coordinate physical and behavioral health services by virtue of this role.

> "Without an integrated system and appropriate reimbursement, we cannot look at patients holistically. We've just kicked the can down the road, and they can't get the care they need."
>
> — *Provider*

There are pros and cons to both of these models. The MMCO model with an integrated benefit provides a single point of clinical and financial accountability, but many express concerns that MMCOs lack expertise to serve the most seriously mentally ill members, particularly those with co-occurring substance use disorders. The MBHP model provides a single entity to which behavioral health providers relate, promoting standardized clinical and administrative policy, but it can exacerbate communication and data exchange challenges between physical and behavioral health providers. Additionally, APMs designed to encourage care management and cost containment across the spectrum of physical and behavioral health services are difficult to implement in delivery models where behavioral health is under a separate funding stream. Such models create incentives for providers and plans to shift responsibility to the "other" funding mechanism.

Most stakeholders express support for a fully integrated care model as being more consistent with MassHealth's Triple Aim goals related to a better member experience, shared accountability that promotes better care, and a "whole person" approach to health care delivery. Stakeholders agree that MassHealth can promote integration of physical health, mental health, and substance use disorder services in the state through payment and purchasing models in which managed care plans and/or providers are responsible for managing all care, including behavioral health services. In particular, several stakeholders point to the One Care program as the model for physical and behavioral health integration. One Care's current target population includes non-elderly dual eligible adults with physical disabilities, developmental disabilities, serious mental illness, and substance use disorders; roughly two-thirds of One Care eligible individuals are estimated to have a behavioral health condition.[36] Enrollees in One Care receive MassHealth and Medicare

36 National Alliance on Mental Illness Blog. "The One Care Program." January 6, 2014, accessed October 1, 2014. Available online at http://www.namimass.org/the-one-care-program.

benefits as well as additional behavioral health and community support services through a single "integrated care organization." Integrated care organizations receive a global payment for delivering and managing care for these individuals. Interviewees note that MassHealth could leverage the One Care model to achieve care and payment integration for more of its high-need enrollees.

Stakeholders also agree that certain regulatory barriers impede integration of behavioral and physical health services for MassHealth members, including license restrictions that prevent co-location of physical and behavioral health services and certification requirements that discourage mental health providers from serving patients with co-occurring substance use disorders.

> "Frankly, we're behind the curve in removing regulatory barriers that prevent providers from doing what we're asking them to do in terms of delivery system reform."
>
> — *State Official*

But integration alone will not solve the challenges in the Commonwealth's behavioral health delivery system. Several interviewees note that private and public insurers, including One Care plans, confront serious gaps in capacity to meet the demand for behavioral health services among their members. Specific service capacity gaps include adolescent mental health, child psychiatry, inpatient detoxification beds, and crisis stabilization programs. Notably, MassHealth generally covers these and other services as part of a more comprehensive scope of behavioral benefits than most private insurers offer.[37] Thus behavioral health capacity gaps are systemic and, according to stakeholders, are significantly driven by limitations in payment rates: private insurers generally do not cover a broad range of behavioral health services, and while MassHealth does provide comprehensive coverage, its rates of payment are inadequate to create and sustain sufficient capacity to meet demand/need.

The Legislature's 2014 Mental Health Advisory Committee report highlights insufficiency in MassHealth rates of payment, citing large gaps between provider costs per unit and MBHP rates for various behavioral health services in 2013.[38] Reiterating the point that provider access is not "just a MassHealth problem," stakeholders (and the Advisory Committee) emphasize that commercial payment rates for behavioral health services have also lagged behind provider costs in recent years and that a substantial and growing number of behavioral health providers do not accept any insurance, public or private—contributing to overall access problems.

Stakeholders also highlight gaps in after-hours access to community-based behavioral health services as well as care transition support for consumers transitioning from inpatient, institutional, and crisis intervention programs to the community. These gaps contribute to high inpatient and emergency department costs, largely related to avoidable emergency department visits and inpatient admissions. Analysis by the Health Policy Commission found that commercially insured

37 Behavioral Health Integration Task Force. *Report to the Legislature and the Health Policy Commission*. July 2013. Available online at http://www.massneuropsych.org/wp-content/uploads/2013/06/Behavioral-Health-Integration-Task-Force-Final-Report-and-Recommendations_July-2013.pdf.

