Speaker of the House of Representatives

Robert A. DeLeo

Report of the Working Group on Medicaid Managed Care Organizations

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Prepared and compiled by the Committee on Health Care Financing

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Executive Summary

Introduction

The Massachusetts healthcare sector has undergone a decade of sweeping transformations through several iterations of health reform. Chapter 58 in 2006, followed by the Affordable Care Act (ACA) in 2010, Chapter 224 in 2012, and Chapter 35 in 2013, emphasized patient access to affordable and high quality healthcare, which continues to be a priority for the Commonwealth. This has resulted in major growth in MassHealth, Massachusetts’s Medicaid program. This growth, paired with unanticipated challenges from the failed Commonwealth Health Information Exchange and Integrated Eligibility System and the introduction of Sovaldi, a cure for Hepatitis C, led to an unprecedented year for MassHealth’s Medicaid Managed Care Organizations (MCOs) in 2014.

In response to these challenges, Speaker of the Massachusetts House of Representatives, Robert A. DeLeo, charged a working group to examine MCOs and the cost of providing benefits to patients. The Medicaid Managed Care Organization Working Group consisted of 13 members with seven members from the House of Representatives, including Representative Jeffrey Sánchez as Chair, as well as six members of industry that spanned providers, payers, and life sciences. The Working Group convened for four meetings and a public hearing from June 2015 to September 2015. In addition to the appointed members of the Working Group, Chairman Sánchez solicited the expertise of independent experts in the areas of health data analytics and public payer policy.

MassHealth and the Managed Care Organization (MCO) Program

MassHealth is the public payer for medical care for the state’s low and middle-income residents and covers one in four Massachusetts residents, or 1.8 million patients. MassHealth itself is comprised of several different programs, dependent on patient population and method of payment. These programs range from traditional fee-for-service Medicaid to comprehensive global payment programs for the older adult population to monthly capitated managed care programs.

Six MCOs in the Medicaid Managed Care Program cover approximately 42 percent of MassHealth members. The MCOs are responsible for coordinating medical services and benefits for MassHealth patients. They are also responsible for providing case management for members, especially those identified as high need, to help minimize costs and improve patient health. MassHealth MCOs are consistently ranked some of the top plans in the nation.

MassHealth contracts with the MCO plans, which then contract with providers regarding the provision of covered services. MCOs agree to provide a comprehensive set of healthcare
services, including behavioral health, medical, and pharmacy services, outlined in a contract with the state, for a fixed rate known as a capitation payment.

Due to the nature of MassHealth, changes in eligibility status are frequent. Additionally, once enrolled in the managed care program, members are able to switch plans on a daily basis. This movement in and out of MassHealth and between plans is called “churn.” Churn, whether due to eligibility or voluntary movement, poses financial problems for MCOs associated with the disruption of patient care and the administrative burden of losing and gaining new members. Longer enrollment periods, such as monthly or quarterly, may lead to reduced patient churn and improve health outcomes.

If members eligible for managed care do not select a plan, MassHealth autoassigns members using an algorithm that takes into account geographic location, as well as other factors. Members may be assigned to one of the six MCOs or to the Primary Care Clinician Plan (PCC), which pays primary care providers to coordinate and manage patient care. In the MCO program, MassHealth autoassigns one MassHealth patient to the MCOs for every one patient assigned to PCC. MCOs have expressed concern about this algorithm since each MCO receives only one new member for every six new members assigned to PCC.

**MCO Rate Setting & Reimbursement**

MassHealth works with an actuarial firm each year to develop actuarially sound rates for the MCOs. For each region and rating category, base rates are determined using the best data available on the use of healthcare services and their costs for people eligible to enroll in a MCO or current MCO members as well as trends and utilization among the MCO population. Rates are also risk adjusted quarterly based on the health status of actual MCO enrollees. MassHealth uses modeling software to generate a risk score for each member which is used to adjust base rates for relative acuity. MCO rates are certified by MassHealth’s consulting actuary and approved by the Centers for Medicare and Medicaid Services (CMS).

After MassHealth sets the capitated per member per month payment rate for that year, the MCO negotiates all aspects of its contracts with hospitals, medical groups, and physicians regarding care delivery. Historically, the MCOs have paid providers primarily on a fee-for-service basis and there continues to be wide variation in prices among providers within individual MCO networks.

Several MCOs expressed to the Working Group that communication with MassHealth throughout the rate setting process has improved markedly over the past year. It is important for all parties that this process continues to be transparent.
Innovative Drugs & Technologies

Pharmacy spending is increasing for both commercial plans and MassHealth. The MCOs in Massachusetts had an especially tough year in 2014 due in large part to unanticipated drug costs. MassHealth capitated rates for 2014 had already been set when Sovaldi, a breakthrough drug that cures Hepatitis C, came on the market in late 2013. These established rates did not take into account such a dramatic change to the healthcare landscape. MCOs report that spending on Sovaldi alone was $10-20 million dollars per MCO in 2014.

New therapies coming on the market, such as Sovaldi, will continue to pose upfront financial challenges for payers. Patient access to medication is important and the immediate investment may lead to savings in the long term by reducing rates of care utilization associated with chronic illness. However, the fact that MassHealth members move in and out of the Medicaid system due to changes in circumstances and life events and also may change MCOs over time, means the long term benefits of these new treatments may not be felt by either MassHealth or its MCOs.

To mitigate the financial impact of such innovative therapies, commercial plans utilize a variety of management tools and procedures that allow them to better handle unexpected drug and device costs. These techniques, such as delays in formulary changes, are not available to MassHealth given existing federal regulation. MassHealth is also limited by the requirement to cover every drug whose manufacturer participates in the CMS mandated drug rebate program. There are other tools, such as prior authorization, bulk purchasing, and pharmacy lock-in programs, which have been and may continue to prove useful for MassHealth to employ in the future.

Case Management & MCOs

All MCOs provide case management services that help members manage their chronic conditions, access medical and behavioral health services, and connect members with social services where needed. MCOs design and implement their own case management programs based on the demographic makeup and needs of their membership, so there is considerable variability among plans.

For purposes of medical loss ratio (MLR), or the proportion of premium dollars that must be spent on medical care and quality improvement, case management is considered an administrative expense. Since MLR restricts the amount of a patient’s premium dollar that can be spent on marketing, overhead, and salaries, it is frequently used to assess health insurance value and ensure that premium dollars are well spent. The federal government, through the ACA, has set minimum MLR standard but states, including Massachusetts, have the option to create more rigorous standards. Programs that improve the efficiency of
the plan, improve health outcomes for patients, and increase access to social services sometimes straddle the line between quality improvement and case management. This lack of clarity may create barriers for plans to implement these valuable types of services.

Effective patient care includes both medical and behavioral health services. MCOs are responsible for providing behavioral health services to their patients. These benefits are often managed and provided by a third-party vendor. Traditionally, behavioral health services have been challenging to provide within the managed care context for a variety of reasons, including the use of more limited provider networks. Both public and commercial payers are working towards more integrated care delivery system.

Alternative Payment Methodologies & Taking on Risk

Providers in Massachusetts are all at different stages in their adoption of alternative payment methods (APMs). Immediately following Chapter 224, there was a swell of APM adoption, but rates of APM uptake have stagnated in the past 18 months. According to MCOs, this is a result of expanding membership in new geographic areas, the enrollment of more members under ACA expansion provisions, and a shift in members to MCOs from discontinued forms of coverage.

There continue to be a number of challenges to APM adoption. IT infrastructure, lack of funding, and adequate panel size are several of the difficulties facing providers. However, a great number are willing to implement APMs. Chapter 224 set goals for Medicaid APM adoption that we have not yet met. All stakeholders will need to continue to support these efforts, both in the public and private sector.

Future of MCOs in the Commonwealth

Under new leadership, MassHealth is undergoing a significant redesign effort that will incorporate new models for care delivery, emphasize value-based care with aligned incentives, and utilize MassHealth’s market power to push the envelope on health reform. While MassHealth will base these new models on the accountable care organization (ACO) frame, there is still uncertainty around what this new MassHealth landscape will look like. The MCOs are an important part of the MassHealth system and will be a vital partner in this work.

Recommendations

Based upon extensive research and stakeholder engagement, several areas of consensus emerged for the Working Group. The Working Group identified key areas for health system reform, as well as specific recommendations for MassHealth to consider in their redesign efforts. Below are the recommendations of the MCO Working Group.
1. Change enrollment policies to improve stability and incentivize plan performance
2. Formalize transparency around MassHealth rate setting process
3. Implement more rigorous data sharing and reporting policies
4. Explore strategies to address the impact of innovative drugs and technologies
5. Urge the MCOs and providers to adopt APMs
6. Examine MLR to eliminate ambiguities
Introduction

The Massachusetts healthcare sector has undergone a decade of sweeping transformations beginning with Chapter 58 in 2006\(^1\), followed by the Affordable Care Act (ACA) in 2010\(^2\), Chapter 224\(^3\) in 2012 and Chapter 35 in 2013\(^4\). This dynamic environment, paired with an increasing emphasis on lowering total healthcare expenditures while maintaining patient access to high quality affordable care, necessitates that payers, providers, and patients change the way they operate within the healthcare system. These reforms have had broad implications across the industry, but at the center of these efforts is the Commonwealth’s Medicaid program, MassHealth.

Following significant MassHealth program growth due to Chapter 58 and the ACA, MassHealth has had to take a hard look at existing infrastructure and programs to ensure ongoing financial sustainability. There have been some significant challenges along the way, further exacerbated by new innovations and market changes. The recent financial struggle of Medicaid Managed Care Organizations (MCOs) is one such example.

Challenges Facing Medicaid Managed Care Organization

Due to state budget challenges since the 2008-2009 recession, MCO monthly capitation rates have been level or increased at rates below inflation or healthcare cost trends in recent years. In 2014, Massachusetts MCOs reported $137 million in losses\(^5\). As MCO plans were grappling with implementation of the ACA, unanticipated challenges from the failed Commonwealth Health Information Exchange and Integrated Eligibility System (HIX-IES) and the introduction of Sovaldi, a cure for people living with Hepatitis C, which launched prior to necessary MCO rate adjustments, contributed heavily to these losses\(^6\).

The ACA expanded Medicaid coverage for a population previously uninsured—even in Massachusetts which had already achieved an insurance rate of 96 percent\(^7\). These new members tended to have higher rates of chronic disease and behavioral health issues\(^8\), and previously may have had limited access to preventive health services. The expansion, as well as some shifting in populations due to ACA changes in income eligibility, led to risk profiles that were different than existing MCO patients. These differences in risk profiles led

\(^1\) Chapter 58 of the Acts of 2006
\(^3\) Chapter 224 of the Acts of 2012
\(^4\) Chapter 35 of the Acts of 2013
\(^6\) Ibid
\(^8\) Jay Gonzales Testimony at Public Hearing, July 16, 2015.
to uneven spreading of risk and therefore discrepancies in risk adjustment. While the 2014 rates took an expanded population into consideration, neither the MCOs nor MassHealth properly evaluated the risk profile of these newly eligible patients.

In October 2013, a new ACA compliant HIX-EIS was launched. The website experienced significant technical failures resulting in people being unable to obtain insurance coverage. Approximately 321,000 were enrolled in temporary Medicaid coverage. The estimated cost of covering those temporary MassHealth members is $658 million, half of which will be funded by the federal government. In 2015, the Commonwealth spent an additional $47 million fixing defects and making upgrades to fix coding errors and improve customer service. The website is functional in time for 2015 open enrollment, but the failed website had a dramatic effect on the state budget as it is still unclear how much the federal government will reimburse the state for those temporarily placed in MassHealth. The MCOs received some of these new members, which affected their member mix and the cost of care.

The introduction of new blockbuster drugs is not an unexpected event for healthcare stakeholders, but the release of Sovaldi in 2014 was unique. Given the high prevalence of Hepatitis C among the Medicaid population, the introduction of a cure spurred patient demand for the drug. The 2014 MCO rates did not take into account the high price tag and far reaching impact. The MCOs spent between $65 and $75 million in 2014 on Sovaldi alone.

While the MCOs appear to have stabilized their financial situations in 2015—5 of the 6 MCOs had a positive margin or neutral budget this year—there are still concerns about the role of MCOs in future health reform implementation and the ability of the rate setting process to adapt to future changes in the healthcare market.

**Charge of the Working Group and Report**

In response to these concerns, the Massachusetts Speaker of the House of Representatives, Robert A. DeLeo, created a working group in June 2015 to examine MCOs and to review the Medicaid benefits delivered by such organizations. Representative Jeffrey Sánchez was named as Chairman of the MCO Working Group. The Working Group was charged with evaluating the costs of providing benefits and identifying any cost drivers and potential

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10 Ibid.


savings, with a particular focus on the cost of rare disease treatment and barriers to adoption of alternative payment methods.

The 13 member Working Group included seven members of the House of Representatives and six members of industry, as follows:

**Representative Jeffrey Sánchez**, House Chair of the Joint Committee on Healthcare Financing and Chair of the Working Group & Chairman of the MCO Working Group

**Representative Lori Ehrlich**, House Vice Chair of the Joint Committee on Healthcare Financing

**Representative Ronald Mariano**, House Majority Leader

**Representative Garrett Bradley**, Second Assistant House Majority Leader

**Representative Paul Brodeur**, House Ways and Means Designee

**Representative Jay Barrows**, Joint Committee on Healthcare Financing

**Representative Mathew Muratore**, Joint Committee on Healthcare Financing

**Susan Coakley**, President, BMC HealthNet Plan

**Christopher Gorton**, President, Tufts Health Public Plans, MA Association of Health Plans Designee

**Steven Walsh**, Executive Director, MA Council of Community Hospitals

**Robert Coughlin**, President & CEO, MA Biotechnology Council

**Timothy Gens**, Executive Vice President & General Counsel, MA Hospital Association

**David Morales**, Executive Vice President & Chief Strategy Officer, Steward Healthcare System, LLC

In addition to the appointed members of the Working Group, Chairman Sánchez requested the expertise of independent experts in the areas of health data analytics and public payer policy. The insights provided by these experts contributed to the group dialogue around key issues.

Chairman Sánchez and the Working Group would like to express their appreciation to the experts who assisted the Working Group throughout this process.
Áron Boros, Executive Director, Center for Health Information and Analysis

Robert Seifert, Principal, Center for Health Law and Economics, Commonwealth Medicine, University of Massachusetts Medical School

Audrey Shelto, President, Blue Cross Blue Shield of Massachusetts Foundation

Kate Nordahl, Senior Director of Massachusetts Medicaid Policy Institute, Blue Cross Blue Shield of Massachusetts Foundation

The Working Group held a total of four meetings and a public hearing from June 2015 to September 2015. The contents of those meetings and testimony given at the public hearing are reflected in this report. This document also incorporates additional research and stakeholder engagement.

This report is divided into eight chapters with the final chapter outlining the Working Group’s findings and recommendations. Chapter One features an overview of MassHealth and its current programs; Chapters Two and Three discuss the MCOs and the rate setting process; and Chapter Four discusses how innovative therapies and technologies impact the finances of MCOs. Chapter Five addresses how MCOs operate, including medical loss ratio and case management. Chapter Six covers alternative payment methods, including the current APM trends and barriers to further adoption. Chapter Seven discusses the future of MCOs in the Commonwealth and a promised MassHealth redesign.

