



NOV - 4 2016

Administrator
Washington, DC 20201

Dan Tsai
Assistant Secretary
Executive Office of Health and Human Services
One Ashburton Place
11th Floor
Boston, MA 02108

Dear Mr. Tsai:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to amend Massachusetts' section 1115 demonstration project, entitled MassHealth (Project Number 11-W-00030/1), effective November 4, 2016, through June 30, 2017. Concurrently, we also are approving an extension of the demonstration, effective from July 1, 2017, through June 30, 2022. The amendment and extension will support the Commonwealth's implementation of Accountable Care Organizations (ACOs). Massachusetts anticipates that ACOs will represent a transformative step forward for MassHealth, building a system of broad and integrated provider-led care delivery organizations operating in partnership with agencies delivering health-related community services.

Extension Beginning July 1, 2017

Under the extension, beginning July 1, 2017, Massachusetts will move forward with the implementation of a statewide ACO program, centered around three ACO models in which Massachusetts providers can choose to participate. Massachusetts' ACO models aim to improve integration of care, coordination among providers and the member experience of care, while reducing the rate of growth in the cost of care and in avoidable utilization, and while maintaining clinical quality and access. Massachusetts' three ACO models hold ACOs financially accountable for cost, quality and member experience. ACOs' financial accountability for cost will initially include covered physical health, behavioral health and pharmacy services. Massachusetts will introduce financial accountability for covered long-term services and supports (LTSS) during the demonstration and the Commonwealth expects this to take place on or about year three of the demonstration.

ACOs will be able to invest in certain approved community services that address health-related social needs and are not otherwise covered under Massachusetts' Medicaid benefit. All MassHealth ACOs will be required to form linkages to state-certified Community Partners of Behavioral Health and LTSS in order to receive infrastructure funding. These community partners will be empowered to support ACOs with care coordination and management for members with complex behavioral health and LTSS needs. Community partners will serve as resources not just to MassHealth ACOs but also to MassHealth MCOs, and will be integral parts of a more integrated, member-centered Massachusetts delivery system.

Massachusetts' three ACO models have different characteristics to accommodate variation among providers within the Massachusetts delivery system: (1) Accountable Care Partnership Plans are managed care organizations (MCOs), each with a closely and exclusively partnered ACO with which the MCO collaborates to provide vertically integrated, coordinated care under a global payment; (2) Primary Care ACOs are provider-led ACOs that contract directly with Massachusetts' Medicaid agency as Primary Care Case Management entities to take financial accountability for a defined population of enrolled members through retrospective shared savings and risk, and potentially more advanced payment arrangements; (3) MCO-administered ACOs are provider-led ACOs that contract directly with Massachusetts' Medicaid MCO contractors to take financial accountability for the MCO enrollees they serve through retrospective shared savings and risk. CMS is authorizing Massachusetts to contract with ACOs through these three models and to pay ACOs using upside and downside risk arrangements.

The new ACO options will be available for MassHealth beneficiaries who are currently required to enroll in either the MassHealth Primary Care Clinician plan or a MCO, currently nearly 1.3 million members out of MassHealth's total population of 1.9 million members. CMS is authorizing MassHealth to offer lower cost-sharing for beneficiaries who choose ACO or MCO enrollment, as an incentive for members to enroll in one of those two delivery systems. All cost-sharing amounts will be consistent with Medicaid statutory and regulatory limits.

This approval incorporates a Delivery System Reform Incentive Payment (DSRIP) program that supports the development of ACOs throughout the state. DSRIP funds will help providers transition towards new care delivery models, improve beneficiary care and experience, and strengthen provider capacity. CMS is approving \$1.8 billion over five years for the MassHealth DSRIP program. This funding will be available only for this period as a one-time federal investment in delivery system reform within Massachusetts and will end after the five-year DSRIP period. Over time, DSRIP funding will phase down as programs should be sustainable without ongoing federal incentive payments. Massachusetts' DSRIP funding expenditure authority is partially at risk, based on Massachusetts' performance on a range of metrics – including metrics related to reduction in the growth rate of costs of care, metrics related to quality and metrics related to ACO implementation.

Massachusetts will use DSRIP funds to support several key reform initiatives. One stream of DSRIP funds will support care coordination and infrastructure costs needed to transition to ACOs. A second stream will support Behavioral Health and LTSS Community Partners for development of infrastructure and implementation of care coordination activities and a third stream of funds will support specific state-wide initiatives intended to support ACO development. This third funding stream includes funding to support primary care providers employed at community health centers, support to providers for participation in alternative payment methodologies, investments to reduce the boarding of members with Substance Use Disorder (SUD) or mental illness in emergency departments, and to support provider investments in improved accessibility to medical care for people with disabilities.

Under the extended MassHealth demonstration, the state will restructure its safety net care pool (SNCP) funding, which will be subject to an aggregate cap of \$4.489 billion plus the provider cap for the Disproportionate Share Hospital-like (DSH-like) pool. This funding is apportioned

among three main categories: 1) payments for uncompensated care, including payments from the DSH-like pool and the Uncompensated Care (UC) Pool; 2) payments for time-limited incentive based pools, including DSRIP; and 3) payments for Health Connector subsidies. Expenditures from the DSH-like Pool will be expressly tied to Massachusetts's federal DSH allotment. Expenditures from the UC pool will phase down by July 2018 to a new level based on the CMS-measured level of uncompensated hospital care for the low-income uninsured, using costs reported on the Healthcare Cost Report Information System. In 2017-18 the uncompensated care pool will be set at a transitional level of \$212 million. The pool will be set at \$100 million each year beginning in July 2018, and will remain at that level during the remainder of the extension period. The uncompensated care pool funds are restricted to charity care for uninsured individuals, and the UC pool distribution must be aligned with CMS uncompensated care pool principles that are specified in the demonstration terms and conditions. These principles were set out in CMS's November 20, 2015, letter to Executive Office of Health and Human Services (EOHHS).

The demonstration also provides authority for the Commonwealth to continue to utilize a streamlined eligibility redetermination process to renew Medicaid enrollments for families who are enrolled in Supplemental Nutrition Assistance Program (SNAP). This streamlined redetermination process will be applied to new categories of beneficiaries, including certain non-pregnant childless adults and parents who are receiving SNAP benefits.

Amendment Effective Through June 30, 2017

Under the amendment, Massachusetts will implement a new pilot ACO program (the ACO Pilot) in state fiscal year (SFY) 2017, preparing for its implementation of a statewide ACO reform in SFY 2018 (running from July 2017, through June 2018). The ACO Pilot will allow MassHealth to begin the transition towards accountable care and population-based payments (and away from fragmented, fee-for-service care) with selected, experienced ACOs under an alternative payment methodology that includes shared savings and risk.

In addition, through this amendment, behavioral health services authorized under the demonstration have been expanded to strengthen Massachusetts' system of recovery-oriented SUD treatments and supports, with one of the goals being to address illicit and prescription opioid drug addiction. Massachusetts will implement a more comprehensive array of outpatient, residential inpatient and community SUD services to promote treatment and recovery. All full-benefit MassHealth beneficiaries will have access to the full continuum of expanded SUD services. Members will be eligible to receive these expanded SUD services regardless of the delivery system through which they receive care.

The amendment also makes a number of other changes to the demonstration. Eligibility for the CommonHealth Program will be expanded to working disabled adults over the age of 65, to ensure continued access to their existing care arrangements and to CommonHealth benefits. For people otherwise eligible for MassHealth and with available coverage through a Student Health Insurance Plan (SHIP), Massachusetts will have the authority to require enrollment in SHIPs and to provide benefits through a premium assistance program. MassHealth will wrap the student health insurance benefit as needed to ensure that eligible students receive equivalent care and pay

equivalent cost sharing relative to MassHealth coverage. The program provides for year-long continuous eligibility regardless of changes in student income or other circumstances, as long as the individual is a student. This provision is contingent on approval of a Medicaid state plan amendment to require enrollment in SHIPs. Finally, the demonstration includes federal support for cost sharing subsidies for Health Connector enrollees with incomes up to 300 percent of the FPL, in addition to premium subsidies for this population that were previously authorized.

The CMS approval of this MassHealth demonstration extension and amendment is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) defining the nature, character and extent of anticipated federal involvement in the project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been waived or specifically listed as not applicable to the expenditure authorities.

This award letter is also subject to our receipt of your written acceptance of the award, including the waiver and expenditures authorities and STCs, within 30 days of the date of this letter. Your project officer is Mr. Eli Greenfield, who may be reached at (410) 786-6157 and through e-mail at Eli.Greenfield@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted to Mr. Greenfield at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding program matters should be sent simultaneously to Mr. Greenfield and to Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
JFK Federal Building
Room 2325
Boston, MA 02203
Telephone: (617) 565-1226
E-mail: Richard.McGreal@cms.hhs.gov

If you have questions regarding this approval, please contact Eliot Fishman, Director of the State Demonstrations Group in the Center for Medicaid & CHIP Services at (410) 786-9535.

Page 5 – Mr. Dan Tsai

The CMS looks forward to continuing work with your staff on future developments within your demonstration.

Sincerely,



Andrew M. Slavitt
Acting Administrator

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

AWARDEE: Massachusetts Executive Office of Health and Human Services
(EOHHS)

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning on the date of the approval letter, through June 30, 2019, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

All previously approved waivers for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable the Commonwealth of Massachusetts (State/Commonwealth) to carry out the MassHealth Medicaid section 1115 demonstration.

1. Statewide Operation Section 1902(a)(1)

To enable Massachusetts to provide managed care plans or certain types of managed care plans, only in certain geographical areas of the Commonwealth.

2. Comparability/Amount, Duration, and Scope Section 1902(a)(10)(B)

To enable Massachusetts to implement premiums and copayments that vary by eligibility group, income level and service, and delivery system as described in Attachment B.

To enable the Commonwealth to provide benefits that vary from those specified in the State plan, as specified in Table B and which may not be available to any categorically needy individuals under the Medicaid state plan, or to any individuals in a statutory eligibility group.

- 3. Eligibility Procedures and Standards** **Section 1902(a)(10)(A),
Section 1902(a)(10)(C)(i)-(iii), and
Section 1902(a)(17)**

To enable Massachusetts to use streamlined eligibility procedures including simplified eligibility redeterminations for certain individuals who attest to no change in circumstances and streamlined redeterminations for children, parents, caretaker relatives, and childless adults.

- 4. Disproportionate Share Hospital (DSH) Requirements** **Section 1902(a)(13) insofar as it
incorporates Section 1923**

To exempt Massachusetts from making DSH payments to hospitals which qualify as a Disproportionate Share Hospital in any fiscal year in which Massachusetts is authorized to make provider payments from the Safety Net Care Pool.

- 5. Financial Responsibility/Deeming** **Section 1902(a)(17)**

To enable Massachusetts to use family income and resources to determine an applicant's eligibility even if that income and resources are not actually made available to the applicant, and to enable Massachusetts to deem income from any member of the family unit (including any Medicaid-eligible member) for purposes of determining income.

- 6. Freedom of Choice** **Section 1902(a)(23)(A)**

To enable Massachusetts to restrict freedom of choice of provider for individuals in the demonstration, including to require managed care enrollment for certain populations exempt from mandatory managed care under section 1932(a)(2), limiting primary care clinician plan (PCC) plan enrollees to a single Prepaid Insurance Health Plan (PIHP) for behavioral health services, limiting enrollees who are clients of the Departments of Children and Families and Children and Youth Services to a single PIHP for behavioral health services, unless such enrollees chose a managed care plan, requiring children with third party insurance to enroll into a single PIHP for behavioral health services; in addition to limiting the number of providers within any provider type as needed to support improved care integration for MassHealth enrollees, and limiting the number of providers who provide Anti-Hemophilia Factor drugs.

To permit the state to mandate that Medicaid eligibles with access to student health plans enroll into the plan, to the extent that it is determined to be cost effective, as a condition of eligibility as outlined in section IV and Table E. No waiver of freedom of choice is authorized for family planning providers. This state's ability to apply this authority is subject to the approval of the state's modification to the state plan to implement a premium assistance program to purchase health insurance through the individual market. This demonstration authority will end should the state not obtain a

freedom of choice waiver as described within the SHIP SPA by December 31, 2017.

7. Direct Provider Reimbursement **Section 1902(a)(32)**

To enable Massachusetts to make premium assistance payments directly to individuals who are low-income employees, self-employed, or unemployed and eligible for continuation of coverage under federal law, in order to help those individuals access qualified employer-sponsored insurance (where available) or to purchase health insurance (including student health insurance) on their own, instead of to insurers, schools or employers providing the health insurance coverage.

8. Retroactive Eligibility **Section 1902(a)(34)**

To enable the Commonwealth not to provide retroactive eligibility for up to 3 months prior to the date that the application for assistance is made and instead provide retroactive eligibility as outlined in Table D, section V.

9. Extended Eligibility **Section 1902(a)(52)**

To enable Massachusetts to not require families receiving Transitional Medical Assistance to report the information required by section 1925(b)(2)(B) absent a significant change in circumstances, and to not consider enrollment in a demonstration-only eligibility category or CHIP (title XXI) eligibility category in determining eligibility for Transitional Medical Assistance.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

AWARDEE: Massachusetts Executive Office of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Massachusetts for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration amendment (date of the approval letter through June 30, 2017), unless otherwise specified, be regarded as expenditures under the State's title XIX plan. All previously approved expenditure authorities for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration amendment.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the Commonwealth of Massachusetts (State/Commonwealth) to operate its MassHealth section 1115 Medicaid demonstration.

The expenditure authorities listed below promote the objectives of title XIX in the following ways:

- Expenditure authorities 11, 12, 13, 14, 19, 20, 21, and 25 promote the objectives of title XIX by increasing efficiency and quality of care through initiatives to transform service delivery networks.
- Expenditure authorities 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 promote the objectives of title XIX by increasing overall coverage of low-income individuals in the state.
- Expenditure authorities 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the state.
- Expenditure authorities 17, 18, 19, 20, 21, and 22 promote the objectives of title XIX by increasing access to, stabilizing, and strengthening providers and provider networks available to serve Medicaid and low-income populations in the state

I. Demonstration Population Expenditures

1. CommonHealth Adults.

Expenditures for health care-related costs for:

- a. Adults aged 19 through 64 who are totally and permanently disabled, not eligible for comprehensive coverage under the Massachusetts state plan.; and

- b. Adults aged 65 and over who are not eligible for comprehensive coverage under the Massachusetts state plan, with disabilities that would meet the federal definition of “permanent and total disability” if these adults were under the age of 65.
- 2. **CommonHealth Children.** Expenditures for health care-related costs for children from birth through age 18 who are totally and permanently disabled with incomes greater than 150 percent of the Federal poverty level (FPL) and who are not eligible for comprehensive coverage under the Massachusetts state plan .
- 3. **Family Assistance [e-Family Assistance and e-HIV/FA].** Expenditures for health care-related costs for the following individuals:
 - a. Individuals who would be eligible for the New Adult Group (MassHealth CarePlus but for the income limit, are HIV-positive, are not institutionalized, with incomes above 133 through 200 percent of the FPL and are not otherwise eligible under the Massachusetts Medicaid state plan. These expenditures include expenditures for health care services furnished during the 90-day period between the time an individual submits an application and the time that the individual provides to the Commonwealth proof of his or her HIV-positive health status.
 - b. Non-disabled children with incomes above 150 through 300 percent of the FPL who are not otherwise eligible under the Massachusetts Medicaid state plan due to family income.
- 4. **Breast and Cervical Cancer Demonstration Program [BCCDP].** Expenditures for health care-related costs for uninsured individuals under the age of 65 with breast or cervical cancer, who are not otherwise eligible under the Massachusetts state plan and have income above 133 percent but no higher than 250 percent of the FPL.
- 5. **MassHealth Small Business Employee Premium Assistance.** Expenditure authority to make premium assistance payments for certain individuals whose MAGI income is between 133 and 300 percent of the FPL, who work for employers with 50 or fewer employees who have access to qualifying Employer Sponsored Insurance (ESI), and who are ineligible for other subsidized coverage through MassHealth or the Health Connector.
- 6. **TANF and EAEDC Recipients.** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not based on an income determination.