38 Abt Associates. *Massachusetts General Court Mental Health Advisory Committee Report*, page 71, table 18. June 2014. Available online at https://malegislature.gov/content/documents/newsitems/Mental%20Health%20Advisory%20Committee%20Appendix%20C%20-%20Final%20Consultant%20Report%206-30-2014.pdf.

individuals with behavioral health conditions have inpatient and emergency department expenditures that are 140 percent and 125 percent greater, respectively, than expenditures for individuals without behavioral health conditions.[39]

Stakeholders point out that access issues are particularly acute for patients with high mental health needs, co-occurring substance use disorders, and complex social needs—all types of patients who are very likely to rely on MassHealth. Some interviewees believe that because these individuals are the most challenging and costly to treat, providers may opt out of serving them, either by forgoing participation in MassHealth or actively "managing out" the most complex patients.

> "The next Governor should not shy away from compelling provider delivery systems to serve high-need MassHealth patients."
>
> — *Health Plan Representative*

OPTIONS FOR CONSIDERATION

Stakeholders note that beyond the obvious imperatives of ensuring that residents of the Commonwealth are able to access quality behavioral health care when they need it, investment in the behavioral health system is a sound fiscal decision for the state. Investment in the behavioral health care infrastructure has the potential to reduce acute care medical costs, as untreated behavioral health disorders can cause complications with physical health issues or functional impairment.[40] Further, children with untreated behavioral health issues are more likely to face disability and higher medical costs as adults.[41]

Stakeholders offer a number of potential policy strategies and options for the next Governor to consider in positioning MassHealth as a leader in behavioral health delivery system investment. First and foremost, the next Administration should revise its approach to purchasing behavioral health services for MassHealth members to better integrate responsibility for managing physical health together with behavioral health. MassHealth could implement a new purchasing approach through managed care plans (including the MMCOs and/or MBHP), MassHealth direct contracting with ACOs, or some combination of the two. Stakeholders note that One Care is an ideal purchasing model for integrating care and payment for the highest-risk MassHealth members and that MassHealth should consider leveraging and expanding the One Care program for this purpose. Stakeholders also note that the Commonwealth should remove regulatory requirements that impede care integration, including streamlining licensing and credentialing requirements for non-traditional providers.

The next Administration should also consider strategies whereby MassHealth can lead the Commonwealth in evaluating and promoting expansion of community-based behavioral health services, including:

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39 Massachusetts Health Policy Commission. *Presentation for the 2014 Health Care Costs Trends Hearing*. 2014. Accessed October 1, 2014. Available online at http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2014/proceedings-and-presentations/health-policy-commission-slides.pdf.

40 Behavioral Health Integration Task Force. *Report to the Legislature and the Health Policy Commission*, page 11. July 2013. Available online at http://www.massneuropsych.org/wp-content/uploads/2013/06/Behavioral-Health-Integration-Task-Force-Final-Report-and-Recommendations_July-2013.pdf.

41 *Ibid.*

- Conducting a study of service availability, including provider participation in private and public program provider networks, to determine specific geographic areas in which the Commonwealth needs to expand access to behavioral health services
- Funding incentives for behavioral health providers to participate in MassHealth and private insurance, such as student loan forgiveness and state-funded coverage of the cost of malpractice insurance
- Increasing MassHealth payment rates for a range of "high value" behavioral health services (community-based services that are alternatives to high-cost inpatient settings) as well as services for which particular capacity gaps have been identified
- Setting access standards for behavioral health providers contracted directly to MassHealth and through managed care plans, including requiring after-hours access, as MassHealth currently requires of primary care providers