The MCOs play an important role in the MassHealth program. This report seeks to assess the current state of MassHealth MCOs, examine key challenges related to the cost of MCO-provided benefits, provide a number of areas of consensus that require further study, and suggest policy proposals. The Working Group hopes that this report is a starting point for more in-depth conversations about the role of MCOs in the Commonwealth.
Chapter 1: Overview of MassHealth & Current Programs

After health reform passed in Massachusetts in 2006, MassHealth was a model for the
country of what Medicaid could be. With expanded coverage and additional subsidies for
eligible patients, MassHealth showed the nation that near-universal coverage was
achievable. Almost ten years later, MassHealth continues its breadth of coverage, but with
an unsustainably high budget at nearly $15 billion dollars for FY15.13 The growing cost of
MassHealth is primarily due to increased enrollment as a result of health reform efforts such
as Chapter 58 and the ACA.14

As pressure mounts to bring down costs and adopt alternative payment methods for
Medicaid programs across the United States, efforts to think creatively about value-based
care and population health are underway here in the Commonwealth. This chapter will
briefly discuss MassHealth as a whole to provide context to the remainder of the report,
which will focus solely on Medicaid Managed Care Organizations and related challenges.

Section 1.1: Brief Overview of MassHealth

MassHealth is the public payer for medical care for the state’s low and middle-income
residents and it is a critical element of the Massachusetts healthcare safety net. Covering one
in four Massachusetts residents, MassHealth is the second largest payer for healthcare in
Massachusetts. A federal and state-funded program administered by the state, MassHealth
includes both Medicaid and the State Children’s Health Insurance Program (CHIP). MassHealth plays an important role in keeping uninsured rates low in the Commonwealth; Massachusetts has the lowest rate of uninsured (3.7 percent) in the country.15

MassHealth serves as the vehicle to implement groundbreaking health reform through the
Section 1115 Waiver. The Waiver is an agreement with the Centers for Medicare and
Medicaid Services (CMS) giving the state flexibility to design and fund innovative
healthcare programs. In the past, Massachusetts has used this funding to pilot new
programs, extend coverage to new populations, and develop improved, cost-effective
healthcare delivery models. This Waiver gives MassHealth the ability to innovate and
challenge the system to seek sustainable value-based reforms that improve health outcomes
for all citizens, but in particular, for the most frail and vulnerable. The Medicaid Managed
Care program, while introduced several years earlier, became fully realized in 1997 as a

13 Massachusetts Medicaid Policy Institute, MassBudget, & the Massachusetts Law Reform Institute. (2014,
September). The Fiscal Year 2015 Budget for MassHealth and Health Reform Programs,
14 Ibid.
15 Skopec, 4.
component of this Waiver. The most recent Section 1115 Waiver was renewed in November 2014 with Massachusetts securing its first ever five year waiver extension.

**Section 1.2: MassHealth Programs**

MassHealth itself is comprised of several different programs, dependent on the patient population and method of payment. MassHealth pays for care in two ways—fee-for-service (FFS) and capitation. FFS is the process in which providers are reimbursed for each individual service provided. Capitation, often used in the context of managed care, is the method of paying for care where providers or plan administrators are paid a flat fee, usually per month for each individual enrolled. Additionally, some services are covered by MassHealth but not included in the capitation rate. These “wrap” services are paid FFS.

**MassHealth Fee-for-Service (FFS)** is a traditional insurance program where fees are paid to providers for each individual service rendered. Members enrolled in FFS are generally seniors not enrolled in an MCO, PCC, SCO or PACE, dual-eligibles in OneCare, individuals with other primary insurance coverage, and patients who live in an institutional setting, such as a nursing home. Approximately 27 percent of MassHealth patients are enrolled in the FFS program.

**Primary Care Clinician Plan (PCC)** is a program for members under 65, where medical services are paid on a FFS basis and primary care providers are directly paid an additional fee to coordinate a patient’s medical care. Behavioral health services under the PCC plan are covered by a capitated payment to a carved out behavioral health plan. Dental and long term care benefits are included and available FFS. Approximately 18 percent of MassHealth patients are enrolled in the PCC plan.\(^\text{16}\)

**Medicaid Managed Care Organization (MCO)** is a program for the under 65 population, where six health insurance plans are paid a per member per day capitated fee to manage MassHealth benefits for patients, for whom they bore full financial risk prior to the rating year 2015 contract. Beginning with rating year 2015, a risk corridor was established for the MCO program where the MCOs share risk with MassHealth for gains or losses between 3 percent and 20 percent. Behavioral health is covered by the capitated payment, although many of the MCOs subcontract with a behavioral health vendor. MassHealth currently uses the same managed behavioral health organization – Beacon Health Options – as several of the MCOs. Dental and long term care benefits are available through the FFS program. MCOs cover about 48 percent of all MassHealth patients.\(^\text{17}\)

**Senior Care Options (SCO)** is a program where healthcare for seniors, aged 65 and older, is managed by a senior care organization. These organizations, paid a capitated per member

\(^{16}\) Secretary Sudders Testimony at MCO Public Hearing, July 16, 2015.

\(^{17}\) Ibid.
per month rate, provide a fully integrated geriatric model of care that incorporates traditional medical services, behavioral health services, dental and long term care, as well as some social services like transportation.

**Program of All-Inclusive Care for the Elderly (PACE)** is a program for MassHealth beneficiaries 55 and older, where medical, social, and recreational services are provided in the community at a central location. An interdisciplinary team located at a PACE Center manages and coordinates all PACE benefits. PACE is a fully capitated Medicare and Medicaid managed care program jointly managed by MassHealth and the CMS.

**One Care** is a MassHealth plus Medicare program for patients ages 21-64 who are dually-eligible for Medicare and Medicaid. One Care is administered by organizations that coordinate long term services and supports, physical healthcare services, and behavioral health services. One Care providers are reimbursed via a capitated payment.

SCO, One Care, PACE, serve about 3 percent of MassHealth consumers.\(^{18}\)

**CarePlus** is part of the expansion of Medicaid coverage under the ACA. The program is for patients ages 21-64 who are not eligible for MassHealth Standard but have an income below 133 percent of the federal poverty level. CarePlus is a managed care program where the plans are paid a per member per month capitation rate for members enrolled in the program.

**Section 1.3: MassHealth Enrolled Population**

One-quarter of the population of Massachusetts, 1.8 million individuals, depend on MassHealth for their health insurance coverage. This population is made up of 34 percent children, 14 percent adults living with disabilities, 43 percent non-disabled adults, and 9 percent seniors.\(^{19}\) The majority of those patients, totaling 1.3 million, are in some form of managed care.

\(^{18}\) Ibid.

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<td>MCO (including CarePlus)</td>
<td>522,256</td>
<td>826,247</td>
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<td>898,437</td>
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<td>SCO</td>
<td>30,548</td>
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<td>17,791</td>
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<td>Temporary Coverage</td>
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<tr>
<td>Total</td>
<td>1,398,847</td>
<td>2,008,329</td>
<td>44%</td>
<td>1,834,950</td>
<td>-9%</td>
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In addition to increasing eligibility under the ACA, the 2014 MassHealth enrollment numbers reflect the malfunctioning HIX-IES and a suspended redetermination process. This led to increased overall MassHealth enrollment from 2013 to 2014, a 44 percent increase in membership.\(^{21}\)

The redetermination process resumed in the spring of 2015 and as of June 2015, 78 percent of those enrolled were still eligible for MassHealth. Only 2 percent of those previously enrolled were neither eligible for MassHealth nor a Health Connector plan. 22 percent of MassHealth members did not respond to redetermination notices.\(^{22}\)

\(^{20}\) MassHealth Enrollment Snapshot, March 2015.
\(^{22}\) Secretary Sudders Testimony at MCO Public Hearing, July 16, 2015.
Section 1.4: MassHealth Budget & Spending

The MassHealth budget has steadily climbed for the last several years, now accounting for about 35 percent of the state’s budget. The federal government reimburses Massachusetts for approximately 50 percent of MassHealth spending each year. MassHealth’s FY15 General Appropriations Act (GAA) spending was $13.6 billion, with the federal government providing $8.7 billion that fiscal year. The FY16 GAA projects spending of $14.8 billion.

The MassHealth MCO program accounts for about 31 percent of MassHealth spend. Expenditures for the MCO program totaled $3.4 billion in 2014. Per member per month (PMPM) cost for MassHealth MCO members was $436 in 2014, only 2.4 percent growth from the previous year. PCC spending is down $155 million (-6 percent) to a total of $2.5 billion in 2014. PCC PMPM increased to $678 last year, a 10 percent increase from the

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23 MassHealth: The Basics, 17.
26 MassHealth: The Basics, 22.
28 MassHealth: The Basics, 23.
previous year.  

The differences in spending between the MCO and the PCC plans are due in part to the populations they serve. PCC plans have a higher percentage of adults and children with disabilities.  

SCO, PACE, and One Care membership grew 63 percent and spending increased $282 million to $1.1 billion, a 33 percent rise.  All three programs combined account for 9 percent of MassHealth spending.  

MassHealth FFS expenditures rose 14 percent, about $773 million, to $6.2 billion last year. The FFS program accounts for 30 percent of MassHealth spending.  

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30 Ibid, 10.  
31 MassHealth: The Basics, 19.  
33 MassHealth: The Basics, 23.  
34 CHIA 2015 Annual Report, 11.  
35 Secretary Sudders Testimony at MCO Public Hearing, July 16, 2015.
Chapter 2: Medicaid Managed Care Organizations

Medicaid Traditional and CarePlus MCOs play an important role in MassHealth since they are responsible for coordinating medical services and benefits for MassHealth patients. They are also responsible for providing case management services to help minimize costs and improve patient health. Case management services are especially important for members identified as high need. MassHealth currently contracts with five MCO plans for the traditional MCO program and one additional plan, Celticare for the CarePlus program:

1) Boston Medical Center HealthNet Plan
2) CeltiCare Health Plan (CarePlus only)
3) Fallon Community Health Plan
4) Health New England
5) Neighborhood Health Plan
6) Tufts Health Plan Network Health

MassHealth’s managed care program began in 1997 as a part of the Section 1115 Waiver as a way to expand access while also keeping a tight rein on healthcare costs. Originally, the MCO program had 4 plans, but Health New England joined in 2010 and CeltiCare in 2014 as part of the CarePlus procurement. CeltiCare members are all enrolled in CarePlus, the ACA expansion managed care program. While, all of the MCO plans also have commercial business and offer products on the HIX-IES, several operate almost exclusively in the Medicaid space. The majority of BMC HealthNet, Neighborhood Health Plan, CeltiCare, and Tufts Health Plan Network Health’s members are in the MCO and CarePlus programs, 86 percent, 71 percent, 82 percent, and 85 percent respectively. Conversely, Fallon and Health New England have a much larger percentage of commercial members compared to MassHealth managed care members.

Section 2.1: Managed Care Demographics & Enrollment

The majority—two thirds— of MassHealth consumers are enrolled in a managed care program. This is similar to the national average which is 71.7 percent. 875,000 lives, or 48 percent of MassHealth members, are enrolled in the traditional MCO program. BMC HealthNet Plan, Neighborhood Health Plan, and Tufts Health Plan Network Health have the largest portion of enrolled MassHealth patients in the MCO program, with about 90 percent of the market.

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36 Health Management Associates, 2.
### Figure 2.1 Number of MassHealth Lives Covered by MCOs, 2013-2015

<table>
<thead>
<tr>
<th>MCO Plan</th>
<th>Number of Members 2013</th>
<th>Number of Members 2014</th>
<th>Number of Members 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston Medical Center HealthNet Plan</td>
<td>192,928</td>
<td>259,024</td>
<td>226,286</td>
</tr>
<tr>
<td>CeltiCare Health Plan</td>
<td>-</td>
<td>33,168</td>
<td>52,866</td>
</tr>
<tr>
<td>Fallon Health Plan</td>
<td>14,053</td>
<td>27,180</td>
<td>32,116</td>
</tr>
<tr>
<td>Health New England</td>
<td>13,171</td>
<td>21,773</td>
<td>65,525</td>
</tr>
<tr>
<td>Neighborhood Health Plan</td>
<td>161,365</td>
<td>226,478</td>
<td>274,281</td>
</tr>
<tr>
<td>Tufts Health Plan Network Health</td>
<td>137,051</td>
<td>197,962</td>
<td>221,704</td>
</tr>
<tr>
<td>Total</td>
<td>518,568</td>
<td>765,585</td>
<td>872,281</td>
</tr>
</tbody>
</table>

### Figure 2.2 MassHealth MCO Membership by Payer, 2015

- **BMC (26%)**
- **Tufts (25%)**
- **NHP (31%)**
- **CeltiCare (6%)**
- **Fallon (4%)**
- **HNE (8%)**

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Section 2.2: Managed Care Contracting

The MCOs serve as administrator and coordinator of MassHealth benefits for their MassHealth patients. MassHealth contracts with the MCO plans, which then contract with providers regarding the delivery of covered services. MCOs agree to provide a comprehensive set of healthcare services, including behavioral health, medical, and pharmacy services, outlined in a contract with the state, for a fixed rate known as a capitation payment. CMS specifies which services must be covered by any Medicaid program but states may elect to cover additional services by adding them to the state Medicaid plan or by requesting a federal waiver.

CMS also sets additional standards for Medicaid managed care plans, but each state may build upon them. For example, CMS mandates certain network adequacy requirements to ensure that patients have access to healthcare facilities and services across the state. MassHealth implements these requirements in contracts with MCOs and providers. Unlike some other states, the MassHealth contracting process in selecting MCOs is not competitive. MassHealth sets the rates each year and any MCO meeting the requirements can participate. MassHealth only opens the program to new MCOs when it does a reprocurement, roughly every five years.

MassHealth pays for additional “wrap” services including dental and long term care on a fee-for-service basis. For behavioral health services, MCOs may manage those benefits internally although most MCOs outsource benefits to a third-party behavioral health vendor. Pharmacy benefits are also frequently contracted out to a separate vendor, a Pharmacy Benefits Manager (PBM). Since October 2014, the MCOs have had a risk corridor in place that limits exposure to financial losses. Under this risk corridor, plans bear full financial risk for the first 3 percent of their gains or losses, share risk with MassHealth at 50/50 for gains or losses between 3 percent and 20 percent, and assume full financial risk for gains or losses over 20 percent. Any money saved by providing efficient care at a cost below the fee amount is profit for the plan or contributions to reserves.

The MCO program relieves MassHealth of the administrative burden of day to day operations and any case management, which falls on the MCO plans. However, MassHealth is still responsible for rate development, contract management and quality monitoring as well as the coordination of Federal and State regulation implementation.

41 42 CFR 438.206-207.
42 Secretary Sudders Testimony at MCO Public Hearing, July 16, 2015.
Section 2.3: MCO Enrollment

Annually, MassHealth is required to conduct an eligibility redetermination to ensure members continue to meet all criteria. During this process, some members fall off because they are no longer eligible and others fall off the rolls not because they are no longer eligible, but because they may not have responded to outreach letters. In addition, unlike many other states, Massachusetts allows members to voluntarily switch plans on a daily basis for the MCO program and on a monthly basis for the CarePlus program. This movement of members in and out of MassHealth, between MassHealth and the HIX-IES, or within individual plans is called “churn.”