7. **End of Month Coverage.** End of Month Coverage for Members Determined Eligible for Subsidized Qualified Health Plan (QHP) Coverage through the Massachusetts Health Connector but not enrolled in a QHP. Expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP, during the period specified in section IV, subject to section IV.
8. **Provisional Coverage Beneficiaries.** Expenditures for MassHealth Coverage for individuals who self-attest to any eligibility factor, except disability, immigration and citizenship.
9. **Presumptively Eligible Beneficiaries.** Expenditures for individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Demonstration Program under the demonstration by qualified hospitals that elect to do so.

II. Service-Related Expenditures

10. **Premium Assistance.** Expenditures for premium assistance payments to enable individuals enrolled in CommonHealth (Adults and Children) and Family Assistance to enroll in private health insurance to the extent the Commonwealth determines that insurance to be cost effective.
11. **Pediatric Asthma Pilot Program.** Expenditures related to a pilot program, as outlined in STC section VI, focused on pediatric asthma. The authority for this pilot program to receive FFP is subject to CMS approval of the protocols and amendments to such protocols as outlined in section V.
12. **Diversionsary Behavioral Health Services.** Expenditures for benefits specified in Table C of Section V to the extent not available under the Medicaid state plan.
13. **Expanded Substance Use Disorder Services.** Expenditures for benefits specified in Table D of Section V to the extent not available under the Medicaid State Plan.
14. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** Expenditures to provide full MassHealth Standard plan benefits to presumptively eligible pregnant women (including Hospital Presumptive Eligibility) with incomes at or below 200 percent of the FPL.
15. **Medicare Cost Sharing Assistance.** Expenditures for monthly Medicare Part A and Part B premiums and for deductibles and coinsurance under Part A and Part B for MassHealth members with incomes at or below the 133 percent of the FPL, who are also eligible for Medicare (without applying an asset test).

Expenditures to cover the costs of monthly Medicare Part B premiums for

CommonHealth members who are also eligible for Medicare with gross income between 133 and 135 percent FPL (without applying an asset test).

16. Continuous Eligibility Period for Individuals enrolled in Student Health Insurance Plans. Expenditures for health care costs, including insurance premiums and cost sharing for individuals who are enrolled while Medicaid eligible in cost-effective student health insurance as determined by the state for periods in which such individuals are no longer Medicaid eligible during a continuous eligibility period. This state's ability to draw down these expenditures is subject to the approval of the state's modification to the state plan to implement a premium assistance program to purchase health insurance through the individual market. . This authority will end should the state not obtain a freedom of choice waiver as described in the SHIP SPA by December 31, 2017.

III. Safety Net Care Pool (SNCP). Expenditures for the following categories of expenditures, subject to overall SNCP limits and category-specific limits set forth in the STCs.

17. Designated State Health Programs (DSHP). Expenditures for designated programs that provide health services that are otherwise state-funded, for health services with dates of service as specified below and in Attachment E of the STCs.

a. Specified State-Funded Programs – Effective as of the date of the approval letter through June 30, 2017, expenditures for designated programs that provide or support the provision of health services and that are otherwise state-funded, as specified in Attachment E of the STCs.

b. Health Connector Subsidies. Expenditures for the payments made through its state-funded program to:

- i. Provide premium subsidies for individuals with incomes up to 300 percent of the FPL who purchase health insurance through the Massachusetts Health Insurance Connector Authority (Health Connector). Subsidies will be provided on behalf of individuals who: (A) are not Medicaid eligible; and (B) whose income, as determined by the Health Connector, is up to 300 percent of the FPL.
- ii. Provide cost-sharing subsidies for individuals who purchase health insurance through the Health Connector. Subsidies will be provided on behalf of individuals who: (A) are not Medicaid eligible; and (B) whose income, as determined by the Health Connector, is up to 300 percent of the FPL.

18. **Providers.** As described in Attachment E, effective beginning July 1, 2014 and limited to the extent permitted under the SNCP limits under section VIII, expenditures for payments to providers, including: acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, Medicaid managed care, and low-income uninsured individuals, and expenditures for payments for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).
19. **Infrastructure and Capacity-building.** Expenditures limited to five percent of the aggregate SNCP cap over the period from the date of the approval letter through June 30, 2017, for capacity-building and infrastructure for:
 - a. The improvement or continuation of health care services that benefit the uninsured, underinsured, MassHealth, demonstration, and SNCP populations.
 - b. Support the improvement of health care services that benefit the demonstration populations as outlined in STCs XX and XX.
 - c. Support pilot ACOs (in addition to hospitals and community health centers) with infrastructure and care coordination expenses during the ACO pilot period.

Activities funded under this expenditure authority are not eligible for Delivery System Transformation Initiative (DSTI) incentive payments.

20. **Delivery System Transformation Initiatives.** Expenditures pursuant to section VIII for incentive payments to providers for the development and implementation of a program that supports hospital's efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve and that will transform the current payment and delivery system models.
21. **Public Hospital Transformation and Incentive Initiatives.** The Commonwealth may claim as allowable expenditures under the demonstration payments that support Cambridge Health Alliance's transformative work through its Public Hospital Transformation and Incentive Initiatives program. The Public Hospital Incentive Initiatives must have a protocol that is approved by CMS.

IV. Streamlined Redeterminations

23. **Streamlined Redeterminations for Adult Populations.** Expenditures for parents, caretaker relatives, and childless adults who would not be eligible under either the state plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.

24. **Streamlined Redeterminations for Children’s Population.** Expenditures for children who would not be eligible under the Title XIX state plan, Title XXI state child health plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.

V. Delivery System Related Expenditures

25. **Pilot Accountable Care Organizations (ACOs).** Expenditures for shared savings payments to participating Pilot ACOs that include risk-based (upside and downside) payments to these ACOs, and that may allow or require Pilot ACOs to distribute some portion of shared savings to or collect shared losses from select direct service providers, that are outside of the ranges for Integrated Care Models (ICMs) provisions and/or are not otherwise authorized under 42 CFR §438.

All requirements of the Medicaid program expressed in law, regulation, and policy statements that are explicitly waived under the Waiver List herein shall similarly not apply to any other expenditures made by the state pursuant to its Expenditure Authority hereunder. In addition, none of the Medicaid program requirements as listed and described below shall apply to such other expenditures. All other requirements of the Medicaid program expressed in law, regulation, and policy statements shall apply to such other expenditures.

The Following Title XIX Requirements Do Not Apply to These Expenditure Authorities.

1. **Cost Sharing** **Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**

To enable Massachusetts to impose premiums and cost-sharing in excess of statutory limits on individuals enrolled in the CommonHealth and Breast and Cervical Cancer Demonstration programs.

In Addition to the Above, the Following Title XIX Requirements Do Not Apply to Expenditures for Family Assistance Coverage.

2. **Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)** **Section 1902(a)(43)**

EPSDT does not apply to individuals eligible for the family assistance program.

3. **Assurance of Transportation** **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To enable Massachusetts to provide benefit packages to individuals enrolled in the Family Assistance demonstration programs that do not include transportation.

4. **Reasonable Promptness**

Section 1902(a)(8)

To enable Massachusetts to cap enrollment and maintain waiting lists for the Family Assistance demonstration programs.

5. **Mandatory Services**

**Section 1902(a)(10)(A)
insofar as it incorporates Section
1905(a)**

To exempt the state from providing all mandatory services to individuals enrolled in the Family Assistance demonstration programs.

The Following Title XIX Requirements Do Not Apply to Expenditures for Medicare Cost Sharing Assistance:

6. **Resource Limits**

Section 1902(a)(10)(E)

To enable Massachusetts to disregard assets in determining eligibility for Medicare cost sharing assistance.

No Title XIX Requirements are Applicable to Expenditures for the Safety Net Care Pool.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS & CONDITIONS**

NUMBER: 11-W-00030/1

TITLE: MassHealth Medicaid Section 1115 Demonstration

AWARDEE: Massachusetts Executive Office of Health and Human Services
(EOHHS)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts MassHealth section 1115(a) Medicaid demonstration (hereinafter “Demonstration”). The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (which is the single state agency that oversees the MassHealth program), (State/Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the Commonwealth’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the State’s expenditures relating to dates of service during this demonstration extension, unless otherwise specified. The demonstration is set to expire on June 30, 2022.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Demonstration Programs and Benefits
- VI. Delivery System
- VII. Cost Sharing
- VIII. The Safety Net Care Pool
- IX. General Reporting Requirements
- X. Monitoring
- XI. Close Out Reporting
- XII. General Financial Requirements under Title XIX
- XIII. Monitoring Budget Neutrality for the Demonstration
- XIV. Schedule of Deliverables for the Demonstration Extension Period

Attachment A.	Overview of Children’s Eligibility in MassHealth
Attachment B.	Cost Sharing
Attachment C.	Quarterly Operational Report Content and Format
Attachment D.	MassHealth Historical Per Member/Per Month Limits
Attachment E.	Safety Net Care Pool Payments
Attachment F.	Pediatric Asthma Pilot Program Protocols
Attachment H.	Safety Net Care Pool Uncompensated Care Cost Limit Protocol
Attachment K.	Cambridge Health Alliance Public Hospital Transformation and Incentive Initiatives (PHTII) Protocol
Attachment L.	Pilot Accountable Care Organization (ACO) Payment Methodology
Attachment M	Reserved for Delivery System Reform Incentive Payment (DSRIP) Program Protocol
Attachment N.	Safety Net Provider Payment Eligibility and Allocation
Attachment O.	Pricing methodology for ACOs and MCOs
Attachment P.	Historical Background regarding Demonstration
Attachment Q.	Managed Care Organization Incentives
Attachment R.	Reserved for Flexible Services

II. PROGRAM DESCRIPTION AND OBJECTIVES

In this extension of the demonstration, the Commonwealth and CMS have agreed to implement major new demonstration components to support a value-based restructuring of MassHealth’s health care delivery and payment system, including a new Accountable Care Organization (ACO) initiative and Delivery System Reform Incentive Program (DSRIP) to transition the Massachusetts delivery system into accountable care models. The Safety Net Care Pool (SNCP) has been redesigned to align SNCP funding with MassHealth’s broader accountable care strategies and expectations and to establish a more sustainable structure for necessary and ongoing funding support to safety net providers.

During the new extension period approved for state fiscal year (SFY) 2018-2022, the goals of the demonstration are:

- (1) Enact payment and delivery system reforms that promote integrated, coordinated care; and hold providers accountable for the quality and total cost of care;
- (2) Improve integration of physical, behavioral and long term services;
- (3) Maintain near-universal coverage;
- (4) Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals; and
- (5) Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children’s Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - A. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such a change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - B. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day, such state legislation becomes effective, or on the last day, such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the

demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
 - A. An explanation of the public process used by the Commonwealth consistent with the requirements of STC 15 to reach a decision regarding the requested amendment;
 - B. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment;
 - C. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - D. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment, if necessary; and
 - E. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 10.
 - A. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.
 - B. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.
9. **Compliance with Transparency Requirements 42 C.F.R. §§ 431.412.** As part of any demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 C.F.R. §§ 431.412 and the public notice and tribal consultation requirements outlined in STC 15 as well as include the following supporting documentation:

- A. Demonstration Summary and Objectives. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.
 - B. Special Terms and Conditions. The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
 - C. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
 - D. Compliance with the Budget Neutrality Cap. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.
 - E. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.
10. **Demonstration Phase-Out**. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- A. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- B. **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- C. **Phase-out Procedures:** The state must comply with all notice requirements found in 42

C.F.R. section 431.206, section 431.210, and § 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 C.F.R. section 431.220 and section 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 C.F.R. section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

D. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to, normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

E. Post Award Forum: Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in Section X associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in Section X.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. The CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
14. **Adequacy of Infrastructure.** The Commonwealth will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section

5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements at outlined in the state's approved state plan, when any program changes to the demonstration including (but not limited to) those referenced in STC 5, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state must to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 C.F.R. section 447.205 for changes in statewide methods and standards for setting payment rates.

16. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.
17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The State shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter. CMS expects the state to implement both an interim and long-term plan to collect, validate and report managed care encounter data, per required T-MSIS reporting and 1115 evaluation. The interim plan must be submitted to CMS by January 31, 2017. The long-term plan must be submitted to CMS no later than June 30, 2017. The system costs associated with this work are eligible for enhanced match. Failure to achieve this condition may result in a reduction in systems FFP for the costs associated with operations of the State's current data warehouse solution.

IV. ELIGIBILITY AND ENROLLMENT

18. **Eligible Populations.** This demonstration affects mandatory and optional Medicaid state plan populations as well as populations eligible for benefits only through the demonstration. Table A at the end of section IV of the STCs shows each specific group of individuals; under what authority they are made eligible for the demonstration; the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed; and the corresponding demonstration program under which benefits are provided. Attachment A provides a complete overview of MassHealth coverage for children, including the separate title XXI CHIP program, which is incorporated by reference.

Eligibility is determined based on an application by the beneficiary or without an application for eligibility groups enrolled based on receipt of benefits under another program.

MassHealth defines the age of a dependent child for purposes of the parent/caretaker relative coverage type as a child who is younger than age 19. A caretaker relative is eligible under this provision only if the parent is not living in the household.

19. **Retroactive Eligibility.** Retroactive eligibility is provided in accordance to STC 48 Table E.
20. **Calculation of Financial Eligibility.** Financial eligibility for demonstration programs is determined by comparing the family's Modified Adjusted Gross Income (MAGI) with the applicable income standard for the specific coverage type, with the exception of adults aged 19 and above who are determined eligible on the basis of disability and whose financial eligibility is determined as described below. MAGI income counting methodologies will also be applied to disabled adults in determining eligibility for MassHealth Standard and CommonHealth; however, household composition for

disabled adults will always be determined using non-tax filer rules, regardless of whether the individual files income taxes or is claimed as a dependent on another person's income taxes. In determining eligibility for MassHealth Standard and CommonHealth for disabled adults, the Commonwealth will apply the five percent income disregard that is also applied to non-disabled adults.

21. **Streamlined Redeterminations.** Under the streamlined renewal process, enrollees are not required to return an annual eligibility review form if they are asked to attest whether they have any changes in circumstances (including household size and income) and do not have any changes in circumstances reported to MassHealth. The process applies to the following populations:

- A. Families with children under the age of 19 who have gross income as verified by MassHealth at or below 150 percent FPL and who are receiving SNAP benefits with SNAP verified income at or below 180 percent FPL.
- B. Families with children up to age 21 whose SNAP verified income is at or below 180 percent FPL, effective to the extent that the state uses an Express Lane eligibility process under its state plan for children up to the age of 21.
- C. Childless adults whose SNAP verified income is at or below 163 percent FPL.

The authority to use streamlined eligibility redetermination procedures will also remain in effect for families with children notwithstanding sunset dates for Express Lane Eligibility applicable to the companion state plan amendments.

22. **TANF and EAEDC Recipients.** The Medicaid agency shall extend MassHealth eligibility to individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. MassHealth eligibility for individuals in this demonstration population does not involve an income determination, but is based on receipt of TANF/EAEDC benefits. Individuals in this demonstration population would not be described in the new adult group, because that is a group defined by an income determination. Therefore, the enhanced match for individuals in the new adult group is not available for this population. If an individual loses his/her TANF/EAEDC eligibility then he/she must apply for MassHealth benefits and receive an income eligibility determination in order to receive MassHealth benefits.

23. **Hospital-Determined Presumptive Eligibility for Additional Eligibility Groups.** Qualified hospitals that elect to do so may make presumptive eligibility determinations for individuals who appear eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration, in addition to populations that are eligible in accordance with the Medicaid state plan.

The hospital determined presumptive eligibility benefit for pregnant women and unborn children is a full MassHealth Standard benefit.

24. **Provisional Eligibility.** MassHealth will accept self-attestation for all eligibility factors, except for disability status, immigration and citizenship status, in order to determine eligibility, and may require post-eligibility verification from the applicant. If MassHealth is unable to verify eligibility through federal and state data hubs, or if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, MassHealth can enroll individuals

for a 90-day “provisional eligibility period,” during which MassHealth will require further verifications from the applicant.