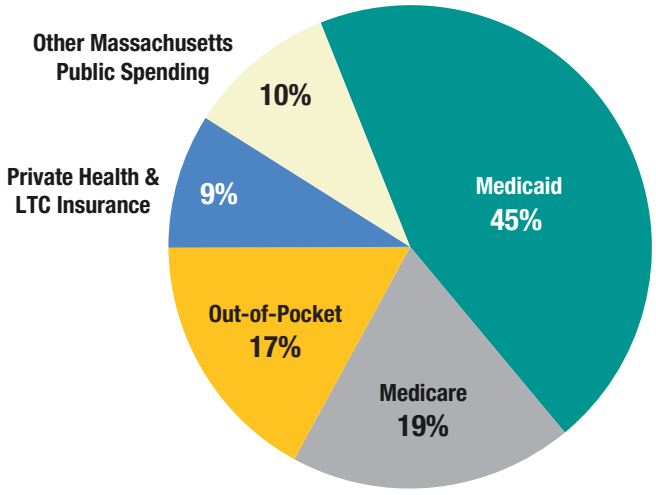
Finally, stakeholders point to the Advisory Committee and Behavioral Health Task Force studies as road maps for the next Governor to consult in designing his reform strategy.

PRIORITY AREA #4: TAKE ON COMPREHENSIVE LONG-TERM CARE REFORM

The phrase "long-term services and supports" (LTSS) refers to a range of services and supports provided in homes, communities, and residential facilities that individuals need to meet their personal care needs (such as bathing, dressing, and eating) and daily routine needs (such as grocery shopping, taking medication, and housework). LTSS help people with disabilities or chronic conditions across the lifespan live independently and fully participate in community life. MassHealth is by far the largest payer of LTSS in Massachusetts, with smaller contributions from Medicare (which pays only for short-term, post-hospitalization use of nursing facility, rehabilitation, and home care services), out-of-pocket spending, private long-term care insurance, and state health and human service agencies.[42]

42 Center for Health Law and Economics and Office of Long-Term Support Studies, University of Massachusetts Medical School, on behalf of the Massachusetts Long-Term Care Financing Advisory Committee. *Securing the Future: Report of the Massachusetts Long-Term Care Financing Advisory Committee.* November 2010. Available online at http://www.mass.gov/eohhs/docs/eohhs/ltc/ma-ltcf-full.pdf.

MASSACHUSETTS SPENDING ON LTSS BY PAYER



Source: Komisar and Thompson. *National Spending for Long-Term Care.* Georgetown University Long-Term Care Financing Project, February 2007 (2005 data), with adjustments made to Other Mass. Public Spending.
Note: Medicare covers only limited-term services such as skilled nursing, therapy, or skilled nursing facility care immediately following hospitalization.

In reality, unpaid family members and other informal caregivers provide the bulk of LTSS—at significant physical, emotional, and financial costs.[43] Researchers predict that nearly 70 percent of people turning age 65 will need some LTSS in their lifetime (16 percent will need over $100,000 worth of services),[44] yet most people remain largely unprotected for these costly services. Many people with moderate income and assets rapidly exhaust other sources of coverage or personal savings when they need LTSS, spending down their resources until they become eligible for MassHealth LTSS coverage.

> "Long-term care is an issue screaming for intervention—and it impacts a significant number of people with a disproportionate resource use."
>
> — *Health Plan Representative*

Stakeholders characterize the lack of a statewide LTSS care delivery and financing strategy as an impending crisis. LTSS utilization and spending are expected to explode in coming years with the aging of the baby boomers and increased longevity for people with chronic and disabling conditions. One analysis projected that Massachusetts' elderly population will grow by 35 percent, and its population over age five with disabilities will grow by 13 percent, between 2007 and 2020.[45] As the primary payer of LTSS, these trends disproportionately impact MassHealth, which covers over 400,000 seniors and people with disabilities of all ages. The same analysis predicted that

43 *Ibid.*, page 1.

44 *Ibid.*, page 6.

45 Center for Health Law and Economics and Office of Long-Term Support Studies, University of Massachusetts Medical School. *Long-Term Supports in Massachusetts: A Profile of Service Users.* April 2009. Available online at http://www.mass.gov/eohhs/docs/eohhs/ltc/ltss-profile-report.pdf.

MassHealth LTSS costs—estimated to be over $3.5 billion in state fiscal year 2015, could, without intervention, more than double to nearly $8 billion in 2030—a cost that would be unsustainable for the Commonwealth.