Loss of members, whether it is due to eligibility or voluntary movement, poses financial problems for MCOs. The MCOs lose revenue associated with those members and when members come back onto MassHealth coverage, it is likely due to more acute healthcare needs resulting in a higher case mix. In the managed care setting specifically, continuity of care is important because case management is only effective if the programs have time to work.
In calendar year 2014, MassHealth experienced 36 percent annual membership churn, with 30 percent due to changes in eligibility and 6 percent attributed to members changing plans voluntarily.\(^{43}\) Voluntary disenrollment for each MCOs ranges from 4-10 percent.\(^{44}\) Several studies demonstrate that continuous enrollment, monthly, quarterly or yearly, can reduce churn, improve health outcomes, and reduce administrative burden. A study of data from the Medical Expenditure Panel Survey demonstrated that when beneficiaries are enrolled in Medicaid for longer periods, the average monthly cost of their care declines.\(^{45}\) MassHealth’s latest plan under the ACA, CarePlus, utilizes monthly enrollment meaning plan members must wait until the first of the next month to switch plans.\(^{46}\)

Several states, including Massachusetts, have implemented express lane eligibility programs. In 2012, Massachusetts implemented express lane renewal for families enrolled in both MassHealth and the Supplemental Nutrition Assistance Program (SNAP). As part of a Section 1115 Wavier, this process was extended to parents and caregivers. This program allows for automatic eligibility renewal for approximately 140,000 MassHealth patients.\(^{47}\) A July 2015 *Health Affairs* study showed that extending Medicaid eligibility until the end of the calendar year or for a twelve month period would significantly reduce churn. Neither shorter term eligibility periods nor using projected income levels yielded equivalent results.\(^{48}\) Extending MassHealth eligibility to reduce churn will have different cost implications depending on the enrollment period, the amount of churn within the program, the financial situation of the state, and the workforce landscape.\(^{49}\)

Closely connected to the issue of churn is the autoassignment of managed care eligible members. Eligible members who do not select a plan on their own will be autoassigned to either the MCO program or the PCC program. Historically, approximately 70 percent of MassHealth consumers voluntarily select a plan.\(^{50}\) If a MassHealth member eligible for managed care does not select a plan within 12 to 14 days, he or she is autoassigned based on an algorithm. Currently, the system alternately assigns one member to a PCC plan and one

\(^{43}\) Secretary Sudders Testimony at MCO Public Hearing, July 16, 2015
\(^{44}\) Ibid.
\(^{48}\) Swartz, K. et al. (2015). Reducing Medicaid Churning: Extending Eligibility for 12 Months or to End of Calendar Year is Most Effective, Health Affairs 34 (7), 1180.
\(^{49}\) Ibid, 1186.
\(^{50}\) Email communications with MassHealth on July 9, 2015.
to an MCO plan, taking into account geographic (regional) location, as well as member rating category distribution in each region. The MCOs receive members in turn, alternating until each plan has received one new member. Under this arrangement, the PCC plan will receive five new members in the time it takes each of the traditional MCOs to receive one member. In the CarePlus program, MCOs receive all autoassigned members. The autoassignment policy has changed over the years, which has impacted the mix of members in the MCOs and PCC plan.

**Figure 2.4 History of Autoassignment Policy**

The MCOs expressed concern that under the current autoassignment algorithm, the MCO-enrolled population is sicker and more complex, and therefore more expensive. The MCOs indicated that healthier people are more likely to not select a plan on their own resulting in plan assignment via the autoassignment algorithm. However, MassHealth data indicates that PCC members are more medically complex than MCO members. MassHealth members with disabilities and other more complex healthcare needs are more likely to enroll in a PCC plan. In 2015, 5 percent of MCO members were adults with disabilities compared to 14 percent of PCC plan members. It is important to the plans that the autoassignment algorithm assign these healthy members equally to the MCOs and PCC plans.

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51 Health Management Associates, 10.
52 MassHealth: The Basics, 19.
53 Ibid.
Section 2.4: MCO Quality

MassHealth monitors the quality of the MCOs by requiring that the MCOs report on a number of Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA), an independent, non-profit organization dedicated to improving healthcare quality. MassHealth requires the MCOs to report on a bi-annual basis and conduct an annual MCO member survey to evaluate patient satisfaction.

Massachusetts MCOs are consistently ranked some of the best in the country by NCQA. In 2014, the top four Medicaid plans in the nation were Massachusetts plans.\textsuperscript{54} Selected measures for reporting are different each year, but in 2014, Massachusetts MCOs scored in the top 25 percent nationally on measures such as Breast Cancer Screening, Well Child Visits in the First Fifteen Months, Controlling High Blood Pressure, and Follow-up After Hospitalization for Mental Illness.\textsuperscript{55}

\textsuperscript{54} National Committee for Quality Assurance, NCQA Health Insurance Plan Rankings 2014-2105, \url{http://healthplanrankings.ncqa.org/2014/}
\textsuperscript{55} Ibid.
Chapter 3: MCO Rate Setting & Reimbursement

MassHealth pays the MCOs a capitated rate for each member covered. The MCO then negotiates separate contracts with providers to cover required services. A capitated rate affords the state a certain amount of budget predictability since the MCOs take on financial risk for all contracted services for all patients once the rates are set.\textsuperscript{56} However, MassHealth will be responsible for sharing in any losses that exceed the risk corridor threshold.

The Working Group heard from plans that transparency and communication with MassHealth during the rate setting process has been an ongoing concern. However, plans did state that they have been pleased with recent improvements.

Section 3.1: MassHealth Rate Setting Process

MassHealth contracts with an outside actuarial firm to develop and certify MCO rates.\textsuperscript{57} Each year, MassHealth staff work with independent actuaries to develop a range of appropriate MCO rates considering a number of factors. CMS requires rates to be actuarially sound, meaning they are certified by an actuary, adequate to cover anticipated costs of healthcare benefits for the plan members, and developed in accordance with accepted actuarial practices.\textsuperscript{58} CMS approves all capitation rates, as well as risk mitigation provisions like risk adjustment. Once the rate range is set and approved by CMS, MassHealth selects the rate for the MCOs from within the range provided.

MCO rates are prospective and developed once per year. This means that rates cannot be adjusted mid-year due to changes in membership or benefits. With no process in place for any mid-year correction, rates that were considered actuarially sound at the time of development may not be actuarially sound at a later point during the rate year. It is critical that the MCO capitation rates reflect the dynamism of the healthcare landscape.

The process can generally be divided into four steps. These steps do not wholly reflect the intricacies of the process and the work of the actuary, but it is helpful to understanding the rate setting process as a whole.

\textsuperscript{56} Christopher Gorton Testimony at MCO Public Hearing, July 16, 2015
The actuarially sound rate ranges are developed using the best data available on the use of healthcare services and their costs for people eligible to enroll in a MCO or current MCO members. Population groups, called rating categories\(^{59}\), are established based on differences in service use and cost.\(^{60}\) These categories are actually a form of risk adjustment since they separate people based on different healthcare needs, as well as different benefit packages.\(^{61}\)

The second step adjusts the base data to account for any missing data as much as possible.

The last two steps in the process make adjustments based on expected changes in the coming year. This includes future trends in price and utilization or newly eligible populations. The final capitation rate also includes an amount for general administration of the program, care coordination or case management programs, a margin for risk, and applicable taxes and fees, which is called the non-medical expense load.\(^{62}\) MassHealth pays this capitated rate to the MCOs through a per member per day (PMPD) fixed rate\(^{63}\) and a per member per month rate (PMPM) for the CarePlus program.

Rates are also risk adjusted based on the health status of actual MCO enrollees. MassHealth uses modeling software that will adjust the rate up or down depending on the risk of the MCO population relative to the average risk. These adjustments are cost neutral, meaning that any upward adjustments are offset by downward adjustments to another MCO.\(^{64}\)

\(^{59}\) Rating categories are outlined in Appendix C

\(^{60}\) Davidson, 5.

\(^{61}\) Ibid, pg.6.

\(^{62}\) Ibid.

\(^{63}\) Ibid, 10.

\(^{64}\) Ibid, 3 & 7
MassHealth uses other risk mitigation tools, including requiring reinsurance and establishing risk corridors, to further protect the MCOs and consumers against rate uncertainty. MCOs are required to purchase reinsurance, also called stop-loss coverage. A reinsurance policy provides additional financial protection for the MCOs in the event that costs exceed a pre-determined amount. Risk corridors also limit financial exposure because the state agrees to partially offset high losses, but may require the MCO to give some savings back to the state if actual costs are below what was budgeted. This kind of arrangement is ideal for newly eligible populations or new covered treatments. MassHealth

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**MassHealth Managed Care Organizations Audit**

This year, the Office of the State Auditor of Massachusetts released a report examining billing practices within MassHealth Managed Care Organizations. The report found that over a 5 year period, MassHealth improperly paid approximately $233 million in fee-for-service claims for members enrolled in a MCO. Additionally, the Auditor’s report claimed that MassHealth’s lack of control over MCO contracts may have caused another $288 million in additional fee-for-service claims. This lack of control included inadequate records of services covered and general contract negotiation and management.

At the public hearing, Auditor Bump reiterated a suggested policy change where MassHealth denies all fee-for-service (FFS) claims submitted on behalf of MCO enrollees, which would allow them to go through the MCO first. If the claim really is outside of the MCO covered services, the MCO would send the claim to MassHealth for FFS payment.

MassHealth and the MCOs must have a common understanding about what specific services are covered in the capitation payment and which are FFS. The range of services covered influences the rate setting process, therefore one must be clear to accurately set the other.

While MassHealth did not agree with all audit findings, they are working to implement system changes to prevent duplicative payments in the future.

The Working Group did not comment on this report.


MassHealth has three different corridors for the MCO and CarePlus program, which apply to all rating categories. For the MCOs, the risk corridors only apply to the medical portion of the capitated payment. For more information on risk mitigation tools, see Appendix C.

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65 Ibid, 11
66 See Appendix C.
67 Davidson, 11.
Capitation rates set the parameters for MCO payments to providers and MCOs have flexibility to establish provider payment methods including quality incentive contracts. These payments and incentives affect patient access and health outcomes for the MCOs enrolled members.\textsuperscript{68} The Working Group emphasized several times during their discussions that patient experience and quality of care should be at the center of this process. During discussion about the rate setting process, the Working Group noted challenges in capturing accurate data as it is sometimes incomplete, missing, or unknown. There is a often a large time lag between when a healthcare service is provided and when payment for the service is received. Where possible, Working Group members suggested the state and actuaries use the most recent data available.

The Working Group discussed the fact that challenges such as homelessness, mental health problems, or maintaining long term employment can greatly affect healthcare costs and outcomes. While the Working Group agreed on the importance of these factors and the services which can help mitigate them, these so called social determinants of health are not taken into account during the current risk adjustment process. MassHealth contracts with the MCOs in part because of strong case management programs that seek to target these larger social issues. Acknowledging the complexity of incorporating additional considerations into the rate setting process, the Working Group expressed hope that one day the social determinants of health can be given additional consideration.

**Section 3.2: MCO Reimbursement to Providers**

After MassHealth sets the capitated payment rate for that year, the MCO negotiates all aspects of its contracts with hospitals, medical groups, and physicians regarding patient care delivery. Historically, the MCOs have paid providers primarily on a fee-for-service basis. In Massachusetts, several larger brand name health systems are paid much higher prices than smaller providers and community hospitals.\textsuperscript{69} The Center for Health Information and Analysis (CHIA) collects data on price variation throughout the Massachusetts market. Price variation is measured by relative price, a calculated metric that allows comparison of different provider prices in a payer's network.\textsuperscript{70}

There is wide price variation in the Commonwealth, according to CHIA’s analysis of the FY2013 relative prices. Among payers, prices for both inpatient and outpatient hospital services were more concentrated around the network average for payers with the largest market share, which may be an indication of their negotiating power. Payers with small market shares had wider variation in prices.\textsuperscript{71} CHIA’s analysis also indicated that

\textsuperscript{68} Ibid, 1.
\textsuperscript{70} Ibid, 2.
\textsuperscript{71} Ibid, 3.
community hospitals have relative prices generally below the network median and hospitals with a larger market share tended to have higher relative prices.  

Figure 3.2 shows a relative price ratio for blended inpatient and outpatient hospital services for each MCO. In the figure, each payer’s network average relative price is 1.0 with payments above 1.0 as higher than average and vice versa. For most payers, the majority of prices are clustered around the network average, but there are a few outliers that may be due to a much higher price or a high acuity case. It is important to note that prices can be compared within a network, but relative price is not directly comparable across payers.

Due to price concerns, some plans have discontinued relationships with providers whose costs are too high but this can be difficult for areas outside of Boston given CMS and MassHealth network adequacy requirements. In some situations, these network adequacy requirements, which are important to patient access to care, work against plan negotiations when the provider knows they are a necessary part of maintaining an adequate care

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72 Ibid, 4-5.  
73 Ibid, 2.  
74 Center for Health Information and Analysis, Health Care Provider Price Variation, http://www.chiamass.gov/relative-price-and-provider-price-variation
network. These providers can negotiate for much higher service prices. Transparent information about provider prices is crucial as Massachusetts continues cost containment and health reform efforts.

During Working Group discussions about provider contracts and pricing, the MCOs indicated that they could not discuss specific provider rates and contracts due to antitrust laws. Other stakeholders responded that price transparency would not violate antitrust laws. The system should not be paying providers radically different prices for the same services of comparable quality. There was some frustration from the Working Group because complete transparency is needed to fully understand the current issues and make policy recommendations.

Section 3.3: Moving Forward

Several MCOs expressed to the Working Group that transparency and communication with MassHealth has improved markedly over the past year. Plans now engage in a dialogue with MassHealth, receive more information about assumptions and rate adjustments, and have time to ask MassHealth follow-up questions once the rates are set. The new rate packet provided by MassHealth includes MCO specific rate setting and adjustment information. The plans are given time to review the packet and ask MassHealth any outstanding questions. Figure 3.2 shows a timeline from the most recent rate setting period, rating year 2016. The plans were pleased with the nature and depth of their discussions with MassHealth. They reported that although MassHealth did not necessarily agree with their concerns, their point of view was considered and feedback was provided.

Figure 3.2: Rating Year 2016 Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 27, 2015</td>
<td>Information Sharing Package and Rate Offers to MCOs.</td>
</tr>
<tr>
<td>July 29, 2015</td>
<td>Meeting with MCOs.</td>
</tr>
<tr>
<td>August 5, 2015</td>
<td>MCOs submit written questions to EOHHS.</td>
</tr>
<tr>
<td>August 14, 2015</td>
<td>Question responses to MCOs.</td>
</tr>
<tr>
<td>August 21, 2015</td>
<td>Acceptance of rates by MCOs.</td>
</tr>
<tr>
<td>August 26, 2015</td>
<td>Final MCO and CarePlus Contract Amendments sent to MCOs for signature.</td>
</tr>
<tr>
<td>Week of September 14, 2015</td>
<td>Contracts Signed and Executed by MCOs and EOHHS.</td>
</tr>
<tr>
<td>October 1, 2015</td>
<td>Contract Year 2016 effective date.</td>
</tr>
</tbody>
</table>

76 Neighborhood Health Plan Testimony at Public Hearing, July 16, 2015.
The MCO initial five year contracts expired on September 30, 2015, but MassHealth exercised its option to extend the contract period one more year to September 2016. MassHealth indicates it will use this time to implement system reforms, including updating the assumptions about population risk pools, considering changes in member mix due to the redetermination process and unforeseen growth in pharmaceutical spending, and requiring rate increase for behavioral health services.\textsuperscript{77}

\textsuperscript{76} MassHealth. (2015, July). Rate Year 2016 EOHHS MCO and CarePlus Program Capitation Rate Development Methodology.