Necessary verifications are required within 90 days of the date the individual receives notice of the provisional eligibility determination in order to maintain enrollment. The date the notice is received is considered to be five days after the date the notice is sent, unless the notice recipient shows otherwise. The reasonable opportunity period for applicants pending verification of citizenship or immigration status aligns with the 90-day provisional eligibility period for applicants pending verification of other eligibility criteria, such that benefits provided may begin prospectively with respect to all applicants as early as the date of application.

Under the demonstration, benefits for children under age 21 and pregnant women who have been determined provisionally eligible begin 10 days prior to the date the paper application is received at the MassHealth Enrollment Center (MEC) or MassHealth outreach site, or an electronic application is submitted through an online eligibility system. FFP is not available for the 10 days of retroactive coverage for children and pregnant women receiving benefits during a reasonable opportunity period pending verification of citizenship, immigration status, or lawfully present status. FFP is available for the 10 days of retroactive-coverage period if the pregnant woman’s or child’s citizenship, immigration or lawfully present status is verified before the end of the reasonable opportunity period. Benefits are provided on a fee-for-service basis for covered services received during the period starting 10 days prior to the date of application up until the application is processed and a provisional eligibility determination is made.

Benefits for all other individuals who have been determined provisionally eligible begin on the date that MassHealth sends the notice of the provisional eligibility determination. If all required verifications are received before the end of the provisional eligibility period, retroactive coverage is provided for the verified coverage type in accordance with Table E. The Commonwealth must not provide retroactive coverage for individuals age 21 and over or for non-pregnant adults until eligibility has been verified through federal and state data hubs or, if the information provided by an applicant is not reasonably compatible with the information available through the data hubs, until MassHealth has obtained further verifications from the applicant verifying eligibility during the retroactive period. For individuals eligible for the New Adult Group, the Commonwealth may not claim the expansion state Federal Medical Assistance Percentage (FMAP) for individuals whose eligibility has not been verified within the provisional eligibility period, but may claim the regular FMAP for those individuals for no longer than a 90 day plus a five-day notice period of benefits (unless the individual can demonstrate that he or she did not receive the notice within five days, in which case benefits would be extended).

The reasonable opportunity period for immigration, citizenship and identity verification will be aligned with the provisional eligibility period. An individual may receive provisional eligibility no more than once within a twelve-month period, starting with the effective date of the initial provisional eligibility determination, unless the individual is transitioning from a Qualified Health Plan (QHP) with an Advanced Premium Tax Credit (APTC), or if the individual self-attests pregnancy. In those cases, an individual may receive provisional eligibility before such 12-month period has passed.

25. Verification of Breast or Cervical Cancer or Human Immunodeficiency Virus (HIV).

For individuals who indicate on the application that they have breast or cervical cancer or HIV, a determination of eligibility will be made in accordance with the procedures described in STC 24. Persons who have not submitted verification of breast cancer, cervical cancer, or HIV diagnosis

within 90 days of the eligibility determination will subsequently have their eligibility redetermined as if they did not have breast cancer, cervical cancer, or HIV.

26. **Eligibility Exclusions.** Notwithstanding the criteria outlined in this section or in Table A, the following individuals are excluded from this demonstration. Payments or expenditures related to uncompensated care for such individuals as defined in STC 51 (b), and for DSHP as described in STC 54, however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP). In addition, SUD services described in STC 40 provided to MassHealth eligible individuals age 65 and over may be included as an allowable expenditure under the demonstration.

Individuals 65 years and older, to the extent that such an exclusion is authorized by MGL Ch118E Sec 9A, except for individuals eligible in accordance within 42 CFR 435.110
Participants in Program of All-Inclusive Care of the Elderly (PACE)
Refugees served through the Refugee Resettlement Program

27. **Enrollment Caps.** The Commonwealth is authorized to impose enrollment caps on populations made eligible solely through the demonstration, except that enrollment caps may not be imposed for the demonstration expansion population groups listed as “Hypotheticals” in Table A. Setting and implementing specific caps are considered amendments to the demonstration and must be made consistent with section III, STC 7.

28. **Twelve Month Continuous Eligibility for Student Health Insurance Program Population.**

Individuals who are enrolled in a cost-effective Student Health Insurance Program will be continuously eligible for a period of up to 12 months while enrolled in the SHIP plan, until the end of the policy year date. The policy year will end on either July 31 or August 31 of each year. The Commonwealth will determine the individual’s eligibility at the completion of each policy year to ensure that the individual remains eligible.

- A. **Exceptions.** Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual’s 12 month continuous eligibility period, the individual’s Medicaid eligibility shall, after appropriate process, be terminated:
 - i. The individual cannot be located for a period of more than one month, after good faith efforts by the state to do so.
 - ii. The individual is no longer a Massachusetts resident.
 - iii. The individual dies.
 - iv. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required.
 - v. The individual provided an incorrect or fraudulent Social Security Number.
- B. Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual’s 12 month continuous eligibility period, the individual’s Medicaid eligibility shall be redetermined
 - i. The individual is no longer enrolled in a SHIP
 - ii. The individual requests termination of SHIP enrollment.

Table A. MassHealth State Plan Base Populations¹ (See STC 89 for terminology)

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
AFDC-Poverty Level infants	< Age 1: 0 through 185%	Title XIX	<u>Base Families</u>	Standard	
Medicaid Expansion infants	< Age 1: 185.1 through 200%	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted 	<u>1902(r)(2) Children</u> <u>1902(r)(2) XXI RO</u>	Standard	

AFDC-Poverty Level Children and Independent Foster Care Adolescents	<ul style="list-style-type: none"> • Age 1 - 5: 0 through 133% • Age 6 - 17: 0 through 114% • Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets • Former Foster Care Adolescents until the age of 26 without regard to income or assets (effective January 1, 2014) 	Title XIX	<u>Base Families</u>	Standard	
AFDC-Poverty Level Children Medicaid Expansion Children I	<ul style="list-style-type: none"> • Age 6 - 17: 114.1% through 133% • Age 18: 0 through 133% 	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted 	<u>Base Families</u> <u>Base Families XXI RO</u>	Standard	

¹ Massachusetts includes in the MassHealth demonstration almost all the mandatory and optional populations aged under 65 eligible under the state plan. All Standard and CommonHealth members who have access to qualifying private insurance may receive premium assistance plus wrap-around benefits. The Massachusetts state plan outlines all covered populations not specifically indicated here.

Table A. MassHealth State Plan Base Populations (continued)*

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	<ul style="list-style-type: none"> Title XIX if insured at the time of application Title XXI if uninsured at the time of application Funded through title XIX if title XXI is exhausted 	<u>1902(r)(2) Children</u> <u>1902(r)(2) XXI RO</u>	Standard	
Medicaid Expansion Children II (effective January 1, 2014)	Ages 19 and 20: 133.1 through 150%	Title XIX	<u>1902(r)(2) Children</u>	Standard	
CHIP Unborn Children	0 through 200%	Title XXI	<u>n/a</u>	Standard	
Pregnant women	0 through 185%	Title XIX	<u>Base Families</u>	Standard	
Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance	0 through 133%	Title XIX	<u>Base Families</u>	Standard	
Disabled children under age 19	0 through 150%	Title XIX	<u>Base Disabled</u>	Standard	
Disabled adults ages 19 through 64	0 through 114%	Title XIX	<u>Base Disabled</u>	Standard	
Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	<u>Base Disabled</u>	CommonHealth	Must spend-down to medically needy income standard to become eligible as medically needy
Pregnant women	185.1 through 200%	Title XIX	<u>1902(r)(2) Children</u>	Standard	

Table A. MassHealth State Plan Base Populations (continued)*

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
“Non-qualified Aliens” or “Protected Aliens”	Otherwise eligible for Medicaid under the State Plan	Title XIX	<u>Base Families</u> <u>Base Disabled</u> <u>1902(r)(2) Children</u> <u>1902(r)(2) Disabled</u> <u>New Adult Group (New Adult Group coverage began January 1, 2014)</u>	Limited	Member eligible for emergency services only under the state Plan and the demonstration. Members who meet the definition and are determined to have a disability are included in the Base Disabled EG Members who are determined eligible via 1902(r)2 criteria are included in the 1902(r)(2) EG
Disabled adults ages 19 through 64	114.1 through 133%	Title XIX	<u>1902(r)(2) Disabled</u>	Standard	
Children eligible under TEFRA section 134, SSA section 1902(e)(3) and 42 U.S.C. 1396a(e)(3) (Kaileigh Mulligan kids)	Age 0 – 17 <ul style="list-style-type: none"> • Require hospital or nursing facility level of care • Income < or = to \$72.81, or deductible • \$0 through \$2,000 in assets 	Title XIX	<u>Base Disabled</u>	Standard	Income and assets of their parents are not considered in determination of eligibility
Children receiving title IV-E adoption assistance	<ul style="list-style-type: none"> • Age 0 through 18 	Title XIX	<u>Base Families</u>	Standard	Children placed in subsidized adoption under title IV-E of the Social Security Act

Table A. MassHealth State Plan Base Populations (continued)*

Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Special Home and Community-Based Waiver (HCBW) Group (individuals who without the HCBW would be eligible for Medicaid if in an institution) under age 65	<ul style="list-style-type: none"> • 0 through 300% SSI Federal Benefits Rate • \$0 through \$2,000 in assets 	Title XIX	<u>Base Disabled</u>	Standard	All other participants under age 65 in a HCBW are reflected in other Base Eligibility Groups in this chart.
Affordable Care Act New Adult Group (effective January 1, 2014)	<ul style="list-style-type: none"> • Ages 19 and 20: 0 through 133% • Individuals with HIV or breast or cervical cancer: 0 through 133% • Individuals receiving services or on a waiting list to receive services through the Department of Mental Health: 0 through 133% • Adults ages 21-64: 0 through 133% 	Title XIX	New Adult Group	Standard (Alternative Benefit Plan) CarePlus (Alternative Benefit Plan)	Ages 19 and 20 treated as children and entitled to EPSDT Individuals exempt from mandatory enrollment in an Alternative Benefit Plan may enroll in Standard

Table A. MassHealth Demonstration Expansion Populations *

Groups with a Categorical Link Made Eligible through the Demonstration (“Hypotheticals”)	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	MassHealth Demonstration Program	Comments
Higher income children with disabilities	<ul style="list-style-type: none"> · < Age 1: 200.1 through 300% · Ages 1 - 18: 150.1 through 300% 	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI via the separate XXI program (Funded through title XIX if title XXI is exhausted) 	<p align="center"><u>CommonHealth</u> <u>CommonHealth XXI</u></p>	CommonHealth	The CommonHealth program existed prior to the separate XXI Children’s Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI state plan and as authorized under this 1115 demonstration. Certain children derive eligibility from both the authority granted under this demonstration <u>and</u> the separate XXI program.
Higher income children with disabilities ages 0 through 18	Above 300%	Title XIX	<u>CommonHealth</u>	CommonHealth	Sliding scale premium responsibilities for those individuals above 150 percent of the FPL
Higher income adults with disabilities ages 19 through 64.	Above 133% Above 150% for 19- and 20-year olds)	Title XIX	<u>CommonHealth</u>	CommonHealth (“working”)	Such individuals are subject to a one-time only deductible except that there is no deductible for individuals who work 40 hours or more per month. Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.

<p>Higher income adults with disabilities who are 65 and older.</p>	<p>Net income above 100% FPL and/or Assets > \$2,000</p>	<p>Title XIX</p>	<p><u>CommonHealth</u></p>	<p>CommonHealth (65+)</p>	<p>Such individuals are subject to a deductible and asset test under the State Plan except there is no deductible or asset test for individuals who have paid employment for 40 hours or more per month. Individuals who met the deductible and asset test under the State plan receive MassHealth Standard.</p> <p>Sliding scale premium responsibilities for those individuals above 150 percent of the FPL.</p>
---	---	------------------	----------------------------	---------------------------	--

Table A. MassHealth Demonstration Expansion Populations (See STC 89 for terminology)

Populations Made Eligible through the Demonstration	Federal Poverty Level (FPL) and other qualifying criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	Massachusetts Demonstration Program	Additional comments
<p>Children ages 1 through 18 (Non-disabled)</p> <p>Children less than age 1</p>	<p>150.1 through 200</p> <p>Above 200 through 300% (effective January 1, 2014)</p> <p>Above 200 through 300% (effective January 1, 2014)</p>	<ul style="list-style-type: none"> • Title XIX if insured at the time of application • Title XXI via the separate XXI program if uninsured <p>(Funded through title XIX if title XXI is exhausted)</p>	<p align="center"><u>-Family Assistance</u></p> <p align="center"><u>Fam Assist XXI</u> (if XXI is exhausted)</p>	<p align="center">Family Assistance</p> <ul style="list-style-type: none"> • Premium Assistance • Direct Coverage <p>The premium assistance payments and FFP will be based on the children’s eligibility. Parents are covered incidental to the child. No additional wrap other than dental is provided to ESI.</p>	<p>Effective January 1, 2014, children ages 0 through 18 from 200-300% FPL who are insured at the time of application are eligible under the 1115 demonstration.</p> <p>Children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration and the XXI program.</p>

<p>Adults under the age of 65 who are not otherwise eligible for medical assistance who work for a small employer and purchase ESI that meets basic benefit level (BBL) standards</p>	<p>133.1 through 300%</p>	<p>Title XIX</p>	<p><u>SEB</u></p>	<p>Small Business Employee Premium Assistance</p>	<p>Individuals must not be eligible for any other MassHealth coverage or for APTCs.</p> <p>No additional wraparound benefits are provided.</p> <p>Individuals whose spouse or children are receiving MassHealth premium assistance for a policy that is available to the individual are not entitled to this benefit.</p>
---	---------------------------	------------------	--------------------------	---	---

Table A. MassHealth Demonstration Expansion Populations (continued)*

Populations Made Eligible through the Demonstration	Federal Poverty Level (FPL) and other qualifying criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	Massachusetts Demonstration Program	Additional comments
Individuals with HIV not otherwise eligible for medical assistance with income above 133% through 200% FPL.	Above 133 to 200%	Title XIX	<u>e-HIV/FA</u>	Family Assistance	Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.
Individuals who receive Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children	N/A	Title XIX	<u>TANF/EAEDC</u>	MassHealth	Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not an income determination.
Provisional Eligibility	Self-Attested income level to qualify for other group, pending verification	Title XIX	<u>Provisional Eligibility</u>	MassHealth	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority in accordance with STC 24.
End of Month Coverage Beneficiaries determined eligible for subsidized Qualified Health Plan (QHP) coverage through the Massachusetts Health Connector but not enrolled in a QHP	Ineligible for MassHealth and Eligible for QHP up to 400% FPL	Title XIX	<u>End of Month Coverage</u>	N/A	Effective January 1, 2014, expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP, during the period specified in STC 29.

<p>Individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Demonstration Program under the demonstration by qualified hospitals that elect to do so.</p>	<p>HIV-Family Assistance – 133.1 through 200 BCCDT – above 133.1 through 250</p>	<p>Title XIX</p>	<p><u>Presumptively Eligible</u></p>	<p>Family Assistance Standard</p>	
<p>Individuals determined eligible for the Breast and Cervical Cancer Demonstration Program under the demonstration.</p>	<p>BCCDT – above 133.1% of the FPL through 250 FPL</p>	<p>Title XIX</p>	<p>BCCPT</p>	<p>Standard</p>	

V. DEMONSTRATION PROGRAMS AND BENEFITS

29. **End of Month Coverage for Members Eligible for Subsidized Coverage through the Massachusetts Health Connector.** When a MassHealth member's enrollment is being terminated due to a change in circumstance that makes the member ineligible for MassHealth but eligible for subsidized coverage through the Health Connector, MassHealth will extend the member's last day of coverage to the end of the month before Health Connector coverage may feasibly become effective. If the termination otherwise would have been effective on or before the 15th of a given month, then MassHealth coverage will be extended to the end of that month. If the termination otherwise would have been effective on or after the 16th of a given month, then MassHealth coverage will be extended to the end of the following month.
30. **Demonstration Program Benefits.** Massachusetts provides health care benefits through the following specific benefit programs. The benefit program for which an individual is eligible is based on the criteria outlined in Table A of Section IV of the STCs. Table B in STC 38, provides a side-by-side analysis of the benefits offered through these MassHealth programs.
31. **MassHealth Standard.** Individuals enrolled in MassHealth Standard receive state plan services including for individuals under age 21, Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. In addition, individuals enrolled in Standard receive additional demonstration benefits specifically authorized in demonstration expenditure authorities.