State leaders have made important, but piecemeal, progress in strengthening the Commonwealth's LTSS system in recent years—particularly in advancing the state's "Community First" LTSS policy agenda, which aims to maximize the use of high-quality, person-centered LTSS in people's homes and communities (settings vastly preferred by most individuals and their families), while preserving critical access to facility-based care for those who need it.[46] Community-based LTSS utilization and spending has grown rapidly over the past decade, with MassHealth LTSS fee-for-service spending now roughly evenly split between community-based and facility-based care.[47] The state is also advancing a managed care purchasing strategy for populations dually eligible for MassHealth and Medicare, who historically have been served in the fee-for-service system. Building on its Senior Care Options (SCO) program and Programs of All-Inclusive Care for the Elderly (PACE) for seniors, the Commonwealth implemented the One Care program in 2013 to integrate Medicare and MassHealth services and financing for dually eligible individuals under age 65. Massachusetts has taken advantage of several federal funding opportunities, some with enhanced federal match, in implementing these reforms, including the Balancing Incentive Program (BIP), the Money Follows the Person (MFP) Rebalancing Demonstration, the Personal and Home Care Aide State Training (PHCAST) program, and the federal fiscal alignment demonstration to implement One Care.

Balancing Incentive Program (BIP) allows Massachusetts to draw down an increased federal Medicaid match to implement diversions to nursing homes and increase access to home- and community-based services (HCBS) through a "no wrong door" single entry point system, conflict-free case management services, and core standardized assessments.

Money Follows the Person (MFP) Rebalancing Demonstration leverages federal Medicaid grant dollars to allow eligible individuals to transition from institutions back into the community, and to improve the quality of HCBS.

Personal and Home Care Aide State Training (PHCAST) Program is a Health Services and Resources Administration program designed to recruit and train individuals as qualified personal and home care aides in shortage or high-demand areas.

46 The state's 2008 Community First Olmstead Plan lays out the framework and action areas for this policy agenda. "Olmstead" refers to a federal court ruling that, in interpreting the Americans with Disabilities Act (ADA), requires states to provide services to people with disabilities in the most integrated setting appropriate to their needs. The action areas include helping people transition from institutional care, expanding access to community-based LTSS, improving the capacity and quality of community-based LTSS, expanding access to affordable and accessible housing with supports, promoting employment of people with disabilities and seniors, and promoting awareness of LTSS. *The Community First Olmstead Plan: A Summary.* Accessed October 1, 2014. Available online at http://www.mass.gov/eohhs/docs/eohhs/olmstead/olmstead-plan-summary.pdf.

47 Massachusetts Medicaid Policy Institute and the Center for Health Law and Economics, University of Massachusetts Medical School. *MassHealth: The Basics. Facts, Trends and National Context.* Updated April 2014. Available online at http://bluecrossmafoundation.org/sites/default/files/download/publication/PDF%20National%20comparisons%20chartpack%20june%202012.pdf.

ISSUES AND CHALLENGES IN MASSHEALTH'S CURRENT LTSS SYSTEM

While stakeholders laud MassHealth's efforts to improve the LTSS system, they express serious concern about the lack of a comprehensive and deliberate strategy to ensure access to LTSS that are person-centered and in compliance with the Americans with Disabilities Act (ADA) for all enrollees who need these services. They also urge MassHealth leaders to develop focused LTSS cost-containment strategies and to work with the private sector on a long-term LTSS financing plan to help ensure the financial sustainability of the MassHealth program. The areas of greatest concern to stakeholders are:

- **Equitable access to community-based LTSS based on identified need.** Current access to critical MassHealth community-based LTSS, including care management services, is based on age, diagnosis, disability, or dual eligibility status. These patchwork eligibility criteria leave major gaps in access to and financing of community-based LTSS for people who do not fit the current eligibility standards but have similar incomes and functional needs.
- **The future role of nursing facilities as more care moves to the community.** With the state's successes to date in expanding access to community-based LTSS, stakeholders are concerned that there has not been a commensurate reduction in institutional spending, a clear LTSS savings reinvestment strategy, or a strategic plan for nursing facility practice redesign or diminishing excess bed capacity as more care moves into the community.
- **Sustainable long-term LTSS financing.** Given the demographic trends, the current financing system for LTSS, with MassHealth at its core, is not sustainable. To ensure the long-term sustainability of the MassHealth program, state officials must work with LTSS providers to achieve cost efficiencies and with the private sector to create viable private financing vehicles to more equitably share the costs of LTSS.
- **The role of LTSS in the state's broader health system reforms.** LTSS providers have largely been left out of the state's broader delivery system and payment reform discussions around ACOs and other integrated delivery systems. LTSS providers play a critical role in ensuring continuity of care for enrollees, meeting their critical behavioral health needs, and addressing complications that can reduce hospital admissions, readmissions, and ED use. Because people using LTSS have costly and complex needs, their care is mostly unmanaged, and because they primarily receive care in the fee-for-service system, they represent a significant opportunity to improve care outcomes while lowering health care costs.