\textsuperscript{77} Secretary Sudders Testimony at MCO Public Hearing, July 16, 2015
Chapter 4: Innovative Drugs & Technologies

The pharmaceutical landscape is changing drastically. Last year, the United States experienced the highest increase in drug spending since 2003. The biggest increase in spending was for specialty drugs, which grew 30.9 percent. Double digit growth in specialty pharmaceutical spending is expected over the next few years due to brand inflation, accelerated development of new, expensive targeted therapies, and increases in utilization. While a national study showed that increases in prescription drug use is associated with a decrease in non-drug Medicaid costs, Medicaid spending is growing steeply. All programs want to ensure both patient access and appropriate use of prescription medications as well as achieve maximum savings when purchasing pharmaceuticals.

In Massachusetts, across all plans and populations, spending on general and specialty pharmaceuticals is increasing. Last year, the MCO spending on pharmacy was approximately 18 percent, a 14 percent increase from the previous year.

Figure 4.1: Pharmacy Spending Growth in Massachusetts

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Full-Claim</td>
<td>16.7%</td>
<td>-0.3%</td>
<td>12.5%</td>
</tr>
<tr>
<td>MassHealth MCO</td>
<td>18.2%</td>
<td>5.0%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

Source: Payer-reported TME data to CHIA, 2012-2014.

Innovative drugs and technologies are an ongoing challenge for MassHealth, the MCOs and commercial plans. Policymakers, MassHealth, insurance plans, and providers must be partners in developing and implementing strategies to handle future breakthrough drugs and medical devices. Solutions may include purchasing strategies, clinical use guidelines, or

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79 Ibid, 44.
80 Roebuck, M., Dougherty, J., Kaestner, R. & Miller, L. Increased Use of Prescription Drugs Reduces Medical Costs in Medicaid Populations, Health Affairs. 2015; 34 (9): 1586-1593.
both. New treatment methods for chronic conditions like diabetes, which affects 10 times as many people as Hepatitis C\textsuperscript{82}, are on the horizon. Medicaid reimbursement methods must be able to keep up with and adjust to new technologies.

**Section 4.1: Impact of Sovaldi & Other Innovative Drugs and Technologies**

The MCOs in Massachusetts had an especially tough year in 2014 due in large part to unanticipated drug costs. MassHealth capitated rates for 2014 had already been set when Sovaldi, a breakthrough drug that cures Hepatitis C, came on the market in late 2013. While payers and providers of services were aware a new Hepatitis C drug was coming to market with a cure rate of over 90 percent, they were not expecting a pre-rebate price of $1,000 a pill, $84,000 for the full cost of treatment.\textsuperscript{83} These costs hit Medicaid programs hard since the 2014 rates did not take this new treatment into account. Moreover, because the 2014 capitation rates were at the bottom of the actuarially sound rate range, the MCO rates had no margin for this additional cost.

The MassHealth population, in general, has different risk factors and a higher prevalence of certain diseases, including Hepatitis C. MCOs report that spending on Sovaldi alone was $10-20 million dollars per MCO in 2014. Tufts Health Plan Network Health reported the prevalence of Sovaldi use among Medicaid members was 2.4 percent compared to 0.5 percent of commercial members and 0.4 percent of Medicare members.\textsuperscript{84}

New therapies can be medically effective, even curing disease, but can require a large amount of upfront investment. While this upfront investment in care may lead to savings in the long term, those long term benefits may not be financially realized by the organization that provided the upfront funding. Sometimes benefits can take 10, 20, or 30 years to be realized. The fact that MassHealth members move in and out of the Medicaid system due to changes in circumstances and life events and also may change MCOs over time, means the long term benefits of new treatments may not be felt by either MassHealth or its MCOs. Working Group members agree that “cost avoidance,” or the long term cost savings associated with drugs that cure diseases, is a critical component of any calculation of drug “costs”. Patients should have access to medications that decrease hospital stays and generally reduce overall medical costs. However, the Working Group also agreed that this analysis can be very complicated and must take into account short term financial and budgetary considerations.


Long term value, or cost effectiveness, may be easier to determine for certain medications. Sovaldi is a good example. A draft report from a panel of medical specialists determined the medication was cost effective as it cured a lifelong condition that would almost certainly cost hundreds of thousands of dollars over the lifetime of a patient. After taking rebates and discounts into account, the health benefits from Sovaldi outweighed the expense and comparable treatments. For other new drugs or medical devices, it may not be so obvious. Medications for chronic disease that will be used by the patient for the rest of his or her life have different considerations and may have a much higher price tag. Prescription medications and their costs have had and will continue to have a significant financial impact on MassHealth and the MCOs.

Section 4.2: Strategies for Drug Management

When a new drug comes to market, MassHealth and the commercial plans have different coverage options available to them. MassHealth, and other state Medicaid programs, must cover every drug whose manufacturer participates in the CMS mandated drug rebate program. However, MassHealth does have the option to manage those drugs using preferred drugs or prior authorization, which they exercised through prior authorization for Sovaldi.

The MCOs are required to cover the same drugs as the PCC plan. Like MassHealth, the MCOs may employ different drug management tools including developing their own prescribing criteria. Therefore, specific drugs may be managed differently among MassHealth MCO plans. For example, Neighborhood Health Plan and Beacon Health Strategies work to ensure appropriate psychotropic drug use through Beacon’s Psychotropic Drug Intervention Program (PDIP). The program promotes evidence-based medication use, helps identify inappropriate use, and encourages intervention strategies most likely to achieve positive outcomes. One intervention is identifying members with psychotropic drugs prescribed to them by multiple prescribers. Beacon informs the prescribers and the member’s primary care provider to ensure proper coordination of care. In the case of Sovaldi, the majority of coverage requirements in the MCOs include a threshold of liver
damage and/or some type of substance use abstinence before they can receive treatment, among other restrictions.\textsuperscript{90}

Commercial plans have different member management tools and procedures at their disposal that in some circumstances allow them to better handle unexpected drug and device costs. Commercial plans wait a few months to add new drugs to their formulary, giving them time to develop a plan for patient coverage and prescribing guidelines.\textsuperscript{91} Commercial plans can also obtain significant discounts from one manufacturer by not offering the competitor’s drug or by offering it with a higher co-payment. Additionally, commercial plans set their rates quarterly so in the event a new drug or device comes to market unexpectedly, the commercial plans can adjust rates to account for these events the following quarter. These types of cost management tools are not available to the MassHealth MCOs.

However, there may be other mechanisms available to help MassHealth manage increasing drug costs including bulk purchasing and pharmacy lock-in programs.

\textit{A. bulk purchasing}

Bulk purchasing has attracted growing attention as a method to lower drug costs. This type of group purchasing can be a partnership between state-level entities, a multi-state collaborative, or occur at the federal-level like current purchasing of vaccines for children. At the national level, there were five operating multi-state bulk purchasing groups in the country in 2014.\textsuperscript{92} In 2015, Missouri and 24 other states negotiated an extra 20-30 percent rebate on a medication for Hepatitis C.\textsuperscript{93}

At the Medicaid level, MassHealth already achieves savings on drugs through CMS rebates and direct negotiations with manufacturers, but there may be additional opportunities for MassHealth to join with other states to negotiate for even greater savings. Over 10 years ago, Massachusetts created the Massachusetts Alliance for State Pharmaceutical Buying (MASPB) to lower drug prices through collective multi-state purchasing. However the program never seemed to take off. A report commissioned by the Executive Office of Health and Human Services and the Executive Office of Administration and Finance in 2004 indicated that while costs might decrease under collaborative purchasing

\textsuperscript{91} Tufts Health Plan. (2015). MCO Advisory Committee Rx Slides.
\textsuperscript{92} National Conference of State Legislatures, Pharmaceutical Bulk Purchasing: Multi-State and Inter-Agency Plans, Updated January 2015, \url{http://www.ncsl.org/research/health/bulk-purchasing-of-prescription-drugs.aspx}
arrangements, that alone is unlikely to yield substantial savings. However, a combination of strategies like using bulk purchasing, in addition to increasing use of generics, disease management, and utilization management could yield noticeable cost savings.\(^{94}\)

All MassHealth MCOs use PBMs, a method of supplying members with drugs that is akin to bulk purchasing. PBMs are third party companies that process prescriptions for insurance companies or corporations. They use their size to negotiate with drug makers and pharmacies for lower prices.\(^{95}\) PBMs bring value to the MCOs by offering drug purchasing programs that improve outcomes and reduce costs. During Working Group discussions, several members inquired if bulk purchasing would help MCOs obtain lower drug prices. The MCOs present indicated that in their experience PBMs yield the highest cost savings available given their ability to leverage the market.

### B. Pharmacy Lock-In Programs

Another way states have dealt with increasing pharmacy costs at the member level is implementing pharmacy lock-in programs to target abuse or inappropriate use of medications. Lock-in programs assist providers and plans in monitoring and correcting inappropriate use of medications for certain individuals. Restrictions are triggered by specific member behaviors that may indicate fraud, abuse or inappropriate use.

This year MassHealth approved Tufts Health Plan’s request to implement a prescriber-based lock-in program.\(^{96}\) The program monitors a variety of factors around prescription drugs including emergency department use, pharmacy claims, and medical history. If the plan witnesses certain member behavior, they have the ability to lock-in that member to a specific prescriber. This is more effective than locking a member into a specific pharmacy because it leads to earlier intervention and prevents unnecessary medical

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harm and medical services. MCO pharmacy lock-in programs offer an area of potential opportunity that merits further consideration by MassHealth.

### Reinsurance

By slightly altering more traditional risk mitigation tools, some states are using reinsurance policies to help plans remain financially stable in the event of unforeseen expenses. Different contingencies could be attached to these kinds of policies including unexpected pharmaceutical costs above a certain threshold. Arizona operates a catastrophic reinsurance plan which covers 85 percent of the cost of care provided to enrollees with specific high-cost diagnoses. New York has a stop-loss program for inpatient care that caps plan risk at $100,000 in spending for any enrollee in a year. The state assumes responsibility for any costs above that threshold.


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97 Ibid.
Chapter 5: Case Management & MCOs

All MCOs provide case management services that help members manage their chronic conditions and connect members with social services where needed. MCOs design and implement their own case management programs based on the demographic makeup and needs of their membership, so there is considerable variability among plans.

In order for any case management program to succeed, there must be sufficient continuity of membership in the plan. MassHealth does not require members to be enrolled for a certain amount of time before switching MCOs or leaving the program entirely. The ability to switch programs so easily adversely affects the ability of case management programs to work, which therefore affects the MCO’s ability to manage their patient population. Medicaid members are greatly in need of these services since studies estimate that more than 60 percent of adult Medicaid enrollees have a chronic or disabling condition.

Section 5.1: Medical Loss Ratio

Medical loss ratio (MLR) is the proportion of premium dollars that must be spent on medical care and quality improvement, compared to administrative expenses like marketing, salaries, and profits.

\[
\text{MLR} = \frac{\text{Claims} + \text{Quality Improvement & Fraud Reduction Expenses}}{\text{Earned Premiums - Taxes, Assessments & Fees}}
\]

MLR is frequently used to assess health insurance value and to ensure that patients’ premium dollars are well spent. When insurers do not meet the MLR standard, they must issue premium rebates to patients to bring their spending in line with MLR requirements. The ACA mandates a MLR of 80 percent for the small group market and 85 percent in the

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100 Center for Health Information and Technology. (2015). Massachusetts Medical Loss Ratios, Performance of the Massachusetts Health Care system Briefing Series, 1.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420250
large group market.\textsuperscript{102} Even though the ACA set national standards, minimum MLR and components can differ between states. In Massachusetts, the Division of Insurance collects and monitors commercial MLR. Large group plans have a MLR of 85 percent, but small group plans must achieve a MLR of 88 percent.\textsuperscript{103}

In 2014, Massachusetts commercial plans had an average MLR of 89 percent\textsuperscript{104} and the Massachusetts MCOs spend approximately 92 percent of every premium dollar on direct medical care and quality improvement.\textsuperscript{105} On PMPM basis, MCOs averaged $18 PMPM on administrative expenses compared to $33 PMPM in the commercial plans in 2014.\textsuperscript{106}

While MassHealth MCO plans are not included in current MLR requirements, recently proposed CMS Medicaid regulations\textsuperscript{107} contain a provision that would impose MLR limits on the MCOs. While Massachusetts MCOs are already well within the limits set by CMS, with a minimum MLR of 85 percent, it raises an issue of clarity surrounding MLR and the kind of initiatives that should be considered quality improvement or administrative. The case management services MCOs provide are at this time considered an administrative expense for MLR reporting purposes\textsuperscript{108}, but are still a grey area. Clarity around MLR is essential so that stakeholders involved in the care of a population can determine where investments are needed and have the freedom to make investments that improve medical care. While this issue warrants further conversation, it is beyond the scope of this report.

**Section 5.2: Case Management**

With the goal of keeping patients healthy and keeping costs down, managed care organizations provide case management services to all members. These services vary greatly from plan to plan but often include a member’s healthcare providers, plan management staff like nurses or social workers, and sometimes family members. Services range in intensity from helping patients keep appointments to home visits to help manage chronic conditions. Case management programs may focus on one disease or health goal, or combine social assistance, like affordable housing and access to food stamps, with traditional medical care needs. Case management services are especially important to populations facing challenging economic or social circumstances.

\textsuperscript{102} 45 CFR 158, \url{http://www.gpo.gov/fdsys/pkg/FR-2012-05-16/pdf/2012-11753.pdf}
\textsuperscript{103} M.G.L. Ch. 176J §6
\textsuperscript{104} CHIA 2015 Annual Report, 33.
\textsuperscript{105} Milliman Report, 5.
\textsuperscript{107} Assistant Secretary Tsai described the new regulations as mostly technical and actuarial with Massachusetts already largely in compliance. If adopted, they would not cause major problems for MassHealth. (MCO Public Hearing, June 16, 2015).
\textsuperscript{108} 211 CMR 147.04
MCOs use claims data to target individual high utilizers of care or a particular quality measure plan-wide that needs improvement like breast cancer screening or diabetes care management. At the individual level, the plan identifies members in need, usually 5-10 percent of the total membership\(^\text{109}\), and the case management team develops a plan to both improve overall health and ensure the appropriate use of services. From October 2013 to September of 2014, the MassHealth MCOs spent 21 percent of the administrative portion of their budget on case management.\(^\text{110}\)

### Neighborhood Health Plan: Asthma Disease Management Program

Neighborhood Health Plan (NHP), the largest MCO in the state, has a multifaceted Asthma Management Program with the goal of improving members’ understanding of asthma and how to control it. NHP both assists primary care providers in actively managing their asthma patients by providing patient-specific data and reaches out to patients at risk.