MassHealth's Standard Alternative Benefit Plan (ABP) is for individuals in the New Adult Group who are ages 19-20, as well as individuals 21-64 who are HIV positive, have breast or cervical cancer or are receiving services from the Department of Mental Health or who are on a waiting list to receive such services. Individuals enrolled in the Standard ABP receive the same benefits offered in Standard and benefits are provided in the same manner as outlined below.

MassHealth Standard benefits will be provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished as described in STC 46 and 47.

MassHealth Standard benefits include, for individuals with incomes at or below 133 percent of FPL who are also eligible for Medicare, (1) payment of monthly Medicare Part B premiums, (2) payment of hospital insurance premiums under Medicare Part A; and, (3) payment of deductibles and co-insurance under Medicare Part A and B. The Commonwealth may establish eligibility for this coverage without applying an asset test. These benefits will begin on the first day of the month following the date of the MassHealth eligibility determination.

32. **MassHealth CarePlus.** MassHealth's CarePlus ABP is for individuals in the New Adult Group ages 21-64 who are not otherwise eligible for MassHealth Standard ABP. CarePlus provides medical and behavioral health services, including diversionary behavioral health service and non-emergency medical transportation, but does not include long term services and supports. Benefits are provided either through direct coverage, cost effective premium assistance, or a combination of both (benefits wrap). Premium assistance will be furnished as described in STC 46 and 47.

33. **MassHealth Breast and Cervical Cancer Demonstration Program (BCCDP).** The BCCDP is a health benefits program for individuals in need of treatment for breast or cervical cancer. This program offers MassHealth Standard benefits to individuals under 65 who do not otherwise qualify for MassHealth.
34. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under Standard; individuals under age 21 receive EPSDT services as well. In addition, individuals enrolled in CommonHealth receive additional demonstration benefits specifically authorized in demonstration expenditure authorities. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished as described in STC 46 and 47. In addition, for CommonHealth members with gross income between 133 and 135 percent FPL who are also eligible for Medicare, the Commonwealth will also pay the cost of the monthly Medicare Part B premium. These benefits shall begin on the first day of the month following the date of the MassHealth eligibility determination. The Commonwealth may establish eligibility for this coverage without applying an asset test.
35. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under Standard. Among other things, individuals enrolled in Family Assistance receive additional demonstration benefits specifically authorized in demonstration expenditure authorities The Commonwealth may waive its requirement for children with access to ESI to enroll in ESI if the Commonwealth determines it is more cost effective to provide benefits under direct Family Assistance coverage than to provide premium assistance. For individuals who derive their Family Assistance benefits via the 1115 demonstration and who are on Direct Coverage, premium assistance will be furnished in coordination with STC 46 There are two separate categories of eligibility under Family Assistance:
- A. Family Assistance-HIV/AIDS.** As referenced in Table A above, for persons with HIV/AIDS whose income is above 133 percent less than or equal to 200 percent of the FPL would be eligible for the New Adult Group (MassHealth CarePlus) but for the income limit. Unlike other coverage types, persons with HIV who have access to ESI do not have to enroll in available ESI; however, if they choose to receive premium assistance, the Commonwealth will provide covered services that are not available from the ESI plan on a fee-for-service (FFS) basis.
 - B. Family Assistance-Children.** As referenced in table A above, children can be enrolled in Family Assistance if their family's income is above 150 percent and less than or equal to 300 percent FPL. Benefits are provided either through direct coverage or cost effective premium assistance. Direct coverage Family Assistance under the title XXI program is provided through an MCO, ACO, or the PCC plan for children without access to ESI. Premium Assistance benefits are limited to premium assistance for ESI, to the extent that ESI is available to these children that is cost-effective, meets a basic benefit level (BBL), and for which the employer contributes at least 50 percent of the premium cost. Premium assistance may exceed the cost of child-only coverage and

include family coverage if cost effective based on the child’s coverage. Direct coverage is provided for children with access to cost effective ESI that meets the BBL only during the provisional eligibility period and the time span while the Commonwealth is investigating availability of and enrolling the child in ESI.

36. **MassHealth Small Business Employee (SBE) Premium Assistance.** Under the SBE Premium Assistance Program, the Commonwealth will make premium assistance payments for certain individuals whose gross family income is greater than 133 percent of the FPL and less than or equal to 300 percent of the FPL, who work for employers with 50 or fewer employees, who have access to qualifying ESI, and where the member is ineligible for other subsidized coverage through MassHealth or the Health Connector. Benefits are limited to premium assistance payments for qualifying ESI that meets basic benefit level (BBL) standards.

37. **MassHealth Limited.** Individuals are enrolled in Limited if they are federally non-qualified non-citizens, whose immigration status makes them ineligible for other MassHealth programs under the state plan. These individuals receive emergency medical services only as described in 42 C.F.R. 440.255.

38. **Benefits Offered under Certain Demonstration Programs.**

Table B. Summary of MassHealth Direct Coverage Benefits are described in Table Below

Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus
EPSDT	X	X		
Inpatient Acute Hospital	X	X	X	X
Adult Day Health	X	X		
Adult Foster Care**	X	X		
Ambulance (emergency)	X	X	X	X
Audiologist Services	X	X	X	X
Behavioral Health Services (mental health and substance abuse)	X	X	X	X
Benefits	Standard/ Standard ABP	CommonHealth	Family Assistance	CarePlus

Chapter 766 Home Assessment***	X	X	X	
Chiropractic Care	X	X	X	
Chronic Disease and Rehabilitation on Hospital Inpatient	X	X	X	X
Chronic Disease and Rehabilitation Hospital Outpatient	X	X	X	X
Community Health Center (includes FQHC and RHC services)	X	X	X	X
Day Habilitation****	X	X		
Dental Services	X	X	X	X
Diversionsary Behavioral Health Services	X	X	X	X
Durable Medical Equipment and Supplies	X	X	X	X
Early Intervention	X	X	X	
Family Planning	X	X	X	X
Group Adult Foster Care	X	X		
Hearing Aids	X	X	X	X
Home Health	X	X	X	X
Hospice	X	X	X	X
Laboratory/X-ray/Imaging	X	X	X	X
Medically Necessary Non-emergency	X	X		X

Transport				
Nurse Midwife Services	X	X	X	X
Nurse Practitioner Services	X	X	X	X
Orthotic Services	X	X	X	X
Outpatient Hospital	X	X	X	X
Outpatient Surgery	X	X	X	X
Oxygen and Respiratory Therapy Equipment	X	X	X	X
Personal Care	X	X		
Pharmacy	X	X	X	X
Physician	X	X	X	X
Podiatry	X	X	X	X
Private Duty Nursing	X	X		
Prosthetics	X	X	X	X
Rehabilitation	X	X	X	X
Renal Dialysis Services	X	X	X	X
Skilled Nursing Facility	X	X	Limited	Limited
Speech and Hearing Services	X	X	X	X
Targeted Case Management	X	X		
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X
Vision Care	X	X	X	X

Chart Notes

****Adult Foster Care Services** – These services are state plan services and the definition of these services

may vary contingent upon the approved state plan. In general, the services are assistance with activities of daily living and instrumental activities daily living, supportive services, nursing oversight and care management provided in a qualified private home by a principal caregiver who lives in the home. Adult foster care is furnished to adults who receive the services in conjunction with residing in the home. The number of individuals living in the home unrelated to the principal caregiver may not exceed three. Adult foster care does not include payment for room and board or payments to spouses, parents of minor children and other legally responsible relatives

***** Chapter 766 Home Assessments** – These services may be provided by a social worker, nurse or counselor. The purpose of the home assessment is to identify and address behavioral needs that can be obtained by direct observation of the child in the home setting.

****** Day Habilitation Services** – These services are state plan services and the definition of these services may vary contingent upon the approved state plan. In general, the services are assistance with skill acquisition in the following developmental need areas: self-help, sensorimotor, communication, independent living, affective, behavior, socialization and adaptive skills. Services are provided in non-residential settings or Skilled Nursing Facilities when recommended through the PASRR process. Services include nursing, therapy and developmental skills training in environments designed to foster skill acquisition and greater independence. A day habilitation plan sets forth measurable goals and objectives, and prescribes an integrated program of developmental skills training and therapies necessary to reach the stated goals and objectives.

39. **Diversionsary Behavioral Health Services.** Diversionsary behavioral health services are home and community-based mental health and substance use disorder services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and substance use disorder services in more community- based, less structured environments. Diversionsary services are also provided to support an individual’s return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionsary services, those provided in a 24-hour facility, and those which are provided on an outpatient basis in a non-24-hour setting or facility. Generally, 24-hour and non-24 hour diversionsary behavioral health services are provided by free-standing (community-based) or hospital-based programs licensed by the Department of Mental Health or the Department of Public Health. Some of the 24 hour service providers of Diversionsary Behavioral Health Services meet the definition of an Institution for Mental Diseases (IMD). Diversionsary services are offered to provide interventions and stabilization to persons experiencing mental health or substance abuse crises in order to divert from acute inpatient hospitalization or to stabilize after discharge. These services do not include residential programs involving long-term residential stays. Any MassHealth member under the demonstration who is enrolled in managed care may be eligible to receive diversionsary services. Managed care entities and the Prepaid Inpatient Health Plan (PIHP) for behavioral health services identify appropriate individuals to receive diversionsary services. Managed care entities maintain a network of diversionsary services and arrange, coordinate, and oversee the provision of medically necessary diversionsary services, as described in Table C.

Table C. Diversionary Behavioral Health Services Provided Through Managed Care Under the Demonstration

<u>Diversionary Behavioral Health</u>	<u>Setting</u>	<u>Definition of Service</u>
Community Crisis Stabilization	24-hour facility	Services provided as an alternative to hospitalization, including short- term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.
Community Support Program (CSP)	Non-24-hour facility	An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services
<u>Diversionary Behavioral Health</u>	<u>Setting</u>	<u>Definition of Service</u>
		to Covered Individuals with a long-standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.

<p>Partial Hospitalization*</p>	<p>Non-24-hour facility</p>	<p>An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.</p>
<p>Acute Treatment Services for Substance Abuse</p>	<p>24-hour facility, Including IMDs</p>	<p>24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co- occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs</p>

<p>Clinical Support Services for Substance Abuse</p>	<p>24-hour facility, including IMDs</p>	<p>24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.</p>
<p>Transitional Care Unit Services addressing the needs of children and adolescents, under age 19, in the custody of the Department of Children and Families (DCF), who need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care.</p>	<p>24-hour facility, including IMDs</p>	<p>A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu**, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.</p>
<p>Psychiatric Day Treatment*</p>	<p>Non-24-hour facility</p>	<p>Services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.</p>

Intensive Outpatient Program	Non-24-hour	A clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.
<u>Diversionary Behavioral Health</u>	<u>Setting</u>	<u>Definition of Service</u>
Structured Outpatient Addiction Program	Non-24-hour facility	Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.

<p>Program of Assertive Community Treatment</p>	<p>Non-24-hour facility</p>	<p>A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community.</p> <p>Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.</p>
<p>Emergency Services Program*</p>	<p>Non-24-hour facility</p>	<p>Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.</p>

Community Based Acute Treatment for Children and Adolescents	24-hour facility	Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specializing (which is defined as one- on-one therapeutic monitoring as needed for individuals who may be at immediate risk for suicide or other self-harming behavior); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.
--	------------------	---

Chart Notes:

* This service is a service provided under the Medicaid state plan, and the definition may be changed pursuant to any state plan amendment.

** In this context, “therapeutic milieu” refers to a structured, sub-acute setting, in which clinical services (therapies) are provided at both the individual and group level, and in which the common social/interpersonal interactions between each patient, and all others who are present in the setting, are incorporated into the treatment approach.

40. Substance Use Disorder Services

As part of this demonstration Project, in addition to the Substance Use Disorder (SUD) services described in Charts B and C, above, FFP is available under the demonstration for the Substance Use Disorder (SUD) services described in Chart D, below. By providing improved access to treatment and ongoing recovery support, EOHHS believes individuals with SUD will have improved health and increased rates of long-term recovery. These SUD services will contribute to reduced use of the emergency department and unnecessary hospitalizations.

As is currently the case, MassHealth anticipates that the Department of Public Health, Bureau of Substance Abuse Services (BSAS), which is the single state authority on SUD services, continue to fund primary prevention efforts, including education campaigns and community prevention coalitions. Intervention and initial treatment will be available to MassHealth members, as described below, in a number of different settings (as set forth herein) and allow for a bio-psycho-social clinical assessment, based on the ASAM principles, to gain an understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability and other issues.

Table D. Additional SUD Authorized Services

<u>Service for People with SUD</u>	<u>Population</u>	<u>Setting</u>	<u>Definition of Service</u>
Clinically Managed Population-Specific High-Intensity Residential Services ASAM Level 3.3 (Specialized 24-hour treatment services to meet more complex needs)	All MassHealth Members, except those in MassHealth Limited	24-hour facility, including IMDs	Treats patients in a 24-hour setting where the effects of the substance use, other addictive disorder, or co-occurring disorder resulting in cognitive impairment on the individual's life are so significant and the resulting level of impairment so great that other levels of 24-hour or outpatient care are not feasible or effective. Includes day programming and individual and group services. This service will be implemented by July 1, 2018.
Clinically Managed Low-Intensity Residential Services ASAM Level 3.1 (24-hour Transitional Support Services)	All MassHealth members, except those in MassHealth Limited	24-hour facility, including IMDs	Services provided to an individual with a substance use disorder in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to ensure safety for the individual, while providing active treatment and reassessment. Includes 4 hours of nursing services.
Clinically Managed Low-Intensity Residential Services ASAM Level 3.1 (24-hour Residential Rehabilitation)	All MassHealth members, except those	24-hour facility, including IMDs	Services provided to an individual with a substance use disorder in a 24-hour setting, with clinical staff and appropriately trained professional and paraprofessional staff to ensure safety for the

Services and 24-hour community-based family SUD treatment services	in MassHealth Limited		individual, while providing active treatment and reassessment. Through this service MassHealth will provide ASAM Level 3.1 services to adults, families, and adolescents. Residential Rehabilitation Services includes day programming and individual and group services.
Recovery support navigator services	All MassHealth members, except those in MassHealth Limited		Under this service, a Recovery Support Navigator develops and monitors a recovery plan in conjunction with the member, coordinates all clinical and non-clinical services, participates in discharge planning from acute treatment programs, works with the member to ensure adherence to the discharge plan, and assists the member in pursuing his or her health management goals.
Recovery coach services	Available to MassHealth members who receive care through an ACO/MCO		Under this service, a Recovery Coach (a person with SUD lived experience) will serve as a recovery guide and role model. Recovery Coaches provide nonjudgmental problem solving and advocacy to help members meet their recovery goals.

Chart Notes: MassHealth Members receiving services on a FFS basis will receive all medically necessary Transitional Support Services (TSS), and up to the first 90 days of a medically necessary stay in Residential Rehabilitation Services (RRS). MassHealth Members who are enrolled in an MCO, ACO or the PCC Plan, will receive all medically necessary TSS and RRS from an MCO or the behavioral health carve out vendor. The Commonwealth's average length of stay (ALOS) in SUD treatment for persons admitted into all DPH-licensed ASAM Level 3.7, 3.5 and 3.1 programs during state fiscal year 2015 was 16.1 days.

VI. DELIVERY SYSTEM

The MassHealth section 1115 demonstration provides benefits through multiple delivery systems and programs. A fundamental philosophy of MassHealth is that the Commonwealth will enable beneficiaries to take advantage of available and qualified employer-sponsored (ESI) or student health (SHIP) insurance if cost effective. These circumstances include the availability of ESI, the employer's contribution level meeting a state-specified minimum, and its cost-effectiveness. MassHealth pays for medical benefits directly (direct coverage) only if no other source of payment is available and cost-effective. Beneficiaries are required, as a condition of eligibility under some coverage types, to obtain or maintain private health insurance if MassHealth determines it is cost effective to do so, with the premium assistance necessary to make it affordable for the beneficiary. All demonstration programs except MassHealth Limited have a premium assistance component.