Stakeholders identify other critical components of a comprehensive LTSS reform strategy including ensuring access to affordable housing and employment supports; providing critical respite and other supports to informal caregivers; enhancing patient/family education and navigation resources; developing a plan to recruit, retain, and train both direct service workers, such as home health aides and personal care attendants, and non-traditional providers, such as community health workers and peer counselors, particularly as the state plans for future growth in demand for these services; expanding the use of telehealth and other creative technologies, such as remote monitoring of home care, to address care needs more efficiently; and reexamining MassHealth coverage policies around emerging effective treatment modalities (for example, around rehabilitation science).

> "The state has punted on this issue because it is such a huge area and difficult to get through politically."
>
> — *Provider*

Comprehensive LTSS reform remains a major gap in health and social policy both nationally and in Massachusetts. This is due, in part, to a decades-long focus by policy makers on expanding access to health insurance coverage and other reforms to the acute care system, and in part to the scope, complexity, and contentiousness of long-term care issues. Tackling LTSS reform requires a "paradigm shift" in how policy makers, providers, and health plans think about health care. The nature of LTSS is different from medical care, as LTSS primarily address individuals' functional and social support needs, often over a long period of time, in addition to their clinical needs. Additionally, MassHealth eligibility, benefit coverage, and financing rules for both institutional and community-based care are complex and very difficult for families and policy makers to navigate. Finally, LTSS financing decisions implicate broader societal questions about the role of private savings and inheritances in paying for LTSS.

> "State leaders need to understand the permanent role that MassHealth plays in many people with disabilities' lives."
>
> — *Consumer Advocate*

OPTIONS FOR CONSIDERATION

The Commonwealth has a unique opportunity to tackle some of these issues and position itself as a national leader in LTSS reform, particularly because state leaders would not be starting from scratch. Three LTSS reform commissions in the past two decades, most recently a 2009–2010 Long-Term Care Financing Advisory Committee, analyzed some of the most intractable LTSS issues and developed reform recommendations upon which little action was taken, frustrating both commission members and key LTSS stakeholders. State legislative leaders also considered and then dropped select LTSS reforms from Chapter 58 in 2006 and Chapter 224 in 2012. These past efforts and a range of pending legislative proposals could serve as a foundation for future analytic work and as the building blocks for developing a comprehensive LTSS system reform strategy. As more MassHealth enrollees "move to the LTSS side of Medicaid," state leaders must take a critical look at how the comprehensive care needs of these populations are managed and financed. This is a national issue, but Massachusetts' commission and Community First work to date position the Commonwealth to be a leader among states on this issue. Key options to be considered by the new Administration include the following:

- Reexamine the analyses and findings of the 2009–2010 Long-Term Care Financing Advisory Committee report and background materials. The report developed short- and long-term options for making affordable LTSS financing mechanisms available to all Massachusetts residents in three key ways:
  - Improving and increasing utilization of private LTSS financing mechanisms, including private long-term care insurance, group coverage of long-term care insurance, life insurance with LTSS riders, reverse mortgages, annuities, and LTSS or health savings accounts
  - Strengthening MassHealth as a source of LTSS financing by strategically expanding MassHealth coverage of community-based LTSS to achieve equitable access to LTSS (the One Care program represents one important step in this direction)

  - Promoting the development of a social insurance, contribution, or other savings program that allows people to prepare for financing their LTSS needs