NHP created a database of asthma patients not managing their condition well. A report is generated from this list several times a year and a summary is given to each provider regarding their patients’ hospital and pharmacy utilization. Additionally, a bi-weekly trigger report is also sent to alert providers when their patients have exceeded their allotted amount of rescue medication or not filled their controller drug prescription. Once identified in the trigger report, an individualized treatment plan is created by NHP for providers and the patient is mailed educational materials. Patients may also be assigned a case manager.

In 2005, NHP added home-based interventions to the program. Through a contract with Boston Asthma Initiative, a community-based organization, NHP case managers visit the homes of patients who are compliant with their medications but still struggle to control their condition. The case manager can assess home factors like dust, mold, or bedding that may be aggravating their condition.

NHP also recognized that some members lacked access to spirometry, a diagnostic tool that measures airflow. It can help with initial diagnosis, as well as periodic monitoring. To increase access, NHP partnered with community health centers and provided them with a spirometer and training.

The program has reduced asthma related emergency department visits by more than 30 percent. It has also reduced asthma related hospitalizations and increased the percentage of patients using controller medications.


Providers and community-based organizations may also have their own case management services. MCO services are unique in that they are available upon request and not linked to

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This 24/7 availability of case management services is especially important for the MassHealth population since members often show up to different facilities that may not be in the same network. The MCOs can track members across facilities and providers and provide appropriate case management services.

The Working Group agreed that case management provided at both the plan and provider level can be duplicative, but plans and the providers have different capabilities, which should be optimized to provide high quality patient care and prevent member confusion. As the healthcare market continues to change, hospitals and plans should work together to bring down spending and share case management responsibilities. Boston Medical Center and Boston Medical Center HealthNet Plan are currently piloting such a program.¹¹²

It can be difficult to quantify the success of case management outside of anecdotal experiences, but these services are incredibly important for complex, high-need patients like those enrolled in MassHealth.¹¹³ In the face of increasing Medicaid budgets and unexpected costs, these valuable services are vulnerable to being crowded out if rates are insufficient.¹¹⁴

Section 5.3: Behavioral Health Subcontracts

Nationally, Medicaid is the largest payer of behavioral health services in the United States.¹¹⁵ Physical and behavioral health systems have traditionally operated separately, which can lead to gaps in care, inappropriate care, and increased costs.¹¹⁶ Many Medicaid managed care programs nationally include behavioral health services in their contracts, but behavioral health services are often provided on a fee-for-service basis or “carved-out” to a separate organization. State Medicaid programs carve out behavioral health services because they can be difficult to include in managed care programs due to concerns about access and payment under managed care, the existence of long-standing relationships, and network limitations.¹¹⁷ Both public and private payers are working towards more integrated, patient-centered care.

¹¹¹ Christopher Gorton Testimony at MCO Public Hearing, July 16, 2015.
¹¹² Susan Coakley at Medicaid Managed Care Working Group Meeting, September 3, 2015.
¹¹³ Meeting with Neighborhood Health Plan on September 8, 2015.
¹¹⁴ Christopher Gorton Testimony at MCO Public Hearing, July 16, 2015.
In Massachusetts, MCOs are responsible for behavioral health services as it is a covered service included in the capitated payment. Many MCOs in Massachusetts “carve-out” behavioral health services to a behavioral health vendor, as does MassHealth. These vendors provide expertise in behavioral healthcare management, often co-locating their case management departments so behavioral health providers can work alongside medical case management teams.\textsuperscript{118} Even if the MCO uses a behavioral health vendor to provide services to members, the MCO must certify annually that they, as well as any contracted behavioral health vendors or third party administrators, are in full compliance with mental health parity laws and regulations. Any areas of non-compliance must be identified and a corrective action plan proposed to bring those practices into compliance. The MCOs submitted reports earlier this year to MassHealth for the 2014 year. MassHealth certified all MCOs were in compliance on July 1, 2015.\textsuperscript{119}

\textsuperscript{118} Beacon Health Options, Integrated Care at the Practice Level, \url{https://www.beaconhealthoptions.com/services/integrated-care-at-the-practice-level/} & email communications with the Massachusetts Association of Health Plans on September 14, 2015.

Chapter 6: Alternative Payment Methodologies & Taking on Risk

Massachusetts is moving towards a more value-based payment and care delivery system including increased adoption of alternative payment methods (APMs) and development of accountable care organizations (ACOs). Chapter 224, a health reform law passed in 2012 addressing cost and quality of care, included a strong preference for alternative payment methods in both the public and private sector. The law set specific targets for APM adoption by MassHealth and encouraged private plans to reduce the use of FFS payments.\textsuperscript{120} The new Administration is currently involved in a major stakeholder process to develop alternative payment models in the MassHealth program that promote integration and coordination of care to reduce siloes, improve care coordination, enhance population health, and take on financial accountability for total cost of care.

Alternative payment methods are payment methods used to reimburse providers for healthcare services that are not solely on a FFS basis. Examples include global payment, bundled payment, and supplemental payments with the goal being to incentivize quality and efficiency in care delivery instead of service volume. Global payments, the most common in the commercial market, establish a spending target for a comprehensive set of healthcare services delivered to a specific population during a defined time period.\textsuperscript{121} In this arrangement, some of the financial risk may shift to the providers. Bundled payments, another kind of APM, reimburse providers for care over a defined health episode like knee surgery or pregnancy. Other APMs include supplemental payments PMPM for care coordination or infrastructure, or payments made to a patient centered medical home.

Several payment methods can exist within one delivery system. MCOs are a great example since MassHealth pays the MCOs by capitation or global payment, one payment PMPM to provide services, and the MCOs contract with providers for services either FFS or through an APM contract. Other states have built supplemental payments into MCO contracts or withheld a portion of the capitation payment contingent on the MCOs achieving certain quality or performance metrics. The MCOs can build APMs in their contracts with providers; however there is wide variation in provider readiness to take on risk. Different types of alternative payment models are appropriate for different practices. Additional resources may be necessary to increase APM adoption including enhanced data analytics and investments in infrastructure.

\textsuperscript{120} Blue Cross Blue Shield of Massachusetts Foundation. (2012). Summary of Chapter 224 of the Acts of 2012, 6-7, \url{http://bluecrossmafoundation.org/sites/default/files/download/publication/Chapter224Summary_2.pdf}

Section 6.1: Alternative Payment Method Adoption

MCOs in Massachusetts are all at different stages in their adoption of APMs. Overall, MCOs had 24.6 percent adoption of APMs in 2012, 32.1 percent in 2013, and between 4 and 74 percent in 2014. The average percentage of APM adoption fell for most MCOs from 2013 to 2014 but the number of members under APMs actually increased slightly, at 0.7 percent. The MCOs explained that APM adoption rates slowed this past year due to expanding membership in new geographic areas, the enrollment of more members under ACA expansion provisions, and a shift in members to MCOs from discontinued forms of coverage. In the commercial market, adoption of APMs increased slightly over the past few years, but also leveled off recently. In 2014, APM adoption increased to 38 percent from 34 percent in 2013.

Figure 6.1: APM Adoption by MassHealth MCOs

Note: “other, non-FFS” includes other types of alternative payment methods like patient centered medical homes

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124 Ibid.
125 Ibid.
In 2015, for the first time, CHIA collected information about the nature of risk arrangements. Providers in the MCO network were less likely than providers in the commercial market to engage in a contract with both upside and downside risk. Slightly more than half of the MCO global budget membership uses this type of risk contract.\textsuperscript{126}

\textbf{Pennsylvania Pay-for-Performance MCO Program}

There are several ways in which APMs can be incorporated into the MCO market. Pennsylvania has a pay-for-performance program for their MCOs. The program has two components: 1) the MCO program, which was implemented in 2005 and 2) a newer provider program that is executed as a pass-through from the MCOs. The MCOs are required to participate in both programs.

MCOs earn rate increases based on performance improvement assessed through quality measures. They can earn up to 1 percent of their PMPM revenue based on how they compare to national HEDIS quality measure benchmarks and an additional 0.5 percent based on improvement from the previous year. In 2008, Pennsylvania implemented a penalty for MCO performance below 50 percent of the national Medicaid benchmark. This change incorporates downside risk into Pennsylvania’s MCO contracts.

The provider pay-for-performance program is operated by the MCOs, who reward providers based on quality measure performance and improvement. State funding for the program is $1.00 PMPM, which must be returned if it is not passed through to providers. The MCOs cannot keep any portion of this for administrative costs. The state decides which performance measures will be included but the MCOs can include additional measures in the contracts.

In the past few years, the MCOs have earned about half of the 1.5 percent potential. Higher earnings in the initial program years are likely due to addressing “low hanging fruit” with more difficult improvements remaining. The state has worked in new areas of performance measurement into the program with input from the MCOs.


\textsuperscript{126} Ibid, 21.
Section 6.2: Challenges to APM Adoption

As MCOs and providers work together to implement APMs, the Working Group examined a few common challenges to adoption. Provider readiness, including infrastructure and small panel size challenges, funding, and membership issues, were the most discussed. Many Massachusetts healthcare providers are ready and able to engage in new APMs, but others are not ready for a variety of reasons and looking to progress by obtaining necessary information technology (IT) infrastructure, increasing data analytic abilities, adding staff related to care coordination and patient education, and establishing new relationships with other providers. Additionally, MassHealth is largely a FFS model and MassHealth members are not locked in for any period of time. The Working Group heard testimony that it is difficult for providers to engage in an APM arrangement with the MCO networks because the MCOs are concerned about the ability to coordinate care in a population that can move so freely.

Providers need a strong infrastructure to support APMs, including financial reporting and data collection, as well as sufficient panel size. All MCOs are providing patient level data to their providers, but there are varying levels of data capabilities at the provider level. Many providers do not have the existing infrastructure to handle new reporting requirements or the funding necessary to obtain those capabilities. Timely access to data is essential and providers must have strong IT systems to both receive and analyze large data sets. Electronic medical record systems are incredibly expensive and smaller providers especially struggle with affordability and implementation. Providers also express concerns about upfront costs and scalability of current pilot programs. Lastly, many providers are simply not confident about their ability to maintain profitability. There is a huge range in provider capacity, experience, and confidence.

Regardless of the challenge, the Working Group members agreed the key to increased alternative care model adoption is acknowledging the fact that providers are not all the same and you must meet them where they are. There is no one size fits all option and providers need to be assured that they will have adequate data and support from MassHealth and the MCOs. Providers have expressed it is difficult to have one “foot” in FFS and one in APMs, but all agree it will be worse for the system if the transition happens badly. A recent report from the Health Policy Commission found that the majority of community hospitals stated they are three to five years away from having half of their business under risk arrangements. Adjusting to new payment methods and care delivery models takes time.

Both commercial plans and the MCOs are making progress in their support of providers and all stakeholders should continue to encourage increased adoption of APMs.
Chapter 7: The Future of MCOs in the Commonwealth

Under new leadership, MassHealth is undergoing a significant redesign effort that will incorporate new models for care delivery, emphasize value-based care with aligned incentives, and utilize MassHealth’s market power to push the envelope on health reform.

From May 2015 to July 2015, MassHealth held a series of public stakeholder listening sessions to seek input from MassHealth members and the public. Executive Office of Health and Human Services Secretary Marylou Sudders testified that MassHealth’s priorities for reform include customer service experience, payment, behavioral health, and long term services and supports. In addition to those policy areas, Secretary Sudders indicated that improving the eligibility system and integrating behavioral health are also priorities.\textsuperscript{129} Longer term goals for MassHealth include exploring a competitive bidding process, linking customer satisfaction and cost to performance, moving away from FFS to value-based care, exploring enrollment options, and technological and structural changes to accomplish these goals.\textsuperscript{130}

Section 7.1: MCO Involvement in Accountable Care Organizations

MassHealth redesign discussions have focused on accountable care organization (ACO)-like models of care but the role of MCOs is still unclear. ACOs assume responsibility for the care of a defined population. ACOs take on financial risk and also potential rewards for effectively coordinating and managing patient care. Like MCOs, ACOs are accountable for healthcare costs and quality.\textsuperscript{131} At the time of this report, MassHealth is conducting stakeholder engagement sessions to design these new ACO-like models of care. While MassHealth leadership has alluded to potential design ideas, there are still few specifics as to what MassHealth will look like in the future.

Nationally, there are a variety of models that incorporate MCOs into health reform. A few states have chosen to completely eliminate traditional MCOs, in favor of ACOs that include both MCO and providers. Several states have eliminated direct FFS Medicaid coverage and instituted all-MCO programs.\textsuperscript{[3]} Other states have maintained MCOs but held them to additional, performance-based measures to help keep costs down and promote quality of care. The Working Group reviewed some of these models but did not conclude that one or more would be applicable to Massachusetts.

A. Minnesota Integrated Health Partnership

\textsuperscript{129} Secretary Sudders Testimony at MCO Public Hearing, July 16, 2015.
\textsuperscript{130} Assistant Secretary Tsai Testimony at MCO Public Hearing, July 16, 2015.
\textsuperscript{[3]} Navigant, 25.
Minnesota’s Integrated Health Partnership (IHP), a Medicaid demonstration project implemented in 2013, builds on existing patient-centered medical home initiatives and aligns with commercial ACOs as well as Medicare’s Shared Savings Programs. The program includes Medicaid beneficiaries in both FFS and managed care. The IHP created Medicaid shared savings arrangements with provider organizations under two options offering upside risk only or upside and downside risk, depending on panel size. The providers are held accountable for the cost of caring for their patient panel for a core set of services.

The program selected both clinical and patient experience quality measures that are tied to payment. It is important to note that 35 to 45 percent of claims incurred are excluded from covered services including long term care, dental, transportation, and mental health and substance abuse services. The MCOs were required to participate alongside the state in shared savings contributions based on the number of managed care lives. MCO continued to provide customer service to members, pay claims, manage the network, and continued to hold financial risk as they had before. The approach allows flexibility for care innovations by letting providers choose their own focus, and smartly piggybacks on Medicare Shared Savings Program. In the first year of the demonstration, the program spent $10.5 million less than projected and expects to add to its 145,000 members in 2015.

B. Oregon Coordinated Care Organizations

In 2012, Oregon passed a bill establishing the Coordinated Care Organization (CCO) payment model. CCOs are community-based organizations governed by local partnerships of healthcare providers and other stakeholders that are responsible for health outcomes and assume financial risk for the population they serve. CCOs provide integrated care by providing physical, behavioral, and oral healthcare to members. By November of 2012, there were 15 CCOs serving around 90 percent of Oregon Medicaid members.

Using “hot-spotting”, the CCOs identify individuals with high utilization, the hot spots, and work to find the root cause. Care specialists are embedded in the primary care process to work on non-medical factors that have a great impact on health but are out of the reach of physicians. Care specialists might go grocery shopping with a diabetes patient or buy an air

132 Health Management Associates, Appendix A.
134 Dybdal, 19
135 Ibid.
138 Dybdal, 22
conditioner for a patient with congestive heart failure to keep them out of the hospital when
the temperature rises.\textsuperscript{139} There non-medical interventions can have a big impact.