41. Direct Coverage and Eligibility for Managed Care

MassHealth benefits provided through direct coverage are delivered through the following delivery systems under the demonstration, grouped into four categories:

- a) Fee for service (“FFS”);
- b) A behavioral health contractor (which is a PIHP);
- c) Two primary care case management (PCCM) delivery systems: the PCC Plan; and Primary Care ACOs (which are PCCM entities); and
- d) Two MCO-based delivery systems: the MassHealth MCOs; and Accountable Care Partnership Plans

Together, all of these delivery systems except for FFS (i.e., the PCC Plan, the Behavioral Health PIHP, Primary Care ACOs, MassHealth MCOs, and Accountable Care Partnership Plans) are referred to as “Managed Care.” Additional detail on these Managed Care delivery systems is provided in STC 43-45. MassHealth may require beneficiaries eligible for direct coverage under any of the following categories to enroll in one of the Managed Care options described above: Standard, Standard ABP, Family Assistance, CarePlus, or CommonHealth members with no third party liability.

In addition, children who are clients of the Departments of Children and Families (DCF) or Youth Services (DYS) who do not choose to enroll in Managed Care may instead choose to receive medical services through FFS, but are nonetheless required to enroll with the behavioral health contractor for behavioral health services.

Children eligible under TEFRA section 134 (Kaileigh Mulligan) and children receiving title IV-E adoption assistance may opt to enroll in Managed Care, or may choose instead to receive health services through FFS. Children who choose fee-for-service will be passively enrolled with the behavioral health contractor for behavioral health services, but have the ability to opt-out and receive behavioral health services through the fee-for-service provider network.

See Table E below for additional details on Managed Care eligibility and enrollment rules.

42. Exclusions from Managed Care Enrollment. The following individuals may be excluded from enrollment in Managed Care:

- A.** Any individual for whom MassHealth is a secondary payer (i.e., a member with other health insurance). For purposes of exclusion from Managed Care, “other health insurance” is defined as any medical coverage plan available to the member, including, but not limited to Medicare, CHAMPUS, or a private health plan. However, MassHealth requires children eligible for MassHealth Standard/Standard ABP and CommonHealth, for whom MassHealth is a secondary payer, to enroll with the behavioral health contractor for behavioral health services;
- B.** Any individual receiving benefits during the hospital-determined presumptive eligibility period or the time-limited period while MassHealth investigates and verifies access to qualified and cost-effective private health insurance or the time-limited period

while the member is enrolling in such insurance;

- C. Any individual receiving Limited coverage;
- D. Any individual receiving hospice care, or who is terminally ill as documented with a medical prognosis of a life expectancy of 6 months or less; and
- E. Any participant in a Home and Community-Based Services Waiver who is not eligible for SSI and for whom MassHealth is not a secondary payer.

MassHealth may permit such individuals to enroll in Managed Care, including the option to enroll with the behavioral health contractor for behavioral health services and receive their medical services through FFS.

43. Managed Care Delivery Systems

MassHealth’s Managed Care delivery systems include two categories as described above: (1) PCCM delivery systems (which includes the PCC Plan and Primary Care ACOs); and (2) MCO-based delivery systems (which includes the MassHealth MCOs and Partnership Plans). Table E below provides an overview of these delivery systems.

Table E. Overview of Managed Care Delivery Systems

Managed Care					
PCCM delivery systems			MCO-based delivery systems		
PCC Plan		Primary Care ACOs (previously “Model B ACOs”)	MassHealth MCOs		Partnership Plans (previously “Model A ACOs”)
<i>Non-Pilot</i>	<i>ACO Pilot</i>			<i>Non-ACO</i>	

44. PCCM delivery systems:

- A. **The PCC Plan.** The PCC Plan is a managed care option operated by MassHealth. Members enrolled in the PCC Plan are also enrolled in a single Behavioral Health Program (BHP) contractor, which is a Prepaid Inpatient Health Plan (PIHP), for behavioral health coverage. Members enrolled in the PCC Plan access other services from MassHealth’s FFS network, subject to PCC referral and other utilization management requirements. Each member enrolled in the PCC Plan is assigned to a designated primary care provider (a “Primary Care Clinician,” or “PCC”) from among the PCC Plan’s available PCCs, who provides primary care case management. A member’s PCC provides most primary and preventive care and is responsible for providing referrals for most specialty services and for otherwise coordinating the member’s services. PCC Plan members may receive family planning services from

any provider without consulting their PCC or obtaining prior approval from MassHealth. Members enrolled in the PCC Plan do not experience fixed enrollment, and may enroll in another Managed Care delivery system (i.e., a Primary Care ACO, a MassHealth MCO, or a Partnership Plan) at any time.

- i. **Enhanced Primary Care Clinician Payments.** In accordance with 42 C.F.R. section 438.6(c), MassHealth may establish enhanced fee-for-service rate payments or capitated rate payments to Primary Care Clinicians for coordination of the care delivered to their enrolled PCC plan members. MassHealth may also establish pay-for-performance incentives using capitated or other payment arrangements for achieving certain quality of care benchmarks, for demonstrating certain levels of improvement for selected Healthcare Effectiveness Data and Information Set (HEDIS) or other quality indicators, and for implementing practice infrastructure designed to support the delivery of high-quality health care services to enrolled members.
- ii. **ACO Pilot.** In state fiscal years 2017 and 2018, MassHealth will contract with ACOs (“Pilot ACOs”) for an ACO Pilot within the PCC Plan; the ACO Pilot is not a separate delivery system or an enrollment option for members. Members in the PCC Plan will not experience fixed enrollment periods for the ACO Pilot, and members will still have access to all PCC Plan benefits and network of providers. Pilot ACOs consist of provider-led entities such as health systems or groups of health care providers that contract with MassHealth to provide care coordination and management and to take financial accountability for cost and quality of care for certain attributed PCC Plan members. Members enrolled in the PCC Plan who are assigned to PCCs that participate with Pilot ACOs will be considered attributed to these Pilot ACOs. MassHealth may establish Referral Circles for Pilot ACOs; Referral Circles are groups of providers within MassHealth’s FFS network, for which MassHealth will eliminate the need for otherwise-required primary care referrals for ACO-attributed members, in order to facilitate increased access and coordinated care. MassHealth will hold Pilot ACOs financially accountable for cost and quality of care through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses). MassHealth will contract with Pilot ACOs selectively. Pilot ACOs are not managed care entities under 42 CFR 438. See Attachment L for additional detail on the ACO Pilot.

- B. Primary Care ACOs.** Primary Care ACOs are managed care options operated by MassHealth using PCCM contractors (“Primary Care ACOs”). MassHealth contracts with Primary Care ACOs to serve as PCCM entities. Primary Care ACOs are not paid directly to provide services. Members enrolled in Primary Care ACOs are also enrolled in MassHealth’s Behavioral Health PIHP for behavioral health coverage and access other services from MassHealth’s FFS network, subject to primary care referral and other utilization management requirements. Each member enrolled in a Primary Care

ACO is assigned to a primary care provider from among the Primary Care ACO's participating primary care providers.. Primary Care ACO enrollees may receive family planning services from any provider without consulting their primary care provider or their Primary Care ACO, or obtaining prior approval from MassHealth.

- i. The State may limit disenrollment for Primary Care ACO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
- ii. MassHealth may establish Referral Circles for Primary Care ACOs; Referral Circles are groups of providers within MassHealth's FFS network, for which MassHealth will eliminate the need for otherwise-required primary care referrals for Primary Care ACO enrollees, in order to facilitate increased access and coordinated care.
- iii. MassHealth will hold Primary Care ACOs financially accountable for cost and quality of care through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses). See Attachment O for additional detail on pricing for Primary Care ACOs.
- iv. Similar to the Center for Medicare and Medicaid Innovation (CMMI) "Next Gen" ACO program and its option for population-based payment, MassHealth may also prospectively pre-pay a Primary Care ACO, at the request of both the Primary Care ACO and the providers. Providers and Primary Care ACOs may choose such arrangements to support greater control of service revenue funds within a coordinated system, to increase accountability for total cost of care, to support up-front investments in infrastructure that supports integrated care delivery, or for other purposes in service of MassHealth's delivery system goals. Under such a payment mechanism, MassHealth would continue to maintain the FFS network and receive claims from network providers for payments for services, but would reconcile those claims to prepayments for such services. The Commonwealth will submit a proposal for any such payment mechanism to CMS for approval prior to implementation.
- v. Primary Care ACOs may be required to implement payment arrangements in their contracts with their participating primary care providers that may include minimum levels and/or frequency of risk sharing. Such arrangements will be consistent with 42 CFR 438.6.
- vi. MassHealth will contract with Primary Care ACOs selectively. Primary Care ACOs are PCCM entities under 42 CFR 438.

C. Other features of MassHealth's PCCM delivery systems. MassHealth will maintain responsibility for requirements of the delivery systems not specifically delegated to the PCCMs or PCCM entities (e.g., member communications about the delivery system).

45. MCO-based delivery systems:

- A. MassHealth MCOs.** MassHealth contracts selectively with Managed Care Organizations (MCOs) that provide comprehensive health coverage, including behavioral health services, to enrollees. Some Direct Coverage services are not provided by the MCOs but are instead

covered directly by MassHealth for members enrolled in MCOs. Over the course of the Demonstration, MassHealth anticipates that enrollees will begin to receive certain of these Direct Coverage services from the MCOs. For example, Long Term Services and Supports (LTSS) are anticipated to be phased into MCO covered services during the Demonstration extension period. Members enrolled in MCOs may receive family planning services from any provider without consulting their PCP or MCO and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in a member's MCO network, MassHealth reimburses the provider on a fee-for-service basis and recoups the funds from the MCO. See Attachment O for additional detail on pricing for MassHealth MCOs. MassHealth MCOs are MCOs under 42 CFR 438.

- A. The State may limit disenrollment for MCO enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
- B. MCO contracts will include requirements to use alternative payment methodologies and other arrangements described in STC 43 and Attachment G, to increase accountability for cost and quality of care through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses).

C. **MCO-Contracted ACOs.** MassHealth will select certain qualified ACOs through a competitive selection process, for accountability for services furnished through MassHealth ACOs. These "MCO-Contracting ACOs" will be provider-led entities such as health systems or groups of health care providers that contract with MCOs to provide care coordination and management and to take financial accountability for cost and quality of care for certain attributed MCO enrollees. They are not managed care entities under 42 CFR 438 and there will not be a separate delivery system or enrollment option for MCO enrollees attributed to MCO-contracting ACOs; such individuals will receive services from the MCO service delivery system. MCO enrollees who receive primary care from primary care providers who participate in MCO-contracting ACOs are considered attributed to those ACOs for the purposes of this cost and quality accountability. MassHealth MCO contracts will include requirements for MCOs to contract with MCO-Administered ACOs using a MassHealth-approved alternative payment contract framework that includes risk tracks and schedules set by the state, which will be broadly consistent with 42 CFR 438.6(c). This alternative payment contract framework will hold MCO-Contracted ACOs financially accountable through shared savings and shared losses (i.e., downside risk), including potentially asymmetric risk (i.e., potential shared savings exceed potential shared losses). As with MCO enrollees not attributed to ACOs, these MCO enrollees may experience fixed enrollment to their MCO, and receive services from their MCO's provider network (except for certain Direct Coverage services provided directly by MassHealth, as described above) subject to their MCO's rules for referral, prior authorization, and primary care provider assignment. See Attachment O for additional detail on pricing for MCO-Administered ACOs.

- B. **Accountable Care Partnership Plans ("Partnership Plans").** MassHealth will contract selectively with Partnership Plans that provide comprehensive health coverage, including behavioral health services, to enrollees. Some Direct Coverage services are not provided by

the Partnership Plans but are instead covered directly by MassHealth for members enrolled in Partnership Plans. Over the course of the Demonstration, MassHealth anticipates that enrollees will begin to receive certain of these Direct Coverage services from the Partnership Plans. For example, Long Term Services and Supports (LTSS) are anticipated to be phased into Partnership Plan covered services during the Demonstration extension period. Members enrolled in Partnership Plans may receive family planning services from any provider without consulting their PCP or Partnership Plan and are not required to obtain prior approval from MassHealth. For family planning services provided by MassHealth providers not participating in a member's Partnership Plan network, MassHealth reimburses the provider on a fee-for-service basis and recoups the funds from the Partnership Plan. See Attachment O for additional detail on pricing for Partnership Plans.

- i. The state may limit disenrollment for Partnership Plan enrollees. Any such limitation will be consistent with 42 CFR 438.56(c).
- ii. Partnership Plans may have certain additional requirements such as requirements to partner with an ACO-based provider network to deliver services and coordinate care for enrollees, and to hold such ACO and providers financially accountable for the cost and quality of care under a MassHealth-approved framework that may include minimum levels and/or frequency of risk sharing. Such arrangements will be consistent with 438.6.
- iii. MassHealth will contract with Partnership Plans selectively. Partnership Plans are MCOs under 42 CFR 438.

44. Primary Care Exclusivity. MassHealth will establish rules to require the exclusivity of primary care providers for certain Managed Care delivery systems, in order to ensure that accountability for cost and quality can accurately be assigned, and to facilitate members' choice among delivery systems options if members wish to choose based on their preferred primary care provider. Specifically, MassHealth will require all Pilot ACOs, Primary Care ACOs, Partnership Plans, and MCO-Administered ACOs (all of which are financially accountable for the cost and quality of attributed members) to each ensure that their participating primary care providers do not simultaneously participate in any other delivery system option, as follows:

- a) A primary care provider participating with a Pilot ACO may not simultaneously participate with another Pilot ACO
- b) A primary care provider participating with a Primary Care ACO may not simultaneously participate with another Primary Care ACO, with a Partnership Plan, or with an MCO-Administered ACO. This primary care provider also may not serve as a PCC in the PCC Plan or a network PCP in the network of a MassHealth MCO. This primary care provider will exclusively serve as a primary care provider for enrollees in the Primary Care ACO.
- c) A primary care provider participating with a Partnership Plan may not simultaneously participate with a Primary Care ACO, with another Partnership Plan, or with an MCO-Administered ACO. This primary care provider also may not serve as a PCC in the PCC Plan or a network PCP in the network of a MassHealth MCO. This primary care provider will exclusively serve as a primary care provider for enrollees in the Partnership Plan.
- d) A primary care provider participating with an MCO-Contracted ACO may not simultaneously participate with a Primary Care ACO, with a Partnership Plan, or with

another MCO-Contracted ACO. This primary care provider also may not serve as a PCC in the PCC Plan. This primary care provider may not serve as a network PCP in the network of a MassHealth MCO, except as part of the MCO-Administered ACO (i.e., the MCO must have a MassHealth-approved ACO contract with the MCO-Administered ACO). This primary care provider will exclusively serve as a primary care provider for MassHealth MCO enrollees who are attributed to the MCO-Administered ACO.

Where this exclusivity applies, it applies only for MassHealth members eligible for Managed Care. Primary care providers may be in MassHealth's FFS network and provide services to non-Managed Care enrolled MassHealth members (e.g., dually eligible FFS members).

45. **Contracts.**

a) Managed Care Contracts. All contracts and modifications of existing contracts between the Commonwealth and MCOs or between the Commonwealth and Partnership Plans must be prior approved by CMS. The Commonwealth will provide CMS with a minimum of 90 calendar days to review and approve changes.

i. MassHealth may make periodic payments of the types described below to managed care entities (MCE), including MCOs, Partnership Plans and PIHPs, and direct that these payments be made to hospitals in the MCEs' networks:

For example, starting in MCO Rate Year 2017 (October 1, 2016-September 30, 2017), MassHealth will direct its contracted MCOs to make payments to hospitals in their networks as an incentive for hospitals to report on and subsequently improve access to appropriate medical and diagnostic equipment for members with disabilities. MassHealth will calculate the payments for which each hospital is eligible based on current year Medicaid Gross Patient Service Revenue and will direct the MCOs to make payments accordingly, contingent on the hospitals meeting requirements set forth by MassHealth. While this program will not be renewed automatically, it will be a multi-year initiative in which the first two years will require reporting by hospitals on access to medical and diagnostic equipment, and future years will include related performance requirements for hospitals. In future years this program may also be administered by Accountable Care Partnership Plans, in accordance with Attachment Q and I.

b) Public Contracts. Contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index), unless the contractual payment rate is set at the same rate for both public and private providers. This requirement does not apply to contracts under the SNCP as outlined in STC 51.

c) Selective Contracting. Procurement processes and the subsequent final contracts developed to implement selective contracting by the Commonwealth with any provider group shall be

subject to CMS approval prior to implementation, except for contracts authorized pursuant to 42 C.F.R. section 431.54(d).