- Use One Care's stakeholder engagement and program development processes as models for future MassHealth policy and program design. The One Care comprehensive stakeholder engagement process was used as a model by CMS in other states developing similar programs. The One Care program is widely supported by diverse stakeholders in Massachusetts and is seen by some as the most cohesive recent policy thinking on MassHealth LTSS care delivery and payment reform. Since the program's inception, a diverse group of key stakeholders (including MassHealth enrollees with disabilities) have worked with state officials to design, implement, and monitor the program. This stakeholder engagement should continue. Additionally, key programmatic features of One Care, including access to community-based LTSS and behavioral health services, care management, and a dedicated independent-living long-term supports services (IL-LTSS) coordinator, should be monitored and evaluated to see what is working and what is not working for populations with chronic, complex, and high-cost care needs.
- Develop targeted strategies to increase enrollment in the Senior Care Options (SCO) program, which provides integrated and managed Medicare and MassHealth benefits to over 30,000 seniors who are eligible for both programs. Strategies could include better marketing of the care coordination, family respite, and other SCO benefits that enrollees do not have access to in the fee-for-service system, or implementing incentives to encourage eligible individuals to enroll in the voluntary SCO program, which could require MassHealth to engage Medicare in discussions around its freedom of choice policy.[48] MassHealth should also conduct a comprehensive outcomes evaluation of the now 10-year-old SCO program to determine its effectiveness in expanding access to community-based LTSS, avoiding or reducing nursing facility use, improving enrollee's quality of care and outcomes, and lowering overall health care costs.
- Include community-based and facility-based LTSS providers in a focused conversation about the future sustainability of the MassHealth LTSS program, including LTSS utilization and spending trends, provider rates, quality improvement and cost-containment activities, and reinvestment of program savings. A key focus of this conversation must be a discussion about the future role of nursing facilities as more care moves into the community, and the development of a strategic plan to ensure that nursing facilities, which receive half of their patient revenue from MassHealth and will continue to care for the sickest patients, remain a critical and viable part of the system.
- Engage both community-based and facility-based LTSS providers in broader state discussions around delivery system and payment reforms to determine the role of LTSS providers in ACOs or other integrated delivery systems, and their information technology, contracting, and risk-bearing capabilities to participate in these reforms.

48 Federal Medicare law guarantees Medicare beneficiaries the right to choose any provider qualified under the program for services offered (42 U.S.C. 1395).

PRIORITY AREA #5: INVEST IN MASSHEALTH INFRASTRUCTURE

Stakeholders across the board question the sufficiency of MassHealth's infrastructure to support the strategic and day-to-day demands of the massive program. While all state agencies have important public responsibilities (and many are underfunded and understaffed), MassHealth is particularly vulnerable given the program's size, scope, and centrality to the state's health care system. Stakeholders identify the need for critical MassHealth infrastructure enhancements in several areas, including staffing covering a wide range of expertise (e.g., financial, data analytics, operational, customer service, state and federal relations, policy development, and program evaluation) and information technology (IT) systems. Stakeholders express concern that the ranks of experienced staff in these key areas at MassHealth are thinning. They single out a critical need for MassHealth to invest in the subject-matter experts and IT systems necessary to perform high-level, sophisticated, and timely data analytics to support program planning, development, monitoring, and evaluations. Stakeholders urge the new Governor to review the program's administrative budget to ensure that it adequately supports these infrastructure needs and is appropriately allocated to drive the Administration's policy agenda.

> "MassHealth is a large business and it should be run like one, with a focus on operations and management functions."
>
> — *Policy Expert*

ISSUES AND CHALLENGES WITH MASSHEALTH'S INFRASTRUCTURE

According to stakeholders, MassHealth significantly lags behind commercial insurers in sufficiently funding staffing and IT resources. Infrastructure investment routinely falls to the bottom of the list in annual state budget discussions. Some interviewees note that as the MassHealth caseload has increased, administrative funding has not kept pace. In contrast to private insurers, which spend roughly 10 percent of premiums on administration,[49] MassHealth receives an administrative budget appropriation that typically hovers around 1 percent of the program's total budget.[50] This figure does not reflect that some MassHealth administrative responsibilities lie in other public agencies, including the Center for Health Information and Analysis (CHIA) and the University of Massachusetts Medical School's Commonwealth Medicine (UMMS), thus making it difficult to even get an accurate accounting of MassHealth's true administrative needs and spending.