Prior to the creation of CCOs, about 80 percent of Oregon’s Medicaid population was
served by MCOs. The state contracted with MCOs separately for behavioral health and
dental services. CCOs were started as new organizations but Oregon allowed MCOs serving
the Medicaid population to transition to CCOs as long as they met the CCO
requirements.\textsuperscript{140} Many MCOs became a local partner in a CCO or contracted with the
CCOs to provide care. Oregon viewed leveraging MCO infrastructure including claims
processes, provider contracts, and other back-office functions, as essential to launching
CCOs so quickly.\textsuperscript{141}

Oregon created a quality incentive pool out of which providers were given incentives for
making specified progress towards or meeting quality benchmarks. A Healthcare
Transformation Center was created to provide organizations with support and guidance as they moved to this new care model.\textsuperscript{142}

Oregon was the first state to move its entire Medicaid population into this kind of coverage.
One year results show that primary care utilization increased 18 percent, emergency
department utilization fell 9 percent, and hospitalization for adult asthma fell 14 percent.
Oregon was able to achieve a decrease in overall Medicaid spending growth by more than 1 percent in the first year.\textsuperscript{143}

MassHealth will be negotiating with CMS regarding Year 4 and Year 5 of the Section1115
Wavier. This may be an avenue to incorporate MCOs into new care delivery and reform
ideas.

\textsuperscript{139} Gebhart, F. (2014). Oregon Coordinated Care Organizations Prove Cost Savings, Modern Medicine Network,
http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-
executive/content/tags/accountable-care/oregon-coordinated-care-organizations-pro?page=full
\textsuperscript{140} Health Management Assoc, Appendix A.
\textsuperscript{141} Dybdal, 24
\textsuperscript{142} Ibid, 24
\textsuperscript{143} Gebhart
Chapter 8: Recommendations

Based upon extensive research and stakeholder engagement, several areas of consensus emerged for the Working Group. The Working Group identified key areas for health system reform, as well as specific recommendations for MassHealth to consider in their redesign efforts. Below are the recommendations of the MCO Working Group.

1. Change enrollment policies to improve stability and incentivize plan performance

   **Switch MCOs members to longer enrollment cycles**

No matter was discussed more in-depth than the issue of churn. Churn affects the plans’ ability to manage population health effectively and also influences provider willingness to take on risk through alternative payment methodologies. The majority of churn is due to changes in eligibility, including changes in employment status, income level, and third party insurance coverage. While these individuals would not be affected by any policy changes to reduce member movement, the 4 to 10 percent of MCO members who switch plans voluntarily have a big impact across the MassHealth managed care program.

The Working Group recommends that MassHealth move to monthly enrollment cycles at a minimum and consider quarterly or annual enrollment. Members enrolled in a MassHealth MCO would not voluntarily be able to switch plan sat any time, but would be required to wait until the end of the enrollment cycle. The capitated rate would continue to be calculated per member per month and paid out per member per day so that MassHealth can still pro-rate the payment in the event a member becomes ineligible mid-cycle. For the MCOs, longer enrollment periods would lead to less frequent enrollment processing activities and decrease discrepancies concerning payment. It is important to note that this policy only targets those members who switch plans voluntarily. There will still be some unavoidable churn due to eligibility changes, given the volatile nature of Medicaid eligibility.

The Working Group recommends that MassHealth work with patient advocates to ensure adequate patient protections. The new enrollment policy should maintain member choice and include events under which a patient can make changes regardless of the enrollment cycle, while at the same time giving the plans and providers more stability. For example, patients should be allowed to move plans if, due to plan changes, the patient’s provider is no longer in network.

Additionally, longer enrollment periods would better align with CarePlus, the new plan created to expand Medicaid under the ACA, and ConnectorCare. If an individual’s income
changes, thereby shifting eligibility to either CarePlus or a subsidized Health Connector plan, aligned enrollment will help streamline the transition for both plans and the patient.144

*Adopt alternative algorithms for managed care auto assignment*

Each year, MassHealth sets thresholds for each MCO plan membership and uses auto assignment algorithms to assign members who do not choose a plan to the different MCOs. Auto assignment is one of MassHealth’s best policy tools to incentivize the MCOs to maximize performance. The MCOs have stated that people who do not choose a plan are often healthier, so plans want these members, as they are paid the same capitation rate for every member. These members financially benefit the MCO.

Depending on plan performance, MassHealth could use auto assignment to reward high performing MCOs with more members.145 MassHealth has made recent changes to the auto assignment algorithm including assigning patients back to their previous plan if they fall off coverage for a period of time and then re-enroll. MassHealth has stated they will institute a more equitable auto assignment methodology that favors high performing plans.146

Starting on October 1, 2015, MassHealth will maintain the 50/50 split between the PCC and MCO plans. The Working Group understands the necessity to keep the status quo while MassHealth rethinks the MCO contracts for 2017. However, as MassHealth moves forward with its redesign efforts, MassHealth should consider a variety of auto assignment algorithms. The Working Group urges MassHealth to use its flexibility in the redesign process to select an attribution method that best aligns with the goals of health reform and Chapter 224 to ensure coordinated, cost effective care.

2. **Formalize transparency around MassHealth rate setting process**

While lack of transparency and avenues for collaboration were cited as problems in the past with the rate setting process, the new Administration has done a commendable job in providing the MCOs with information on the actuarial calculations and data that goes into the rates, while also giving sufficient opportunities for comment and feedback. Rates should be actuarially sound and fall within a range that fully accounts for the costs of coverage with appropriate incentives for efficiencies.

The Working Group recommends that MassHealth formalize this process to ensure that rate setting will remain transparent in the future, regardless of changes in leadership. The Working Group would also like to emphasize the need for up to date MCO and patient data

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144 Email communications with MassHealth on July 9, 2015
145 MassHealth Payment Policy Advisory Board and Medical Care Advisory Committee, September 25, 2015.
146 Ibid.
for the actuarial analysis. This will result in a rate that is more responsive to market trends. This can be facilitated by better data infrastructure.

3. Implement more rigorous data sharing and reporting policies

*Require annual public reporting of MassHealth*

The Working Group successfully collaborated with the MCOs and with MassHealth to gather necessary data for this report. However, without a consistent public source for this information, it was time-consuming and challenging to understand the full picture of MCOs in Massachusetts and to understand the performance of the Medicaid program as a whole. This is information that should be readily available.

The Working Group recommends MassHealth make available each year the most recent MCO data. At a minimum, this data should include financial information, enrollment statistics, and member demographics. MassHealth should continue regular reporting of quality measures. While it is outside the scope of this report, MassHealth should prepare an annual report on all their programs.

*Implement enhanced data analytics and information technology between MassHealth, MCOs, and providers*

While an often repeated requirement for more efficiency and progress towards health reform goals, it is imperative that timely, accurate, and actionable data is shared between and among MassHealth, the MCOs, and providers. Accurate, real-time data is essential to patient care management and patient care coordination, especially for providers who assume clinical and financial risk for their patients. While the MCOs each have their own sophisticated data capabilities and regularly submit information to MassHealth, there are gaps in what information is shared and the level of sophistication varies. Additionally, even when plans do submit timely data, it is often not in the same format, which prohibits MassHealth from making comparisons across plans.

MassHealth requires all MCO plans to regularly submit data as outlined in the MCO contracts but they do not harshly enforce these provisions. To help plans comply, MassHealth included $3 million into the 2016 rates to promote increased data sharing compliance. The data elements MassHealth will require in order for plans to receive an increased payment have yet to be determined.\(^{147}\) If the new CMS Medicaid rules are adopted, MassHealth may have to forcefully require data submission requirements. The

\(^{147}\) Ibid.
new CMS rules mandate additional, uniform reporting to CMS. MassHealth cannot effectively comply without consistent and accurate MCO reporting. 148

As much as possible given privacy laws, MCOs and providers who assume any level of Medicaid risk should be given access to members’ MassHealth claims history, regardless of whether they were previously in a FFS program or another MCO. Especially with members who switch plans frequently, it is important for an MCO and providers to better understand a new patient’s history to determine how best to manage his or her care and predict and plan for patient costs. 149 This should include medical, behavioral health, and pharmacy records, as well as any interactions with other EOHHS agencies, such as the Department of Mental Health and the Department of Transitional Assistance.

Providers will need to invest in data and analytic capabilities, but MassHealth and the MCOs must be able to give providers timely and detailed information about their patients, performance, costs, and trends that impact case management and savings initiatives. There needs to be an infrastructure in place for MassHealth to analyze data and present it in a meaningful and actionable way for MCOs and providers to successfully coordinate and manage care for their patient panel, while also monitoring utilization, cost, and care trends.

Accurate, timely, clean data is also incredibly important as the state begins to move to an ACO model. It is unclear exactly what these new care delivery models will look like but they must have access to good data in order to effectively manage care.

*Leverage data sharing among state agencies*

To minimize redundancy and streamline data sharing between various entities and agencies, the Working Group suggests a thorough review of all reporting requirements between MassHealth, CHIA, and the MCOs.

MassHealth and CHIA need to work together to ensure that MassHealth data is shared with CHIA in a more timely fashion. This will eliminate duplicative reporting and augment CHIA’s ability to provide additional analysis to MassHealth. It will also allow CHIA to paint a more comprehensive picture of healthcare costs and trends in their annual report on healthcare system performance.

While CHIA data may not be appropriate for real-time operational management of the MCO program (primarily due to the timeliness of data), MassHealth and CHIA need to work together to identify ways to maximize the value of CHIA data and further the cause of administrative simplification.

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148 Meeting with MassHealth on September 1, 2015
149 Health Management Associates, 19
The Working Group recommends that MassHealth and CHIA meet to review reporting requirements, data sharing protocols, and deadlines before December 30, 2015.

4. **Explore strategies to address the impact of innovative drugs and technologies**

Patient access to effective, innovative therapies is a priority for the Commonwealth. Cost effectiveness research can be a useful tool to determine what treatment is best for the patient considering the cost relative to the medical benefits. That is, certain therapies that require upfront investments may, over the long term, decrease overall healthcare costs associated with acute or chronic diseases. This is an important consideration when the upfront cost of a treatment or a drug is substantial. Cost effectiveness data is a missing tool for providers and policymakers to make good decisions about whether a new therapy is a worthwhile alternative to current treatment options. The Working Group recommends learning more about how cost effectiveness research can be used to craft better care protocols for the MassHealth population, as well as the broader commercial market.

Based on research discussed previously in this report, it is unlikely that Massachusetts will be able to find significant savings in bulk purchasing on its own. However, a partnership with other states may give Massachusetts the market leverage to secure reduced prices for select innovative therapies and technologies. The Working Group recommends assessing the feasibility of such a partnership and for what drugs this might be a beneficial practice.

The Working Group also recommends that MCOs, MassHealth, providers, and other stakeholders meet regularly to discuss new and upcoming drugs and therapies. The MassHealth Technology and Pharmacy Committee could collaborate on best practices, use guidelines and any challenges surrounding the introduction of new drugs or technologies into the market.

5. **Urge MCOs and providers to adopt alternative payment methodologies**

The Working Group reaffirms the importance of transitioning to APMs to align incentives, bring down costs, and improve patient outcomes. Chapter 224 set high expectations for APM adoption, which the Commonwealth has not been able to meet at this juncture. The stagnant adoption of new payment methods is disappointing. While we recognize that changing the way we pay for healthcare is a difficult process that requires major changes, providers and payers must continue to push to a value-based payment methodology. Chapter 224 has been in effect for two years but we must persistent in our efforts. The Working Group recommends continued efforts to support APM adoption.
6. Examine medical loss ratio to eliminate ambiguities

The Working Group engaged in an extensive discussion about MLR. Assessing MLR encourages plans to strike a favorable balance between medical and administrative spending in order to minimize waste, maximize resources, and ensure the best possible health outcomes. However, MLR is not a well-defined concept, and as a result, the process of measuring and calculating MLR lacks clarity.

In particular, it remains unclear whether investments in IT or infrastructure should be categorized as quality improvement and whether case management should be considered medical or administrative spend. For MLR to encourage efficient spending and investment, plans need more explicit guidelines on what factors to consider and how to weigh them. Increased transparency of this measure will allow MLR to be a better indicator of medical and non-medical spending and guarantee consumer dollars are spent appropriately.

There was no clear consensus among Working Group members as to how to remedy these issues, but in general, members agreed that it is important to increase clarity and standardize the methodologies used to measure MLR. To avoid these ambiguities, the Working Group recommends that the Division of Insurance re-examine MLR and strive to define it more explicitly.

Consider the following topics for further discussion

The Working Group had lengthy debate on both risk adjustment and price variation. Risk adjustment is an important part of the rate setting process. This process takes into consideration circumstances that affect the cost of care, including geographic location and patient acuity. While there is much to discuss when considering different risk adjustment methodologies, this was beyond the expertise of the Working Group.

Another important topic covered by the Working Group is price variation. This is a topic that has been at the forefront of many recent healthcare discussions. The Working Group also found it to be a topic of much disagreement. There are many reasons for provider reimbursement variation, including the dynamics between MassHealth, the commercial market, the provider market power. This issue proved too intricate for in-depth conversation given the timeline of this Working Group. This is an issue that MassHealth should address as part of their larger reform effort.

While members were unable to fully consider these issues, both topics warrant further investigation.

Finally, the Working Group encourages MassHealth to survey other state managed care programs for additional efficiencies and best practices to improve quality, cost effectiveness,
and customer service for patients, payers, and providers. These managed care program improvements can be accomplished in tandem with MassHealth’s system redesign.
Appendix A: List of the MCO Working Group Members

The Working Group members are as follows:

Legislators
1. Representative Jeffrey Sanchez, Chair
2. Representative Ronald Mariano
3. Representative Garrett Bradley
4. Representative Lori Ehrlich
5. Representative Paul Brodeur
6. Representative Jay Barrows
7. Representative Mathew Muratore

Industry Stakeholders
8. MA Council of Community Hospitals Executive Director Steve Walsh
9. Massachusetts Hospitals Association Executive Vice President Timothy Gens
10. Steward Healthcare Executive Vice President David Morales
11. MA Biotechnology Council President & CEO Robert Coughlin
12. Tufts Network Health President Christopher Gorton
13. Boston Medical Center HealthNet President Susan Coakley
Appendix B: List of Organizations at MCO Public Hearing

MCO Public Hearing Testimony

- Health Law Advocates
- American Nurses Association
- Fallon Health Plan
- Massachusetts Association of Health Plans
- Tufts Plan – Network Health
- Massachusetts Medical Society
- Association of Behavioral Health
- League of Community Health Centers
- Health New England
- Commonwealth Connector Authority
- Secretary of Health and Human Services, Marylou Sudders
- Healthcare For All
- Boston Medical Center – HealthNet Plan
## Appendix C: MassHealth Capitated Rate Structure & Risk Mitigation Tools

### Overview of MassHealth Payment Provisions for MCOs

<table>
<thead>
<tr>
<th>Capitation Rate Structure for Medicaid Only MCOs, Under 65 Years of Age</th>
<th>MassHealth Standard</th>
<th>MassHealth CarePlus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rating Category</strong></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Covered Populations</strong></td>
<td>Includes Temporary Aid to Needy Families (TANF), and Aid to Families with Dependent Children (AFDC)</td>
<td>Includes persons with disabilities</td>
</tr>
</tbody>
</table>

### Use of Risk Mitigation Tools

- **Risk Adjustment**: MassHealth uses a DxCG risk adjustment model to adjust the base capitation rates paid to MCOs for the risk of its enrollees. Using the DxCG system, MassHealth assigns a risk score to each individual that is based on the diagnosis recorded on the inpatient and outpatient records for the individuals. (This cannot be done for new populations if there are records to use.) The individual scores are used to develop a composite score for each rating category served by each MCO.