- d) Capitation Rate Development. Capitation rates for MCOs and Partnership Plans shall comply with the rate development and certification standards in 42 CFR §438. The Commonwealth shall develop its capitation rates in a manner consistent with Attachment O

46. **MassHealth Premium Assistance.** For most individuals eligible for MassHealth, the Commonwealth may require as a condition of receiving benefits, enrollment in available insurance coverage. In that case, Massachusetts provides a contribution through reimbursement, direct payment to the insurer, or direct payment to an institution of higher education (or its designee) that offers a Student Health Insurance Plan (SHIP), toward an individual's share of the premium for an employer sponsored health insurance plan or SHIP which meets a basic benefit level (BBL). The Commonwealth has identified the features of a qualified health insurance product, including covered benefits, deductibles and co-payments, which constitute the BBL. Each private health insurance plan is measured against the BBL, and a determination is then made regarding the cost-effectiveness of providing premium assistance. For individuals eligible for premium assistance only through the SBE ESI program, this same test will apply.

If available and cost effective, the Commonwealth will provide premium assistance on behalf of individuals eligible for Standard (including ABP 1), CarePlus or CommonHealth coverage, to assist them in the purchase of private health insurance coverage. The state will also provide coverage for additional services required to ensure that such individuals are receiving no less than the benefits they would receive through direct coverage under the state plan. This coverage will be furnished, at the state option, on either a FFS basis or through managed care arrangements. These individuals are not required to contribute more towards the cost of their private health insurance than they would otherwise pay for MassHealth Standard (including ABP 1), CarePlus or CommonHealth coverage. Cooperation with the Commonwealth to obtain or maintain available health insurance will be treated as a condition of eligibility for all of those in the family group, except those who are under the age of 21, or pregnant.

47. **Student Health Insurance (SHIP) Plans.** For individuals with access to SHIP plans, the Commonwealth may require enrollment in such plan as a condition of receiving benefits. Once the individual enrolls in the SHIP Plan, premium and cost sharing assistance will be provided for the entire plan year or the duration of the SHIP plan enrollment, if less than one year. The state will also ensure individuals receive comparable benefits to those offered in Medicaid programs the individual is eligible for receiving, for the duration of the individual's enrollment in SHIP. In addition, for those individuals enrolled in SHIP plans with premium assistance, the Commonwealth will provide continuous eligibility that will coincide with the SHIP plan year, or the duration of the SHIP plan enrollment, if less than one year, for which premium assistance is provided.

48. **Overview of Delivery System and Coverage for MassHealth Administered Programs.** The following chart provides further detail on the delivery system utilized for the MassHealth administered programs and the related start date for coverage:

Table E. Delivery System and Coverage for MassHealth Demonstration Programs

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
<u>Standard/Standard ABP</u>					
Individuals with no third party liability (TPL)	Managed Care (PCC Plan, MCO, or Accountable Care)	x			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS		x		10 days prior to date of application
Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application

<p>Kaileigh Mulligan eligible children and children receiving title IV-E adoption assistance</p>	<p>Behavioral health is typically provided via BHP PIHP, although a FFS alternative must be available; all other services are offered via Managed Care or FFS.</p>		<p>x</p>		<p>Kaileigh Mulligan - may be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided.”</p> <p>Title IV-E adoption assistance - start date of adoption</p>
<p>Medically complex children in the care/custody of the DCF</p>	<p>Special Kids Special Care MCO</p>		<p>x</p>		<p>Start date of state custody</p>
<p>Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF</p>	<p>All services are offered via Managed Care or FFS, with the exception of behavioral health which is provided via mandatory enrollment in BHP PIHP unless the child enrolls in an MCO or Accountable Care Partnership Plan</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>Start date of state custody</p>

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
	in which case, behavioral health is provided through the MCO or Accountable Care Partnership Plan				
Provisionally eligible pregnant women and children, for an up to 90-day period, before self-attested family income is verified	FFS			x	10 days prior to date of application if citizenship/immigration status is verified
Individuals in the Breast and Cervical Cancer Treatment Program	Managed Care	X			10 days prior to date of application
<u>CommonHealth*</u>					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Adults with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Children with TPL	Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP	x		x	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for HIV/AIDS*</u>					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			x	10 days prior to date of application

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage****
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>Family Assistance for Children***</u>					
Individuals with no TPL	Managed Care **	X			10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			x	10 days prior to date of application
<u>CarePlus</u>					
Individuals with no TPL	Managed Care	X			10 days prior to date of application
Individuals with TPL	Receive wrap benefits via FFS			X	10 days prior to date of application
Individuals with qualifying ESI or SHIP	Premium assistance with wrap			X	10 days prior to date of application

<u>Small Business Employee Premium Assistance</u>					
Individuals with qualifying ESI	Premium assistance for employees			N/A	First month's premium payment following determination of eligibility
<u>Limited</u>					
Individuals receiving emergency services only	FFS			X	10 days prior to date of application
<u>Home and Community-Based Waiver, under age 65</u>	Generally FFS, but also available through voluntary Managed Care			X	May be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided.
Health Connector Subsidies	Premium and cost sharing assistance	X			Start date of Health Connector benefits
<u>Chart Notes</u>					

Coverage Type	Delivery System Type	Mandatory	Voluntary	FFS Only	Start Date of Coverage*****
*TPL wrap could include premium payments					
** FFS until member selects or is auto-assigned to MCO, ACO or PCC Plan					
***Presumptive and time-limited during health insurance investigation					
**** All retroactive eligibility is made on a FFS basis.					

VII. COST SHARING

49. **Overview.** Cost-sharing imposed upon individuals enrolled in the demonstration and eligible under the state plan or in a “hypothetical” eligibility group is consistent with the provisions of the approved state plan except where expressly made not applicable in the demonstration expenditure authorities. Cost sharing for individuals eligible only through the demonstration may vary across delivery systems, demonstration programs and by FPL, except that no co-payments are charged for any benefits rendered to children under age 21 or pregnant women. Additionally, no premium payments are required for any individual enrolled in the demonstration whose gross income is less than 150 percent FPL. Please see Attachment B for a full description of cost-sharing under the demonstration for MassHealth-administered programs. The Commonwealth has the authority to change cost-sharing for the Small Business Employee Premium Assistance programs without amendment. Updates to the cost-sharing will be provided upon request and in the annual reports,

- a. **State Differential Cost Sharing and Network Adequacy.** The Commonwealth’s ability to implement premiums and copayments cost sharing that vary by eligibility group, income level, delivery system and service as described in Attachment B through June 30, 2020 may be extended with approval from CMS, based on findings of an evaluation of aggregate provider networks in the ACO and MCO programs relative to the PCC Plan, as further described in Section XII (language below in Evaluation section), using metrics created by the state. If the findings are satisfactory to CMS then the waiver authority and the waiver is extended, such renewal shall not require that the state submit an amendment request to the demonstration.

VIII. THE SAFETY NET CARE POOL (SNCP)

50. **Description.** The Safety Net Care Pool (SNCP) was established effective July 1, 2005 for the purpose of reducing the rate of uninsurance in the Commonwealth while providing residual provider funding for uncompensated care, and care for Medicaid FFS, Medicaid managed care, Commonwealth Care and low-income uninsured individuals, as well as infrastructure expenditures and access to certain state health programs related to vulnerable individuals, including low-income populations as described in Attachment E. As the Commonwealth has achieved significant progress in increasing access to health coverage, the SNCP has evolved to support delivery system transformation and infrastructure

expenditures, both aimed at improving health care delivery systems and thereby improving access to effective, quality care. During the current extension period, the SNCP has been restructured to include the following expenditure categories:

- i. Payments that offset Medicaid FFS and managed care underpayment, and uncompensated care for uninsured and underinsured (DSH – shortfall and uninsured).
- ii. Uncompensated care pool restricted to charity care for uninsured and underinsured, aligned with CMS uncompensated care pool policy as applied in other states (UCC – uninsured care). CMS will only make changes to the base methodology during the negotiation of another demonstration extension with the Commonwealth.
- iii. Time-limited incentive based pools, that phase down over the course the five year extension period; and
- iv. Expenditures for Health Connector subsidies.

51. **Expenditures Authorized under the SNCP.** The Commonwealth is authorized to claim as allowable expenditures under the demonstration, to the extent permitted under the SNCP limits under STC 52, for the following categories of payments and expenditures. The Commonwealth must identify the provider and the source of non-federal share for each component of the SNCP. Federally-approved payments and expenditures within these categories are specified in Attachment E. The Commonwealth must only claim expenditures at the regular FMAP for these programs.

a) **Payments for Uncompensated Care**

- i. **Disproportionate Share Hospital-like (DSH-like) Pool.** As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the demonstration, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, and low-income uninsured individuals consistent with the definition of uncompensated care in 42 CFR 447.299, except that DSRIP and PHTII incentive payments will not be included as patient care revenues for this purpose. The Commonwealth may also claim as allowable expenditures payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease. Payments are limited to uncompensated care costs incurred by providers and verified in cost reports or other cost records, in serving individuals who are eligible for Medicaid, or have no health care insurance for the service. These payments are subject to the SNCP limits under STC 52 The DSH Pool may include expenditures for:
 1. Public Service Hospital Safety Net Care payments to hospitals for care provided to eligible low income uninsured and underinsured patients;
 2. Health Safety Net Trust Fund payments to hospitals and community health centers for care provided to eligible low income uninsured and underinsured patients;
 3. Payments to Institutions for Mental Disease (IMDs) for care provided to MassHealth Members, to the extent these expenditures are not claimed under the SUD authority described in STC 40;
 4. Certified public expenditures for uncompensated care provided by Department of Public Health (DPH) and Department of Mental Health (DMH) hospitals; and
 5. Safety Net Provider Payments to qualifying hospitals, as described in (2) below.

- ii. **Safety Net Provider Payments.** The Commonwealth may make Safety Net Provider Payments to eligible hospitals, in recognition of safety net providers in the Commonwealth that serve a large proportion of Medicaid and uninsured individuals and have a demonstrated need for support to address uncompensated care costs consistent with the definition of 42 CFR 447.299. These payments are intended to provide ongoing and necessary operational support; as such, they are not specifically for the purposes of delivery system reform and are not time limited.

The Commonwealth will determine, based on the eligibility criteria listed below, the hospitals that are eligible to receive the Safety Net Provider Payments. The eligibility criteria below use hospitals' fiscal year 2014 Uncompensated Care Cost Report (UCCR) and, if a UCCR is unavailable, Massachusetts 403 hospital cost reports for these calculations:

To be eligible, the hospital must meet the following three criteria:

1. Medicaid and Uninsured payer mix by charges of at least 20.00%;
2. Commercial payer mix by charges of less than 50.00%;
3. Is not a MassHealth Essential hospital as defined in Massachusetts' approved State Plan.

Once meeting the above eligibility criteria, a hospital may only receive a Safety Net Provider payment if its FY14 UCCR or, if an FY14 UCCR is unavailable, its FY14 403 cost report demonstrates that it experienced a shortfall for the combination of its Medicaid FFS, managed care, and Uninsured payments versus costs for Medicaid and Uninsured patients, excluding Safety Net Care Pool payments other than Health Safety Net Trust Fund payments. Hospitals that qualify for Safety Net Provider payments because they meet these eligibility criteria and have a demonstrated Medicaid and Uninsured shortfall are listed in Attachment N. Safety Net Provider Payments to any provider may not exceed the amount of documented uncompensated care indicated on these reports.

Safety Net Provider Payments will have accountability requirements, aligned with the Commonwealth's overall delivery system and payment reform goals. In each year of the demonstration extension period, hospitals that receive Safety Net Provider Payments must participate in one of MassHealth's ACO models. In addition, an increasing portion of Safety Net Provider Payments each year of the demonstration extension period will be tied to ACO performance measures as defined in the approved DSRIP Protocol. The benchmarks for ACO performance and methodology for calculating the ACO Accountability Score and associated payment will be the same as the benchmarks and methodology used in the DSRIP program and specified in the approved DSRIP Protocol. The risk levels for each year are specified below:

The portion of the Safety Net Provider Payments that is at-risk will follow the same at-risk Budget Period structure as for the ACOs. The Budget Period is January 1 through December 31. Funds for the 6 month Preparation Budget Period (July 1, 2017 to December 31, 2017) for each safety net provider will be equal to half of the provider's Safety Net

Provider Payments in Demonstration Year 1. Budget Period 1 funds for each safety net provider will be equal to the sum of half of the provider's Safety Net Provider Payments in Demonstration Year 1, and half of the Payments in Demonstration Year 2. Budget Periods 2 through 4 for each safety net provider will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds for each safety net provider will be equal to half of the provider's Safety Net Provider Payments in Demonstration Year 5.

The risk levels for each Budget Period are specified below:

1. 6 month Preparation Budget Period: 5% of each provider's total Safety Net Provider Payments / – hospitals that participate in a MassHealth ACO model will have met the accountability requirement for the 6 month Preparation Budget Period
2. Budget Period 1: 5% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
3. Budget Period 2: 5% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
4. Budget Period 3: 10% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
5. Budget Period 4: 15% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures
6. Budget Period 5: 20% of each provider's total Safety Net Provider Payments at risk – tied to ACO performance on DSRIP measures

iii. **Uncompensated Care (UC) Pool**

1. As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the demonstration, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for non-Medicaid-eligible, uninsured individuals. Payments to an individual provider cannot exceed uncompensated care expenditures documented in cost reports or other records, except that DSRIP and PHTII incentive payments will not be included as hospital patient care revenues for this purpose. Consistent with the Cost Limit Protocol, incentive payments, including DSRIP and PHTII, will not be included as hospital patient care revenues for this purpose. Expenditures provided under the UCC Pool are not subject to the Provider Cap for the DSH Pool described in STC 52. The UCC Pool will include expenditures for:
 - a. Health Safety Net payments to hospitals specifically for costs incurred by the hospital in providing care to Health-Safety Net qualified low income, uninsured patients;
 - b. Certified public expenditures for DPH and DMH hospital expenditures for care provided to uninsured patients, when the source of the non-federal share of such expenditures is not derived from federally-supported funds.
2. Massachusetts will only claim expenditures under the UC Pool to the extent that such expenditures for a particular hospital, when added to amounts paid through the DSH

- Pool, do not exceed the hospital's documented uncompensated care (except as specified below, for critical access hospitals). The methodology used by the state to determine UC payments will ensure that payments to hospitals are in no way subject to any manifest partiality based on sources of nonfederal share or other funding considerations.
3. Prior to the initiation of the Uncompensated Care Pool and at any time in which there is a material change in the pool's distribution methodology, the Commonwealth shall submit a Uncompensated Care Pool Distribution Methodology Report that describes the specific allocation methodology of the pool and demonstrates compliance with the above STCs.