System transformation and payment reform of the sophistication and scale that stakeholders call for require core capabilities in complex data analytics. MassHealth program staff must be able to use the wealth of existing program data to identify, measure, and evaluate population needs;

49 Center for Health Information and Analysis. *Annual Report on the Performance of the Massachusetts Health Care System*, page 19. September 2014. Available online at http://www.mass.gov/chia/docs/r/pubs/14/chia-annual-report-2014.pdf.

50 Massachusetts Medicaid Policy Institute, MassBudget, and the Massachusetts Law Reform Institute. *The Fiscal Year 2015 Budget for MassHealth and Health Reform Programs.* Budget Brief, September 2014. Available online at http://massbudget.org/reports/pdf/FY-2015_GAA-Brief_FINAL.pdf.

translate this information into data-driven policy making, responsible contracting, and accountable financial management; and measure program performance and outcomes. MassHealth also needs IT experts who can assess the systems needed to support the program, ensure those technologies are effectively applied, and manage IT procurements.

> "The state has been penny wise and pound foolish in its investments in administrative capacity and infrastructure, and this results in poor service for members, providers, and others and in a less nimble program."
>
> — *Provider*

Stakeholders uniformly agree that MassHealth has not done these things effectively and needs better clinical informatics capabilities and technology to provide the relevant analyses in a timely, reliable, and transparent manner. Some stakeholders note that even basic information on MassHealth program enrollment, utilization, and spending is not made publicly available and is difficult to obtain upon request. MassHealth recently created a data analytics unit to address some of these concerns, but the unit is very small and the director position currently is vacant.

While the state is building an all-payer claims database (APCD) that should enable complex health care analytics by both agency analysts and external researchers, stakeholders claim that MassHealth's data is limited in that it does not include claims for behavioral health services provided through MBHP and does not include claims from all of the SCO or One Care plans. Further, researchers requesting MassHealth data for their studies must go through an additional request process to gain access, requesting both the approval of the CHIA data review board and MassHealth itself. Most notably, stakeholders encourage MassHealth to provide broader access to aggregate level data from the MassHealth data warehouse, which is a richer database than MassHealth claims data, and to data on MassHealth behavioral health services (while simultaneously protecting enrollee privacy). The APCD also lacks standardized data across MassHealth and other payers. For example, coding taxonomies are different across providers, and claims cannot be matched to produce reliable and complete data. The lack of a standardized provider index also results in real challenges to cataloging and matching claims. So while the APCD has immense promise, it has not yet realized its potential.

Another promising data source is the Senior Information Management Systems (SIMS), which is overseen by the Executive Office of Elder Affairs (EOEA). EOEA is working with UMMS to analyze this comprehensive data set for the first time. SIMS is a statewide consumer database that includes data on over 42,000 users of home-care services in the Commonwealth, including roughly 15,000[51] seniors in the MassHealth Frail Elder Home and Community-Based Services (HCBS) Waiver. The repository has rich data on individuals' use of HCBS, their health and functional assessments, and their individualized care plans. EOEA and the federal Administration on Community Living are encouraged about the database's ability to enable new research on long-term care populations' needs. EOEA is in the process of obtaining access to MassHealth claims data to

51 Centers for Medicare and Medicaid Services website. *MassHealth 2014 Frail Elder HCBS 1915(c) Waiver Renewal Application*, accessed October 1, 2014. Available online at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/MA0059.zip.

match the information in the SIMS database with Medicaid claims (and it plans to add Medicare data in the future), which would allow even more powerful analyses on the effectiveness of the HCBS programs in which these members are enrolled in improving care quality and reducing or avoiding nursing facility stays.

Improving data analytics capabilities and capacity at MassHealth has significant benefits. Not only will it improve MassHealth program operations and oversight on behalf of its enrollees, but it will improve MassHealth's relationships with external stakeholders and can deepen public understanding and support of the MassHealth program. Providers, especially those who will take on financial risk and accountability as MassHealth moves toward ACO and other integrated delivery models, need better and more timely MassHealth data. The Legislature and public, including MassHealth enrollees, would benefit from more transparent data on basic program metrics, key MassHealth cost drivers, and any savings MassHealth is achieving from implementing program efficiencies. Such information would help key program stakeholders better understand and advocate for the program during annual state budget discussions. Stakeholders across the board assert that little of this information is shared outside the program and are uncertain if it is even produced internally at MassHealth.