- **Reinsurance**: Contract silent. MassHealth requires MCOs to purchase reinsurance from MassHealth or from commercial carriers.

- **Risk Corridors**: MassHealth has three risk corridors for the MCO program and they apply to all rating categories. It is important to note that risk corridors only apply to the medical component of the capitation rates.
  - Risk corridor 1: MCOs at 100% risk of gain or loss between 97% and 103% of the rate.
  - Risk corridor 2: MCOs are at 50% above or below 3% through 20% of the rate.
  - Risk corridor 3: MCOs are at 100% risk of gain or loss beyond 20% above or below the rate.

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Note: RC1 includes Family Assistance and RC2 includes CommonHealth MassHealth now requires reinsurance in all MCO contracts

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<sup>150</sup> MMCO Primer pg.11
Appendix D: Glossary

Accountable Care Organizations (ACOs): Definitions vary, but in general ACOs are provider-based organizations compromised of different types of collaborating providers that assume responsibility both clinically and financially for a defined population.

Alternative Payment Methodologies: Payment methods used by a payer to reimburse providers for healthcare services that are not solely on a fee-for-service basis. Examples: global payment, bundled payments, and shared savings.

Bundled Payment: A provider is compensated per patient for a predetermined amount of time for a defined set of services or diagnosis. Payment can be episode based, for a particular health event, or global, for one patient for a defined period of time.

Capitation: A per person per month (PMPM) payment made to providers or contractors for services, regardless of how many services the member actually receives. See Global Payment.

Fee-for-service (FFS): The providers are paid directly for each service rendered.

Global Payment: A fixed payment for the total cost of the care of a member or for the total cost of care for a population (global budget) over a defined time period. This may also be referred to as capitation. See Capitation.

Medical Loss Ratio: As established by the Division of Insurance, the sum of a payer’s incurred medical expenses, expenses for improving quality, and their expenses for deductible fraud, abuse detection and recovery services, all divided by administrative expenses (different in premiums minus taxes and assets).

Rating Category: An identifier used by the Executive Office of Health and Human Services (EOHHS) to identify a specific grouping of enrollees base on assignment plan and disability status, as determined by EOHHS or the Social Security Administration, for which a discrete capitation rate applies pursuant to the contract.

Shared Savings/Risk: This approach allows providers to retain a portion of savings generated from better management of care for a given population and a defined set of services. Savings are calculated based on established spending targets. Downside risk may be incorporated requiring providers to share in losses, meaning make payments back to the state, if spending is higher than the target amount.
Appendix E: Public Hearing Testimony

Testimony by Marylou Sudders, Secretary of the Executive Office of Health and Human Services, and Daniel Tsai, Assistant Secretary for MassHealth

Secretary Sudders opened by stating that the Working Group and MassHealth share the same mutual goal: a sustainable, patient-centered future for MassHealth and MassHealth MCOs. She discussed the membership of MassHealth, which serves 1.8 million Massachusetts residents, 25 percent of population. This population consists of the most vulnerable citizens, and it is not a homogeneous population. MassHealth is currently growing at an unsustainable rate and takes up almost 40 percent of Commonwealth’s budget.

The lack of a functioning Health Connector website in the 2014 and 2015 calendar years negatively impacted enrollment, healthcare costs, and administrative resources. Consequently, the redetermination process had to be suspended while the Health Connector failures were addressed. On redetermination, MassHealth is currently halfway through their backlog. 78 percent of those contacted have responded to the redetermination process, and the vast majority of respondents are still eligible. Only 2 percent of respondents are ineligible for MassHealth or subsidized coverage through the Connector.

MCOs have struggled financially, but this is changing. Currently, 5 out of the 6 MCOs are profitable or breaking even. Appropriate and improved rate setting processes should continue this trend. In improving the rate setting process, MassHealth is working with the health plans on many topics, including risk adjustment and specialty drugs. MassHealth is also taking a look at best practices in other states. They are funding rate increases for behavioral health and looking into process improvement and savings opportunities. On the topic of churn, Massachusetts is unique among states in allowing members to switch plans on a daily basis. There is discussion around changing this policy to increase stability for MCOs while continuing to protect continuity of care and preserving choice for consumers. Churning is largely a function of member enrollment fluctuations driven by changes in eligibility, as opposed to voluntary choice. In calendar year 2014, 36 percent of members “churned” with only 6 percent of members voluntarily changing their plan. MassHealth recognizes that MMCOs are important to the future of the MassHealth.

Assistant Secretary Tsai discussed the context of MCOs, MCO program improvements, the scope of MCO services, and MCO contract rates. MassHealth is currently engaging other states in conversations to determine best practices around rate setting. The 5-year contract between MassHealth and the MCOs is coming to an end. MassHealth is extending the current contracts by one year. In the short term, MassHealth is engaging actuaries and updating them on key topics, including the risk pool, which reflects a higher acuity population, the specialty drug trend, and changes to the risk adjustment process. Over the
longer term, MassHealth hopes to develop a more competitive bidding process that focuses on quality and member satisfaction, enhance auto-enrollment, and enhance member enrollment options. The goal is to move away from the volume-driven FFS payment model toward a model that incentivizes value and quality of care where providers to come together to address health issues, such as reducing hospital readmissions.

The Secretary and Assistant Secretary also submitted written testimony to the Working Group. Highlights from that written testimony not mentioned in the public hearing are outlined below:

- In addition to meeting the federal requirement to eliminate the backlog of 1.2 million redeterminations by the end of calendar year 2015, major MassHealth priorities include: improving customer service for members and providers; improving their eligibility systems and operations; integrating behavioral health and physical healthcare; implementing better care delivery and payment models focused on value and person-centered care; and improving care for members with disabilities
- MCOs assume responsibility for a wide range of, but not all, services for their members. Traditional and CarePlus MCOs cover physical health, behavioral health and pharmacy services while MassHealth directly covers some “wrap” services, transportation, dental and long term services and supports on a fee for service basis. The SCO and One Care plans, which serve elder and disabled members who are typically also covered by Medicare, cover the full range of Medicare and MassHealth Services.
- Design improvements MassHealth plans to incorporate into their next MCO procurement include:
  o A more competitive bidding process that rewards plans with higher quality, higher customer satisfaction, and better cost effectiveness
  o Member enrollment options that address plan stability and member choice
  o Different risk adjustment methodologies
  o Timing of claims lag and other data
  o The level of data provided
  o Approaches for high cost specialty drugs that are on the horizon
- Included in the goals stated in the oral testimony, MassHealth plans to implement reforms that enhance fairness of the rate setting process. These reforms include updated changes in the member mix due to redeterminations, updated forecasts in the growth of pharmacy and high cost specific drugs, and other adjustments to the risk adjustment process. They will be requiring and funding rate increases for behavioral health in these MCOs in acknowledgement of the disparity and inadequacy of the current rates.
- Voluntary disenrollment in MassHealth plans ranges from 4 percent to 11 percent among the MCOs.
Chairman Sánchez inquired about the new CMS proposed regulations and how they might impact MassHealth programs. Assistant Secretary Tsai explained that some of the regulations relate to the actuarial process, while others are very technical, such as regulations related to medical loss ratio requirements and reporting. Overall, these regulations are in concordance with the goals and efforts of MassHealth. When asked about daily, monthly or yearly enrollment processes, Secretary Sudders stated that in order to grant the plans some level of stability, there will be some adjustments. At the moment, the amount of people moving between plans ranges from 4 percent to greater than 10 percent of the population. Before jumping to conclusions, MassHealth wants to see why people are changing plans. Secretary Sudders reiterated that there needs to be a balance between health plan stability and patient choice.

Testimony by Louis Gutierrez, Executive Director of the Health Connector, and Ashley Hague, Deputy Executive Director of Strategy and External Affairs for the Health Connector

Director Louis Gutierrez began his testimony by describing the context of the Health Connector. The Health Connector began working with MCOs in 2006. After a three year exclusivity period for the MCO plans, the Connector launched a competitive procurement strategy. MCOs with favorable cost structures were able to grow, as MCOs with lower bids received higher enrollment numbers.

Commonwealth Care, for individuals with incomes up to 300 percent of the FPL who did not qualify for MassHealth, filled the gap for residents who were very low income but did not qualify for MassHealth. A new program, ConnectorCare, offers similar plan designs to former Commonwealth Care plans, but functions in the private market, not within Massachusetts’ 1115 waiver, to meet the requirements of the Affordable Care Act.

The Executive Director also submitted written testimony to the Working Group. Highlights from that written testimony not mentioned in the public hearing are outlined below:

- Many of the same MCOs offer commercial market products, and those products have been made available through ConnectorCare. This helped minimize continuity of provider issues as members continue to churn between MassHealth and Health Connector.
- While the Health Connector no longer operates its subsidized program exclusively in the MCO space, it has taken its experience with CommonwealthCare and has tried to mimic some of the procurement strategies when launching the successor program, ConnectorCare. That program similarly rewards carriers that offer lower price points with additional subsidies to make them more attractive to our members. It also encourages innovation in network and plan design to offer our members choice without increasing costs to the Commonwealth. These strategies not only keep the
ConnectorCare program affordable to the Commonwealth, but also have the added benefit of exposing strategies employed in the subsidized market to the broader commercial market, expanding opportunities for more affordable coverage to individuals and small businesses that do not receive financial assistance. In fact, the Health Connector’s enrollment for unsubsidized individuals and small businesses is highly concentrated in these plans.

Leader Mariano followed up on the topic of churn, asking for more details. Hague responded that churn within the Health Connector has been different than churn within MassHealth, and that it truly depends on how you define churn. When consumers move from MassHealth to ConnectorCare, they do not experience a lapse in insurance coverage. When consumers move in the other direction, however, consumers often have lapses in coverage due to MassHealth eligibility timelines. Both agencies are working to implement eligibility determinations in real time.

**Testimony by Suzanne Bump, Auditor of the Commonwealth of Massachusetts**

Auditor Suzanne Bump began by emphasizing the limited scope of the audit relative to the larger scope of the Working Group on MMCOs. The audit spanned 5 years (2009 to 2014) and looked at 25 million claims submitted to MassHealth. The auditing process identified 1.4 million unnecessary claims amounting to $233 million in MassHealth FFS payments that should have been covered by MCOs. Auditor Bump stated that this does not represent a failure on the part of the MCOs, but rather MassHealth. MassHealth were billed for and paid for services that they should not have paid for, resulting in $288 million in unnecessary spending. The duplicative payments are largely the result of communication errors between MassHealth and MCOs related to service coverage and payment. Additionally, there is not an appropriate system of edits in place within the MassHealth claims system to identify claims that should be paid by the MCO versus FFS. These significant management deficiencies prevent MassHealth from achieving potential cost controls.

Auditor Bump proposed some suggestions including the development of edits within the MassHealth system that would identify duplicative claims. She stated that the high rate of churning contributes to the problem of determining who is responsible for payment, whether churning is a result of eligibility changes or from voluntary switching. A simple policy change would be to deny all FFS payments for services rendered to MMCOs the first time, allowing the MMCOs to review them before submitting them again. This policy is one that is in effect in other states. When Auditor Bump approached the MCOs about this suggestion, they said it would not be a huge administrative burden. Encounter data has a lot of potential to help with issues highlighted above and increased utilization of encounter data could thus be beneficial.

**Testimony by Boston Medical Center HealthNet Plan, Karen Boudreau**
Ms. Boudreau began by describing the basic details of the BMCHP, which was established in 1997 as an MMCO. BMCHP currently accounts for 30 percent of MCO membership in MassHealth managed care. BMCHP works actively to provide high quality care to their beneficiaries and maintain a comprehensive statewide network. When considering the needs of a beneficiary, BMCHP takes into account all aspects of the individual, including behavioral health, social supports, and community resource needs. They are able to achieve this tight-knit integration of care by having behavioral health personnel and care managers sit side-by-side in the office to help manage the needs of the population.

Over the past year and a half, BMCHP has tackled the triple aim: better health, lower costs, and an improved patient experience. The health plan works to meet their most vulnerable members where they are. To illustrate this, a case study was presented about a health plan member whose lack of stable housing led to increased emergency room use due to respiratory illness. Her care management team identified and addressed barriers to care, including stable housing. Her trips to the hospital and emergency room decreased. While not all interventions are this successful, BMCHP takes a holistic approach to the individual.

Ms. Boudreau stated that there are enormous challenges within the complex healthcare system. BMCHP members don’t always know where to go. While medical providers can help them, they aren’t always able to look up the eligibility status of the patient. This ultimately adds to expenses, as well as to work for everyone in the system. BMCHP is working on these challenges.

**Testimony by CeltiCare Health Plan, Jay Gonzalez**

CeltiCare joined MassHealth in 2014 to enroll CarePlus members. CeltiCare has 47,000 members statewide, and they aim to deliver high quality, cost effective care to that population. They are attempting to accomplish this through several interventions, including integrated care management. They have developed a robust management program for their sickest members, taking a holistic view of the individual.

The most prevalent healthcare issue in their population is substance abuse. Their single greatest expenditure is methadone so one goal is effective engagement of those with substance use problems. A few of their initiatives include member connections representatives who are sent to assist high utilizers of care to help manage their care and provide social support services. Mr. Gonzalez stated that the Commonwealth should expect value from MCOs, which is something that CeltiCare has managed to do in a sustainable way with the budget they receive.

Leader Mariano noted that the CeltiCare population must be difficult to connect with and noted the consumer outreach programs described earlier. He asked how CeltiCare can measure the benefits that the outreach programs provide. Mr. Gonzalez responded that while there is no “one size fits all” solution, the members targeted by these programs are
CeltiCare’s highest acuity members. They use analytics modeling with claims data to predict who will become a high utilizer, thus target their members proactively instead of reactively. Leader Mariano what percent of their population are high acuity members. Mr. Gonzalez responded 5-10 percent of their population. In analyzing the impact of those programs, CeltiCare looks at traditional indicators, such as emergency room visits, to see if they are effective. Another common indicator used is hospital readmissions. There are a multitude of reasons why someone may be readmitted to the hospital and CeltiCare care management looks into various factors with the ultimate goal of helping the member.

Testimony by Fallon Community Health Plan, Richard Burke

Mr. Burke described the origins of Fallon, which began serving the Commonwealth in 1997 and is a not-for-profit plan that has commercial, Medicare and MassHealth plans. They are the longest running MCO in the Commonwealth. Fallon serves 30,000 individuals primarily in Worcester County.

A large issue for Fallon has been the rate setting process: rates are set once per year and making sure that the rates are actuarially sound is a complex and difficult process. Consequently, there are times when rates do not cover everything, and the resulting losses can be significant. The prime example of this is Sovaldi, the cost of which was not included in the 2014 capitation rates from MassHealth. MassHealth has made improvement in transparency and Fallon hopes for further improvements. With regard to the recent changes in senior leadership at MassHealth and their rethinking the program, Fallon is strongly supportive of public input through stakeholder meetings and the larger structural redesign. They also support the expansion of alternate payment methods (APMs) and currently have a large portion of members enrolled in programs using APMs. Mr. Burke stated that one size does not fit all and MassHealth should pursue flexible, creative APMs. Lastly, the most salient issue facing Fallon is data. It is essential for MassHealth to succeed in its work.