52. Expenditure Limits under the SNCP.

- a) Aggregate SNCP Cap. For SFYs 2018-2022 (July 1, 2017 through June 30, 2022) (SNCP extension period), the SNCP will be subject to an aggregate cap of up to \$4.451 billion added to the provider cap for the DSH-like pool described in STC 52. b) below, as well as the overall budget neutrality limit established in section XI of the STCs, provided, however, that allowable expenditures for Health Connector subsidies will not be subject to the aggregate SNCP cap. Because the aggregate SNCP cap is based, in part, on an amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate SNCP cap, and a corresponding change to the provider cap as described in subparagraph (b). Such a change shall be reflected in this STC 52(b), and shall not require a demonstration amendment.
- b) Provider Cap for the DSH-like Pool. The Commonwealth may expend an amount for purposes specified in STC 51(b) equal to no more than the cumulative amount of the Commonwealth's annual DSH allotments for the SNCP extension period. Any change in the Commonwealth's federal DSH allotment that would have applied for the SNCP extension period absent the demonstration shall result in an equal change to the aggregate amount available for the DSH-like pool. Such change shall not require a demonstration amendment. The DSH-like Pool funding is based on the amount equal to the state's entire DSH allotment as set forth in section 1923(f) of the Act, ("DSH"). In order to align DSH amounts with each SFY, the state's DSH allotment for the federal fiscal year will be pro-rated. In any year to which reductions to Massachusetts' DSH allotment are required by section 1923(f)(7) of the Social Security Act, the amount of the DSH allotment attributable to the SNCP in a given DY shall be reduced consistent with CMS guidelines. The funding limit does not apply to expenditures under the UC Pool, though the Commonwealth may only claim expenditures under the UC Pool to the extent that the DSH Pool has been fully expended.
- c) Uncompensated Care Pool Cap. The Commonwealth may expend up to \$212 million (total computable) for SFY 2018 and up to \$100.4 million (total computable) annually in SFYs 2019-2022 for allowable UC Pool expenditures, as further described in Attachment E. Any unused expenditure authority in SFY 2018 can be expended in SFY 2019, subject to any applicable approval processes described in STC 76.

d) **Budget Neutrality Reconciliation.** The Commonwealth is bound by the budget neutrality agreement described in section XIII of the STCs. The Commonwealth agrees to reduce spending in the SNCP to comply with budget neutrality in the event that expenditures under the demonstration exceed the budget neutrality ceiling outlined in section XIII, STC 106.

53. **Cost for Uncompensated Care.** The SNCP payments pursuant to STC 51(b) support providers for furnishing uncompensated care. This protocol ensures that all provider payments for uncompensated care pursuant to STC 50(b) will be limited on a provider-specific basis to the cost of providing Medicaid state plan services and any other additional allowable uncompensated costs of care provided to Medicaid eligible individuals and uninsured individuals, less payment received by or on behalf of such individuals for such services. DSRIP and PHTII revenues will not be considered to be patient care revenues for this purpose along with other revenues as described in Massachusetts' Cost Limit Protocol approved by CMS in December 2013. Notwithstanding the generality of the foregoing, Critical Access Hospitals may receive 101% of the cost of providing Medicaid services, and 100% of uncompensated care costs as specified by the provisions of Section 1923(g) of the Act as implemented by 447.295(d).

54. **Transition of Specified Safety Net Provider Payments and Public Hospital Transformation and Incentive Initiatives into Medicaid Managed Care/ACO Incentive Payment Mechanisms.** As the delivery system reforms are implemented, the Commonwealth and CMS seek to shift payments to risk-based alternative payment models focused on accountability for quality, integration and total cost of care. These payments are described in Attachment Q, MassHealth MCO Incentives.

55. **Designated State Health Programs.** The Commonwealth may claim as allowable expenditures under the demonstration Health Connector subsidies as described below. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide subsidies for individuals with incomes at or below 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; and (2) whose income is at or below 300 percent of the FPL through 300 percent of the FPL. The state may also claim as allowable expenditures under the demonstration the payments made through its state-funded Health Safety Net (HSN) program to provide gap coverage subsidies for individuals eligible for coverage through the Health Connector with incomes at or below 300% FPL. HSN-Health Connector gap coverage subsidies are provided to eligible individuals during the time designated to select and enroll in a plan through the Marketplace.

Federal financial participation for the premium assistance, gap coverage, and cost-sharing portions of Health Connector subsidies for citizens and eligible qualified non-citizens will be provided through the Designated State Health Programs authority under the SNCP pursuant to this STC. Allowable expenditures for Health Connector subsidies will not be subject to the aggregate SNCP limit described in STC 52 or other SNCP sub-caps.

56. **Cambridge Health Alliance (CHA) Public Hospital Transformation and Incentive Initiatives (PHTII).** CHA is the Commonwealth's only non-state, non-federal public acute hospital and has

among the highest concentration of patients participating in MassHealth demonstration programs of any acute hospital in the Commonwealth.

The PHTII program, which was established in the previous demonstration extension period, will evolve to focus on two areas that align with the Commonwealth's plans for a restructured MassHealth delivery system centered around ACOs and emphasizing the integration of care across physical and behavioral health care, long term services and supports, and health related social services. The two areas of focus for PHTII are:

- a) Participation in an ACO model and demonstrating success on the corresponding ACO performance measures, utilizing the same performance measures as specified for the DSRIP initiative; because CHA relies on PHTII as an important component of its overall MassHealth funding structure, enhancing the level of incentive funding tied to these critical measures will ensure alignment across payment streams and enable CHA to devote attention and resources to improving these outcomes;
- b) Continuation and strengthening of initiatives approved through PHTII from the prior demonstration period, including but not limited to initiatives focusing on access to behavioral health services and integration of behavioral health care with physical health care, given CHA's role as a major provider of behavioral health services. These PHTII initiatives will build on work done during the 2014-2017 period and will include a strengthened set of outcome and improvement measure slates that reflect the potential for greater measurable impact over time.

Attachment E specifies the total potential funding available for CHA's Public Hospital Transformation and Incentive Initiatives. An increasing proportion of PHTII funding will be at-risk based on ACO performance, outcome and improvement measures over the course of the demonstration period. For example, the proportion of total PHTII funding tied to CHA's performance on MassHealth DSRIP accountability measures as part of an ACO increases from 5% to 20% over the course of the demonstration period. In addition, 10 percent of total PHTII funding each year will be tied to performance on outcomes and improvement measures associated with continuing PHTII initiatives from the prior demonstration period. The remainder of PHTII incentive funding is contingent on CHA's successful completion of initiative activities and reporting. Further details regarding the Metrics and Evaluation of the initiatives are outlined in Attachment K.

PHTII payments are an incentive for successfully meeting associated metrics and outcomes rather than payment of claims for the provision of medical care. For this reason, Public Hospital Transformation and Incentive Initiative payments shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the cost limit protocol approved under the demonstration authority.

To the extent that CHA fails to meet PHTII accountability measures and does not receive PHTII payments, the expenditure authority for PHTII will be reduced by the amount not payable.

Intended Funding Source: The non-federal share of PHTII payments will be provided through permissible intergovernmental transfer provided by CHA (from funds that are not federal funds or are

federal funds authorized by federal law to be used to match other federal funds in accordance with 1903(w) of the Act and implementing regulations).

57. **Delivery System Reform Incentive Program (DSRIP).** The state may claim, as authorized expenditures under the demonstration, up to \$1.8 billion (total computable) for five years, performance-based incentive payments to providers that support change in how care is provided to Medicaid beneficiaries through payment and delivery system reforms. DSRIP payments are an incentive for successfully meeting associated metrics and outcomes rather than payment of claims for the provision of medical care. For this reason, DSRIP payments shall not be considered patient care revenue for purposes of offsetting allowable uncompensated care costs under the Safety Net Care Pool Uncompensated Care Cost Limit Protocol under demonstration authority. DSRIP will be a time limited program, and Massachusetts' efforts undertaken through DSRIP will be sustainable after the demonstration period concludes.

Specifically, the Commonwealth may claim as allowable expenditures under the demonstration, payments to Accountable Care Organizations (ACOs), certified Community Partners (CPs), social service organizations, providers, sister agencies, full-time staff, and contracted vendors for activities that will likely increase the success of the payment and care delivery reform efforts and the overall goals as outlined above and in the 1115 demonstration. Such activities include: (1) start up and ongoing support for ACO development, infrastructure, and new care delivery models; (2) support for ACOs to pay for traditionally non-reimbursed flexible services to address health-related social needs; (3) transitional funding for certain safety net hospitals to support the transition to ACO models and to smooth the shift to a lower level of ongoing Safety Net Provider funding; (4) support to Community Partners for care management, care coordination, assessments, counseling, and navigational services; (5) support to Community Partners for infrastructure and capacity building; and (6) initiatives to scale up statewide infrastructure and workforce capacity to support successful reform implementation. DSRIP funds must be subject to limitations that prevent their use as the non-federal share of claimed Medicaid expenditures.

Massachusetts may also claim as allowable expenditures under the demonstration payments for state implementation and robust oversight of the DSRIP program as described below in STC 98.

DSRIP payments are incentive payments and are therefore not subject to the Safety Net Care Pool Uncompensated Care Cost Limit Protocol

- a. **Objective and Goals.** The objective of the DSRIP program is to further key goals of the 1115 demonstration, including: (1) enacting payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold providers accountable for the quality and total cost of care; (2) improving integration among physical health, behavioral health, long-term services and supports, and health-related social services; and (3) sustainably supporting safety net providers to ensure continued access to care for Medicaid and low-income uninsured individuals.

The goal of the DSRIP program is to provide a time-limited investment into the provider community that will facilitate transition away from a fee-for service payment model to one that moves toward alternative payment models. These models assure that health care services

are member-driven, integrated, and coordinated and that begins to address social determinants of health while moderating the cost trend.

- b. **Accomplishment of Goals.** Massachusetts seeks to accomplish its goals through the creation of three ACO models, certification of and investment in Community Partners, and investments in statewide infrastructure and workforce development. Minimal funds will be used for state implementation and oversight.
- c. **Funding Sources.** MassHealth must use a permissible source of non-federal share to support the DSRIP program. FFP is only available for DSRIP payments to Participant ACOs and CPs that comply with the DSRIP Protocol and Participation Plans; or to other entities that receive funding through the DSRIP statewide investments or DSRIP-supported state operations and implementation funding streams. The Commonwealth may claim FFP for up to two years after the calendar quarter in which the State made DSRIP payments to eligible entities. MassHealth's DSRIP expenditures are subject to availability of funds.
- d. **Expenditure Limits.** The Commonwealth may claim FFP for up to \$1.8 billion in DSRIP expenditures.
 - i. An increasing amount of state DSRIP expenditure authority will be at-risk over the five-year period (See STC 67).
 - ii. If the Commonwealth, or a provider participating in a DSRIP project on an at risk basis, loses any of its at-risk expenditure authority based on the State's DSRIP Accountability Score or the DSRIP accountability applicable to the provider's DSRIP project, the State's expenditure authority will be reduced. MassHealth will reduce DSRIP payments in proportion to the reduced expenditure authority.
 - iii. **Enrollment Adjustments.** Given that a significant portion of DSRIP expenditure authority will be disbursed on a PMPM bases, lower than anticipated member participation in the ACO or CP programs may lead to lower actual expenditures in a given DSRIP year. Therefore, the state may carry forward prior year DSRIP expenditure authority from one year to the next. The state may only carry forward funds from one DSRIP year to the next for reasons related to member participation fluctuations. If the carry forward amount from any given year to the next is more than 15%, the state must obtain CMS approval. The state must ensure that carry over does not result in the amount of DSRIP for DY 25 being greater than the amount for DY 24.
- e. **Funding Allocation and Methodologies.** The funding table below shows anticipated amounts of funding per DSRIP funding stream by waiver demonstration year. The State and CMS recognize that these funding amounts may vary due to a variety of reasons, including fluctuations in the number of members enrolled in ACOs, and the number of members who require BH and LTSS CPs services. As such, the state may reallocate funding amounts between funding streams at its discretion. If the actual funding amounts per DSRIP funding stream vary by more than 15% from the amounts provided in the table below, the state must notify CMS 60 calendar days prior to the

effective reallocation of funds. CMS reserves the right to disapprove any such reallocations.

Table F. DSRIP Funding Allocation Total Computable (In Millions)

Funding Stream	DY 21	DY 22	DY 23	DY 24	DY 25	Total
ACO Funding	\$329.2M	\$289.9M	\$229.4M	\$152.0M	\$65.1M	\$1,065.6M
Community Partners	\$57.0M	\$95.9M	\$132.2M	\$133.6M	\$128.0M	\$546.6M
Statewide Investments	\$24.2M	\$24.6M	\$23.8M	\$24.8M	\$17.4M	\$114.8M
State Operations and Implementation	\$14.6M	\$14.6M	\$14.6M	\$14.6M	\$14.6M	\$73.0M
Total:	\$425.0	\$425.0	\$400.0	\$325.0	\$225.0	\$1,800.0

58. **DSRIP Protocol.** The State must develop and submit to CMS for approval a DSRIP Protocol, and work collaboratively with CMS towards an approval date of December 15, 2016. Once approved by CMS, this document will be incorporated as Attachment M of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved waivers, expenditure authorities and STCs. The Protocol lays out the permissible uses of DSRIP specific funding for ACO and CP, as well as state implementation and oversight of the DSRIP program. Changes to the Protocol will apply prospectively, unless otherwise indicated in the Protocols. DSRIP payments for each participating entity or organization are contingent on fully meeting requirements as specified in the DSRIP Protocol. In order to receive incentive funding the entity must submit all required reporting, as outlined in the DSRIP Protocol.
- a) **Protocol Purpose:** The Commonwealth may only claim FFP for DSRIP expenditures in accordance with the DSRIP Protocol. The DSRIP Protocol:
- i. Outlines the context, goals, and outcomes that the Commonwealth seeks to achieve through payment reform;
 - ii. Specifies the allowed uses for DSRIP funding, and the methodologies/process by which the Commonwealth will determine how to distribute DSRIP funding and ensure robust oversight of said funds;
 - iii. Specifies requirements for the DSRIP Participation Plans and Budgets that ACOs and CPs are required to submit and have approved by the Commonwealth;
 - iv. Specifies requirements for how the Commonwealth will procure and oversee any statewide investments in support of the key goals of the demonstration.
- b) **DSRIP Protocol Requirements:** At a minimum the DSRIP protocol must contain the following information:
- i. Specify a State review process and criteria to evaluate and monitor each ACOs and Community Partners individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;

- ii. Specify a review process and timeline to evaluate DSRIP progress, in which first the State and then CMS must certify that a targets were met as a condition for FFP for the continued release of associated DSRIP funds;
 - iii. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating entity may be eligible to receive during the implementation of the DSRIP project, and a formula for determining the incentive payment amounts, quality incentive payments, any other outcomes- or performance-based payments, etc.;
 - iv. Specify that an entity's failure to fully meet performance targets under its DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
 - v. Include a process that allows for potential modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which potential protocol modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and
 - vi. Include a State process of developing an evaluation of DSRIP as a component of the evaluation design as required by STC 84. When developing the DSRIP Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating entities should use similar metrics for similar projects to enhance evaluation and learning experience. To facilitate evaluation, the DSRIP Protocol must identify a core set performance targets that all participating entities and/or the State must be required to report.
- c) **Review and Approval of Modifications to DSRIP Protocol:** Massachusetts has the right to modify the DSRIP Protocol over time with CMS approval, taking into account evidence and learnings from experience; unforeseen circumstances; or other good cause.
- i. CMS and Massachusetts agree to a targeted approval date of 60 business days after submission of the DSRIP Protocol modification.
 - ii. If CMS determines that the DSRIP Protocol modifications are not ready for approval by the target date, CMS will notify Massachusetts of its determination, and CMS and Massachusetts will then work collaboratively together to address the reasons provided by CMS for not granting approval.

59. **ACO & CP Participation Plans:** In order to receive DSRIP funding, ACOs must submit their Participation Plan, Budget, and Budget Narratives to MassHealth, and receive MassHealth approval. The Participation Plans must describe how the ACO will use DSRIP funding to support the transition to the new MassHealth ACO models.
- a. At a minimum, the Participation Plans must include the following sections: executive summary, patient and community population, partnerships, narrative, timeline, milestones and metrics, and sustainability.
 - b. The Budget is a line item budget for the ACO's proposed DSRIP-funded investments and programs; the accompanying Budget Narrative explains uses of the funds. See DSRIP Protocol for more details about the Participation Plans and Budgets.
 - c. MassHealth Review and Approval: MassHealth must review the ACO Participation Plans, Budgets, and Budget Narratives and notify ACOs of approval.
 - d. Participation Plan, Budget, and Budget Narrative Modification Process. An ACO or CP may request modifications to its Participation Plan, Budget, and Budget Narrative by submitting a request for modification to MassHealth in writing.
 - e. MassHealth will provide CMS with approved Participation Plans upon request.