Finally, as noted earlier, some key administrative functions that support MassHealth are undertaken at CHIA (e.g., rate setting for fee-for-service providers) and UMMS (e.g., program evaluation, project management, financial and program integrity, pharmacy services, clinical affairs). While MassHealth's relationship with UMMS, in particular, is widely recognized as valuable, many stakeholders recommend that the new Administration take a fresh look at MassHealth's outsourcing of critical administrative functions to determine if these resources are being effectively and efficiently leveraged. Some stakeholders recommend that more of these functions need to be developed within MassHealth and observe that decentralized administrative functions make coordinated data gathering and analysis difficult and contribute to a lack of clarity or consistency in program-wide decisions on staffing, IT, and other needed infrastructure.

OPTIONS FOR CONSIDERATION

Stakeholders recommend several options a new Administration should consider for enhancing MassHealth's data analytics and IT infrastructure, including:

- Conduct a complete end-to-end review of current MassHealth data analytics and IT capacity, identify gaps, and lay out a clear path forward to obtain needed resources to close the gaps. This activity should include a focused strategy for recruiting strong candidates for the MassHealth data analytics unit and for determining whether certain functions should be outsourced or developed internally at MassHealth.
- Encourage more active participation by MassHealth in the APCD, enhance access to more robust MassHealth data, including managed care encounter data, and implement stronger coding standards across payers to improve data in the APCD.
- Enhance MassHealth data analytics capacity by developing committed partnerships and information sharing with providers and external researchers, who sometimes view MassHealth only as a regulator, payer, or program administrator. Many stakeholders interviewed note that

the provider community, in particular, could offer expertise in data analytics to support and manage the health of the MassHealth population.

- Develop and publish an annual MassHealth business plan and provide other transparent views into plans for the future of the program.

CONCLUSION

By addressing these priorities, the new Governor has the opportunity to demonstrate Massachusetts' ongoing commitment to lead in health care reform through innovations aimed at increasing the effectiveness of MassHealth and its ability to sustainably promote the health, well-being, independence, and quality of life of its diverse members, their families, and their communities. Equally important, the Governor can position MassHealth as a major catalyst for transformation of the Commonwealth's health care delivery system and continue Massachusetts' legacy of national health care reform leadership by providing a model for Medicaid as a critical driver of payment and delivery system reform nationally.

APPENDIX: INTERVIEWEES

Josh Archambault
Pioneer Institute

Katherine Baicker and Benjamin Sommers
Harvard School of Public Health

Corinne Broderick, Elaine Kirshenbaum, Bill Ryder, and Charlie Alagero
Massachusetts Medical Society

Bruce Bullen
Blue Cross Blue Shield of Massachusetts

Neil Cronin and Vicky Pulos
Massachusetts Law Reform Institute

Tom Dehner
Health Management Associates

Deborah Ekstrom
Community Healthlink

Deb Enos
Neighborhood Health Plan

Christine Ferguson
State of Rhode Island Health Insurance Exchange

Matt Fishman
Partners HealthCare

Tim Gens and Anuj Goel
Massachusetts Hospital Association

Ann Hartstein
Massachusetts Executive Office of Elder Affairs

Roberta Herman
Navigant Consulting

Jim Hunt
Massachusetts League Community Health Centers

Philip Johnston
Philip W. Johnston Associates

Amy Lischko
Tufts University School of Medicine

Rick Lord
Associated Industries of Massachusetts

Cindy Mann
Centers for Medicare and Medicaid Services

Laurie Martinelli
Massachusetts National Alliance on Mental Illness

Bob Master
Commonwealth Care Alliance

Senator Richard Moore
Massachusetts Legislature

Tim Murphy, Jim Spink, and Briana Duffy
Beacon Health Strategies

Ellen Murphy-Meehan
Alliance of Massachusetts Safety Net Hospitals

Al Norman
Mass Home Care

Lora Pellegrini and Sarah Chiaramida
Massachusetts Association of Health Plans

Scott Plumb
Massachusetts Senior Care Association

John Polanowicz, Kristin Thorn, Ann Hwang, and Robin Callahan
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