Testimony by Health New England, Jody Gross

Mr. Gross began by explaining that Health New England (HNE) is a 200,000+ member health plan that serves primarily western Massachusetts. They also have commercial and Medicare plans. HNE employs care managers who meet with high risk beneficiaries to coordinate and improve their care. They utilize innovative APMs, such as their enhanced primary care payment, where PCPs and behavioral health specialists work together to reduce hospital visits and inpatient care. In this model, PCPs coordinate care by helping members figure out how to take medication, or which specialists to go to, with the overarching goal of improving the health of the communities served.

There are three primary issues that HNE raised: adequate funding of MCOs; the continuity of enrollment for health plan enrollees; and the streamlining and simplification of administrative processes. HNE has specific recommendations for these three areas. First,
HNE would like to work with MassHealth-contracted actuaries to set achievable targets, and possibly look at other states for best practices. Secondly, periodic “check-ups” on the rate setting process could be beneficial in allowing MassHealth to account for discrepancies in rate-setting that occur mid-year, such as with the introduction of Sovaldi to the MassHealth formulary. HNE also wonders if MassHealth can leverage the all-payers claims database and if the reports sent by MCOs to MassHealth are being used. Lastly, it’s important to address the issue of continuity of care. When a provider comes up with a treatment plan for a patient and then the patient is in a new plan, work is lost and the system becomes inefficient. HNE encourages establishment of a minimum enrollment or lock-in period, so that each eligible enrollee would remain with the same health plan for six months to a year, in order for a care management programs to have continuity to take root. In order to expose the maximum number of enrollees to these programs, they continue to urge consideration of equitable autoassignment, by having each MCO plan and the PCC receive equal autoassignment.

Testimony by Neighborhood Health Plan, David Segal

Neighborhood Health Plan (NHP) serves 270,000 MassHealth members, of which 180,000 are in CarePlus. NHP is a leader in integrating social care, behavioral health, and physical health. NHP believes that partnership with the state is more important now than ever, but the last 18 months have been very challenging in that regard.

NHP focused on 4 issues. First, the data used in rate setting is significantly lagging and outdated. If MassHealth is to set actuarially sound rates so that MCOs can support their populations, they need to understand current data trends. The discrepancy was especially pronounced due to the enrollment spike from last year resulting from the Affordable Care Act and Health Connector difficulties. Secondly, MassHealth MCO contractual requirements may not be aligned in a way that meets the overall goals of MCOs. As an example, provider network requirements often prevent reasonable contracts from being negotiated between MCOs and medical providers. Third, reimbursement protocols for MCOs have not kept pace with new, highly effective and costly pharmaceuticals. In addressing this issue, MassHealth must consider how to fund these costly pharmaceuticals in the short-term. Lastly, NHP stated that there is opportunity to break down barriers between health plans to ultimately improve patient care. In doing so, care models can be built that leverage payers and providers to deliver patient-centered care. There is also opportunity to coordinate with community health centers (CHCs) and leverage their expertise and unique skill set in new care models.

Testimony by Tufts Health Plan – Network Health, Christopher Gorton

Mr. Gorton presented a case study to illustrate the distinction between services we are contracted to provide directly and those that are not medical but lower costs. Mr. C., a man
with behavioral health issues and diabetes, without familial support, had many hospital visits, but was difficult to locate due to his homelessness. With an outreach worker, medical director, and behavioral health worker, Tufts Health Plan – Network Health (THP-NH) was able to find him and eventually, after several failed attempts, coordinate care to deliver the services he needed. While THP-NH cannot say if he'll be fully employed, his situation has improved dramatically and he has completed an adult education program. Although extreme, Mr. C's case is not unusual. Mr. Gorton pointed out that while high cost drugs are important, care coordination is at the heart of what MMCOs do, and THP-NH is the case manager that follows patients wherever they go. THP-NH believes that this creates huge value. Last year when THP-NH spent all of their money on care, with an MLR greater than 100, there was nothing left for care management, which ultimately results in quality of care losses for the patient.

Leader Mariano asked how THP-NH measures the impact of the care coordination. Mr. Gorton stated that THP-NH uses quality measures such as inpatient stays to measure the impact. In the case of Mr. C, his inpatient stays went from 36 in the first half of the year to 0 in the second half.

Representative Barrows finished by asking if Mr. C can fit into ACO model of care. Mr. Gorton stated that Mr. C is an outlier on the spectrum of patient complexity, but that the vast majority of people can be adequately cared for in ACO model.

**Testimony by Beacon Health Options/MBHP, Christine Hager**

Beacon Health Options (BHO) is a close partner to the MMCOs, working with them to facilitate the delivery of behavioral healthcare to 1.4 million people in the Commonwealth, including 900,000 for MassHealth. Beacon provides behavioral health management expertise to the MCOs, including targeted care management and community outreach. Beacon emphasizes the importance of a continuum of care and the integration of services at both the health plan and provider level.

Beacon has several unique methods for improving behavioral healthcare management. They have developed a tool for evaluating integration of care at the medical provider level, called the integrated provider assessment tool. They developed a psychotropic drug intervention program for people receiving prescriptions from multiple providers, as a way to monitor prescriptions to that patient. Their long term behavioral health plan uses a recovery coach with life experience to make sure patients keep follow up appointments and identify necessary social supports. BMC HealthNet Plan, in partnership with Beacon, reviews high-cost high-utilizer cases to more effectively manage the care of these beneficiaries, and also has a program aimed at their homeless population, the homeless initiative program.

Chairman Sánchez inquired about the challenges related to data sharing within behavioral health. Ms. Hager stated that federal law impedes the ability for behavioral health and
physical health providers to collect data, develop metrics, and ensure continuity of care through data sharing. As such, they are hoping for a resolution on federal level. Although Beacon works with both physical and behavioral health providers in attempting to integrate the full medical record together, such efforts are difficult with the federal restrictions that are in place.

**Testimony by Association for Behavioral Healthcare, Vic DiGravio**

The Association of Behavioral Healthcare (ABH) represents behavioral health provider organizations in the Commonwealth. While there are behavioral health challenges, these providers are successful in identifying and trying to tackle problems, where other states are less successful.

ABH raised four issues that should be addressed with regards to behavioral health in the Commonwealth. First, there is a large tension between health plans and medical providers. This issue may be able to be resolved by aligning the incentives of care delivery with the goals of the system. Second, there are issues related to transparency in behavioral health in general. With regard to carving in or carving out behavioral health services, patients have positive and negative experiences with both, so determining which method to use is difficult. Regardless, if services are carved out, there needs to be transparency. Third, it is difficult working with multiple payers due to the different authorization processes, rates, and other unique factors of MCOs. ABH advocates for greater standardization across insurers. Lastly, the FY15 budget had a provision mandating MassHealth to collect the terms of behavioral health carve out contracts. MassHealth is working on this and so are the plans, but it hasn’t happened yet. This data would be very useful.

**Testimony by Massachusetts League of Community Health Centers, Jim Hunt**

The League represents and advocates for community health centers (CHCs) throughout the Commonwealth. The League first and foremost advocates for strong MCOs, since strong MCOs encourage more investment in coordination of care between the full spectrum of providers. When they are not strong, such as in the 2014 fiscal year, they are unable to invest in care coordination because the cost of medical care consumes all of their resources.

Mr. Hunt proposed several recommendations related to MCOs. First, MassHealth needs to be committed to providing actuarially sound rates that will then result in actuarially sound payments to MCOs that will allow them to expend resources for care coordination. Second, the issue of specialty drugs is complex. They are expensive, but can be life-saving, and therefore should be provided. Third, all CHCs now have robust data infrastructures that can be leveraged in changes moving forward. Lastly, the League advocates for consistent state policy changes, referencing the after-the-fact policy changes related to the Primary Care Payment Reform Initiative (PCPRI) that occurred after 17 CHCs contracted with PCPRI.
Mr. Hunt also submitted written testimony to the Working Group. Highlights from that written testimony not mentioned in the public hearing are outlined below:

- Massachusetts Community Health Centers suggest that the state:
  - Recognize and account for the expenses related to pent-up demand when the MCOs are required to enroll people whose care has not been well managed in the past, as was the case when 75,000 Medicaid patients were put into MCO-only CarePlus programs;
  - Sanction new therapies, such as Sovaldi, that are expensive, but effective;
  - Understand that with the kind of tracking and focus that the MCOs bring to the care of patients with chronic medical and behavioral health conditions, they will in time become less costly to the system, but only if they are adequately reimbursed for their services.
  - Encourage innovative community-based approaches for supporting the Patient Centered Medical Home and measuring results of care management initiatives at the local level; and
  - Develop consistent policies that strengthen confidence within the insurance and provider stakeholder communities.

**Testimony by Healthcare for All, Amy Whitcomb-Slemmer**

Healthcare For All (HCFA) is a statewide non-profit organization that advocates for the most vulnerable populations within Massachusetts. Given the time constraints, Ms. Whitcomb-Slemmer touched on highlights from their written testimony. First, she noted that none of the committee members on the Working Group are MassHealth members, and thus encouraged the Working Group to add MassHealth members to the group or engage them in discussions to hear their needs. HCFA noted that the idea of daily churning within MassHealth is a myth and that some churning may be a result of patients following their providers when providers switch plans. The Working Group may be aware of this with MassHealth members in the group. Second, MCO payments should allow for innovation in care management. Third, in beginning the second half of redeterminations, HCFA advocates that MassHealth develop a very rigorous process to reach out for non-English speakers, who may have missed out on redeterminations during the first half of the year and who are a difficult population to reach in general.

Ms. Whitcomb-Slemmer also highlighted the cost of prescription drugs. There should be care coordination to ensure that drugs are taken and used appropriately to ensure efficacy. Cost transparency is critical for improved rate setting and improved negotiation of drug rates. HCFA supports S.1048, which mandates drug price transparency.
On the issue of integration of behavioral health, HCFA advocates for the development of innovative relationships between community supports and medical providers, as well as the development of innovative payment models.

Ms. Whitcomb-Slemmer also submitted written testimony to the Working Group. Highlights from that written testimony not mentioned in the public hearing are outlined below:

- In addition to suggesting that a MassHealth member would be a good addition to the Working Group, Ms. Whitcomb-Slemmer also suggests it would be helpful to include a consumer point of view in the group as well.
- The experience of their HelpLine is that members change plans primarily to ensure that they have access to health providers they need. HCFA encourages the Working Group to examine MCO network adequacy standards and the frequency at which MCOs make changes to their provider network.
- Ms. Whitcomb suggests that dental coverage be integrated. When dental needs go untreated, it can lead to avoidable medical complications just as is true with untreated behavioral health matters.

Testimony by American Nurses Association, Myra Cacace

The American Nurses Association (ANA) represents nurses across the U.S. There are several issues they have experienced related to MCOs in the Commonwealth. First, patients do not necessarily realize that they have been assigned to a MCO when enrolling in MassHealth. Sometimes, these patients are also randomly assigned a new PCP, which they are unaware of. This can result in a delay of care provision. Second, nurse practitioners are paid 85% of what doctors are paid for the same primary care services. MCOs should recognize nurse practitioners as PCPs. This would increase access and also save money. Third, there are inefficiencies with prior authorization procedures that need to be addressed. Additionally, changes to drug formularies occasionally require removing patients from their medications and there are cases where the new drug is not necessarily cheaper. It would be wise to review the formulary designation process. Fourth, MCOs do a great job of improving care, but there should be greater oversight of MCOs and their processes.

Ms. Cacace also submitted written testimony to the Working Group. Highlights from that written testimony not mentioned in the public hearing are outlined below:

- Due to an influx of patients enrolling in the program, there have been a few hiccups in the provision of care leaving some patients stranded without promised transportation, but these glitches are being worked out.
- Ms. Cacace states that her office manager “is happy to work with the personnel at the MCOs because they provide more personalized customer service to help us
provide the needed patient services, more timely payments for our care and an easier referral process (when required).

- The American Nurses Association's suggestion is that the workgroup require private health insurers take significant steps to include Nurse Practitioners in private health insurance networks.
- In addition to her oral testimony about managing MCO costs, she offers another observation: an all MCO system means that Massachusetts must contract with several entities for administration of health insurance coverage, which leaves the Commonwealth less able to control its own costs in healthcare. She suggests the committee look at the payment structure and determine whether or not it truly serves the patients in the Commonwealth.

Testimony by Massachusetts Association for Behavioral Health Systems, David Matteodo

The Massachusetts Association for Behavioral Health Systems (MABHS) is a trade association focused on inpatient psychiatric and substance abuse issues. First, Mr. Matteodo advocated for increased access to behavioral health services. Second, he encouraged the reduction of recidivism as a component of care management. Third, insurers and organizations that participate in carved out services should utilize coaching to encourage care management, thus keep people out of emergency department and ultimately saving space for people who truly need emergency services. Lastly, MABHS encouraged examination of the OneCare plan since Fallon recently dropped out and the other two OneCare providers seem to be having issues. This is essential to ensuring equitable access to behavioral healthcare regardless of MCO enrollment. MABHS supports Bill S.585, which ensures all contracted health plans provider the same behavioral health services and medications, regardless of provider.

Testimony by Health Law Advocates, Andrew Cohen

Mr. Cohen began by also drawing attention to the fact that there is no MassHealth consumer representation on the Working Group. HLA encourages inclusion of those voices in the decision-making processes of the Working Group. With limited time, HLA pointed to their written testimony, but touched on several highlights. First, their clients experience confusion due to a lack of transparency within MCOs and MassHealth. Second, HLA clients feel that there is a lack of accountability of MCOs. Lastly, HLA reiterated that access to behavioral health services is supposed to be no more restrictive than and equitable to physical health services, and feels that this requirement may not be met in the current MassHealth system.

Mr. Cohen also submitted written testimony to the Working Group. Highlights from that written testimony not mentioned in the public hearing are outlined below:
• In order to improve transparency, HLA believes that MCOs should prioritize improvement of member communication.

• HLA provides an example of why carve outs are a problem for MMCOs. HLA clients do not understand the relationship between their MCOs and carve out benefit management companies, which causes difficulty with navigating between these entities. MassHealth members need clarification about where to go and who to call when problems arise with carve out benefit managers. MCOs should take responsibility for decisions made by carve outs to avoid mixed messages, member confusion, and access barriers arising from these problems.

• HLA urges MMCOs to engage in more consumer education regarding provider networks, as well as increase transparency and access to this information for consumers.

• MMCOs develop medical necessity guidelines that are often different from the MassHealth FFS program, and different from those of MCOs. For certain services, specific provisions within the medical necessity guidelines can create a higher barrier to accessing care compared with other MCOs or MassHealth FFS. HLA urges MCOs to review their medical necessity guidelines and remove criteria that create unnecessary barriers to care, particularly where the criteria are unsupported by international standards and are more stringent than those promulgated by MassHealth FFS or other MCOs.

• Lastly, HLA encourages MassHealth and the MMCOs to build upon the current parity certification process, and develop a model process to elevate and ensure parity across all MMCOs.