DSRIP Investment Domains

60. **Accountable Care Organizations.** The Commonwealth will provide DSRIP investment funds to its contracted ACOs, which are generally provider-led health systems or organizations that focus on integration of physical health, Behavioral Health, Long Term Services and Supports, and social service needs; ACOs will be financially accountable for the cost and quality of their members' care. MassHealth's ACO models are described in STC 43 above.
- a) Eligibility: ACO entities that are eligible to receive DSRIP payments from MassHealth are entities that have signed contracts to be MassHealth ACOs (i.e., Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs).
 - b) Funding Use: MassHealth may pay ACOs under the DSRIP expenditure authority for the following:
 - i. ACO startup/ongoing support
 - ii. Support for flexible services. These services will be delineated in the post-approval Flexible Services Protocol. The Commonwealth will submit the protocol for CMS review and approval by May 2017. The protocol will include eligibility criteria and service definitions, payment methodologies, specific interventions, a description of the methodology used to identify the target population(s) including data analyses and a needs assessment of the target population, the nature of the individualized determination that would need to be made to determine potential for institutional placement and description of services that will be made available to beneficiaries including medical, behavioral, social and non-medical services. Flexible services include:
 1. Transition services for individuals transitioning from institutional settings into community settings consistent with the guidance provided on the provision of

- transition services as a home and community based service.
2. Home and Community-Based Services to divert individuals from institutional placements.
 3. Services to maintain a safe and healthy living environment.
 4. Physical activity and nutrition.
 5. Experience of violence support.
 6. Other individual goods and services.
 - a) Address medical needs and provide direct benefit and support specific outcomes that are identified in the individual waiver participant's care plan; and
 - b) Promote the delivery of covered services in community settings;
 - c) Decrease the need for other Medicaid services;
 - d) Reduce the reliance on paid support; or
 - e) Are directly related to the health and safety of the member in his/her home or community; or
 - f) Satisfy the other criteria listed below
- iii. These flexible services must satisfy the following criteria:
1. Must be health-related
 2. Not covered benefits under the MassHealth State Plan, the 1115 demonstration Expenditure Authority, or a home and community based waiver the member is enrolled in.
 3. Must be consistent with and documented in member's care plan
 4. Determined to be cost effective services that are informed by evidence that the service is related to health outcomes.
 5. May include, but are not limited to, classes, programs, equipment, appliances or special clothing or footwear likely to improve health outcomes, prevent or delay health deterioration.
 6. Other criteria established by MassHealth and approved by CMS
- c) Limitations on FFP for Flexible Services: The state must provide detailed information, as part of its quarterly report, on the exact flexible service, number and dollar amounts provided by each ACO and CP during the quarter. If during the course of the demonstration CMS finds that flexible services provided by an ACO or CP are outside of the scope of the STCs or other CMS federal policy guidance, CMS reserves the right to modify and/or terminate the expenditure authority for flexible services only.
- d) Additional Limitations on Flexible Services. Flexible service dollars may not be used to fund or pay for the following: (Section 5.1 of MassHealth Proposal for *Integration of Social Needs and MassHealth Reform and Flexible Services Funding*)
- i. State Plan, 1115 demonstration services, or services available through a Home and Community Based waiver in which the member is enrolled
 - ii. Services that a member is eligible to receive from another state agency
 - iii. Services that a member is eligible for, *and able to*, receive from a publically funded program (recognizing that certain public programs, periodically run out of funds)
 - iv. Services that are duplicative of services a member is already receiving

- v. Services where other funding sources are available.
 - vi. Alternative medicine services (e.g., reiki)
 - vii. Medical marijuana
 - viii. Copayments
 - ix. Premiums
 - x. Ongoing rent or mortgage payments
 - xi. Room and board, including capital and operational expenses of housing
 - xii. Ongoing utility payments
 - xiii. Cable/television bill payments
 - xiv. Gift cards or other cash equivalents
 - xv. Student loan payments
 - xvi. Credit card payments
 - xvii. Memberships not associated with one of the allowable domains
 - xviii. Licenses (drivers, professional, or vocational)
 - xix. Services outside of the allowable domains. For example:
 - xx. Educational supports
 - xxi. Vocational training
 - xxii. Child care not used to support attendance of medical or other health-related appointments
 - xxiii. Social activities not related to the health of an individual
 - xxiv. Hobbies (materials or courses)
 - xxv. Clothing (beyond specialized clothing necessary for fitness)
 - xxvi. Auto repairs not related to accessibility
- e) Transitional “glide path” funding for DSTI safety net hospitals: This funding will only be available to ACOs that include a DSTI safety net hospital, and is allocated according to a MassHealth-determined schedule that was developed based on negotiations with CMS regarding the overall funding glide path for DSTI hospitals, inclusive of other funding streams.
- f) At-Risk DSRIP Funding: A portion of DSRIP ACO startup/ongoing funds and glide path funding will be at-risk. An ACO’s DSRIP Accountability Score will determine the amount of at-risk funding that is earned (STC 67).
- g) Funding Methodology: The amount of DSRIP payments MassHealth provides to an ACO will be the summed amount of the three funding streams described in these STCs. An ACO’s DSRIP funding allocation for startup/ongoing support and for flexible services will be determined by multiplying the number of lives attributed to the ACO by a per member per month (PMPM) rate. DSTI Glide Path funding will be based on a schedule determined by MassHealth for each specific DSTI hospital.
- h) Startup/ongoing support: The PMPM amount for startup/ongoing funds decreases over the five year period, and will vary for each ACO, depending on the ACO’s payer revenue mix and the ACO model and risk track selected, as determined by MassHealth.
- i) Flexible services support: The PMPM amount for flexible services decreases over the DSRIP period, and is the same for every ACO.

- j) **Sustainability.** The base PMPMs used to calculate payment amounts will decrease over the five years so as to avoid a funding cliff at the end of the DSRIP program. At that point, ACOs will be required to absorb incremental costs associated with new care expectations under TCOC management.

61. **Assessments and Person-Centered Planning for LTSS.** Consistent with the requirements at 42 CFR 438.208(b), the state will develop methods to identify members enrolled in MCO-based delivery systems and Primary Care ACOs who have LTSS needs. The state will establish policies for the scope of services MassHealth MCOs, Partnership Plans, and Primary Care ACOs must include in assessments and person-centered care plans to reflect the phasing in of LTSS accountability over the duration of the Demonstration. Where MassHealth MCOs, Partnership Plans, and Primary Care ACOs are accountable for members' LTSS needs, or as otherwise defined by the state, enrollees with LTSS needs in these delivery systems will have comprehensive assessments and person-centered care plans.

- a) **Assessments.** The state will develop policies and procedures to ensure comprehensive assessments are completed for members enrolled in MCO-based delivery systems and Primary Care ACOs with identified LTSS needs. MassHealth MCOs, Partnership Plans, and Primary Care ACOs will be responsible for comprehensively assessing each enrollee with LTSS needs, consistent with the requirements at 42 CFR 438.208(c)(2). MassHealth will develop and set standards to ensure assessments of LTSS needs are independent, as described in STC 61(c) below.
- b) **Person-Centered Planning.** MassHealth MCO, Partnership Plan, and Primary Care ACO enrollees with identified LTSS needs will have a person-centered care plan maintained at the MassHealth MCO, Partnership Plan, or Primary Care ACO, consistent with the requirements at 42 CFR 438.208(c)(3). Person-centered planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level and support systems. The person-centered plan will be developed by a person trained in person-centered planning using a person-centered process and plan with the enrollee, the assistance of the enrollee's providers, and those individuals the enrollee chooses to include. The plan will include the services and supports that the enrollee needs. The plan will be reviewed and revised upon reassessment of functional need, at least every 12 months, if the enrollee's needs change significantly, or at the request of the enrollee. Person-centered plans will be developed in accordance with 42 CFR 441.301(c)(4)(F)(1) through (8).
- c) **Avoiding Conflict of Interest for LTSS.** EOHHS will establish policies and procedures to ensure that individuals with LTSS needs enrolled in MassHealth MCOs, Partnership Plans, and Primary Care ACOs receive independent LTSS assessments.

Providers of facility- or community-based LTSS may not conduct LTSS needs assessments, except as explicitly permitted and monitored by the state (e.g. because a provider has select expertise, or is the only qualified and willing entity available). In such circumstances, the state will require that the provider entity establish a firewall or other appropriate controls in order to mitigate conflict of interest. An organization providing only evaluation, assessment, coordination, skills training, peer supports, and Fiscal Intermediary services will not be

considered a provider of LTSS.

62. **Independent Consumer Support Program.** To support the beneficiary's experience receiving services in an MCO or ACO environment, the state shall create and maintain a permanent independent consumer support program to assist those beneficiaries in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.
- a) **Organizational Structure.** The Independent Consumer Support Program shall operate independently from any MCO or ACO. Additionally, to the extent possible, the program shall also operate independently of the state Medicaid agency.
 - b) **Accessibility.** The services of the Independent Consumer Support Program shall be available to all Medicaid beneficiaries enrolled in an MCO or an ACO and must be accessible through multiple entryways (e.g., phone, internet, office) and also provide outreach in the same manner as appropriate.
 - c) **Functions.** The Independent Consumer Support Program shall assist beneficiaries to navigate and access covered services, including the following activities:
 - i. Offer beneficiaries support in the pre-enrollment state, such as unbiased health plan choice counseling and general program-related information.
 - ii. Serve as an access point for complaints and concerns about health plan enrollment, access to services and other related matters.
 - iii. Help enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the state level, and assist them through the process if needed/requested.
 - iv. Conduct trainings with MCO and ACO providers on community-based resources and supports that can be linked with covered plan benefits.
 - d) **Staffing.** The Independent Consumer Support Program must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs.
 - e) **Data Collection and Reporting.** The Independent Consumer Support Program shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly.
 - f) **Geographic expansion of ACO.** In any geographic location where the state is operating an ACO or where ACO may enroll into an ACO, the state must have the Independent Consumer Support Program in place at least 30 days prior to enrollment procedures for that geographic location.

63. **Community Partners.** Certified Community Partners (CPs) are community-based organizations that offer members linkages and support to community resources that facilitate a coordinated, holistic approach to care.

Behavioral Health (BH) CPs are responsible for providing services for members (adults and children) with serious mental illness (SMI), serious emotional disturbance (SED), and/or serious and persistent substance use disorder (SUD).

Long Term Services and Supports (LTSS) CPs are responsible for providing services to support members with LTSS needs including physical disabilities, members with acquired or traumatic brain injury, members with intellectual or developmental disabilities (ID/DD).

- a. Eligibility: Entities that are eligible to receive DSRIP funding are entities that have been certified by MassHealth and have signed contracts to be MassHealth BH CPs or MassHealth LTSS CPs and have executed contracts with ACOs or MCOs.
- b. Funding Use: Community Partners DSRIP funding uses depends on whether the organization is a BH CP or LTSS CP
 - i. A BH CP may utilize DSRIP funding for the following purposes. The CP may not bill Mass Health, MCOs or ACOs for services funded through DSRIP:
 - ii. Provision of person-centered care management, assessments, care coordination and care planning, including but not limited to:
 1. Screening to identify current or unmet BH needs
 2. Review of members' existing assessments and services
 3. Assessment for BH related functional and clinical needs
 4. Care planning
 5. Care management
 6. Care coordination
 7. Managing transitions of care
 8. Member engagement outside of existing care provision (e.g., adherence, navigation)
 9. Member and family support
 10. Health promotion
 11. Navigation to and engagement with community resources and social services providers
 12. Other activities to help promote integration across physical health, behavioral health, LTSS and health-related social needs for BH CP members, as agreed upon by the care team
 - iii. The CP may not bill Mass Health, MCOs or ACOs for services funded through DSRIP. An LTSS CP may utilize DSRIP funding for the following purposes, including but not limited to:
 1. LTSS assessments and counseling on available options
 2. Support for person-centered care management, care plan support and care coordination activities, including but not limited to:

3. Screening to identify current or unmet LTSS needs
4. Review of members' existing LTSS assessment and current LTSS services
5. Independent assessment for LTSS functional and clinical needs
6. Choice counseling including navigation on LTSS service options and member education on range of LTSS providers
7. Care transition assistance
8. Provide LTSS-specific input to the member care plan and care team
9. Coordination (e.g., scheduling) across multiple LTSS providers; coordination of LTSS with medical and BH providers/services as appropriate
10. Member engagement regarding LTSS
11. Health promotion
12. Other activities to help promote integration across physical health, behavioral health, LTSS and health-related social needs for LTSS CP members, as agreed upon by the care team

iv. Infrastructure and capacity building

- c. At-Risk DSRIP Funding: A portion of DSRIP Community Partners funding will be at-risk. A CP's DSRIP Accountability Score will determine the amount of at-risk funding that is earned (see Section 7.vii).
- d. Funding Methodology: The amount of MassHealth's DSRIP payment any CP receives will be based on the total number of members that the CP serves each DSRIP year, as well as other funding methodologies, such as a needs-based grant program for infrastructure and capacity building support. DSRIP payments will be adjusted for at-risk performance.
- e. Sustainability. MassHealth will evaluate the Community Partners program to assess whether the program should be continued after the DSRIP period concludes. If MassHealth determines that the CP program should continue, then it will work to identify other funding sources to support the CP program, such as contributions from the budgets of ACOs/MCOs.

64. **ACO & CP Reporting Requirements.** ACOs and CPs must submit semiannual progress reports, including expenditures for the semiannual periods upon which the semiannual progress reports are based

- a) ACOs must also annually submit clinical quality data to the Commonwealth for quality evaluation purposes; and their ACO revenue payer mix, for safety net categorization purposes
- b) CPs must also annually submit clinical quality data to the Commonwealth for quality evaluation purposes
- c) State Reporting to CMS. The State must compile ACO and CP quarterly operational reports to submit to CMS as part of the broader 1115 demonstration quarterly reports.
- d) State Reporting to External Stakeholders and Stakeholder Engagement. The State must compile public-facing annual reports of ACO and CP performance.
 - i. The State must give stakeholders an opportunity to provide feedback on reports
 - ii. The State must allow for stakeholder engagement through meetings, access to web resources, and opportunities to provide feedback.

65. ACO Accountability to the State.

- a) ACO DSRIP Accountability Score: The amount of at-risk funding earned by an ACO will be determined by an ACO's DSRIP accountability score, which is based on performance in the following two domains:
 - i. ACO Total Cost of Care (TCOC) Performance
 - ii. ACO Quality and Utilization Performance
- b) Additional Accountability Considerations.
 - i. If an ACO performs below a MassHealth-determined performance threshold for two consecutive years, MassHealth may increase the proportion of DSRIP funds at risk for that ACO in the following year.
 - ii. If an ACO decides to exit the DSRIP program prior to the end of the five year 1115 waiver demonstration period, it will be required to return at least 50 percent of DSRIP startup/ongoing and DSTI Glide Path funding received up to that point.
- c) CP DSRIP Accountability Score: The amount of at-risk funding earned by a CP will be determined by a CP's DSRIP accountability score, which will be based on performance in the following domains: CP quality and member experience measures; progress towards integration across physical health, LTSS and behavioral health; and efficiency measures. See DSRIP Protocol for information about CP Accountability to the State

66. Statewide Investments: Statewide investments allow the Commonwealth to efficiently scale up statewide infrastructure and workforce capacity. These Statewide investments are limited to those provided for by the DSRIP funding pool, and specified in the DSRIP protocol.

- a.) Massachusetts will make eight different statewide investments to efficiently scale up statewide infrastructure and workforce capacity, including the following:
 - i. Student Loan Repayment: program which repays a portion of a student's loan in exchange for a two year commitment (or equivalent in part-time service) as a (1) primary care provider at a community health center; or (2) behavioral health professional or licensed clinical social worker at a community health center, community mental health center, or an Emergency Service Program (ESP).
 - ii. Primary Care Integration Models and Retention: program that provides support for community health centers to allow primary care providers to engage in one-year projects related to accountable care implementation
 - iii. Investment in Primary Care Residency Training: program to help offset the costs of community health center residency slots for both community health centers and hospitals
 - iv. Workforce Development Grant Program: program to support health care workforce development and training to more effectively operate in a new health care system
 - v. Technical Assistance: program to provide technical assistance to ACOs, CPs, or their contracted social service organizations as they participate in payment and care delivery reform
 - vi. Alternative Payment Methods (APM) Preparation Fund: program to support providers that are not yet ready to participate in an ACO, but want to take steps towards APM adoption
 - vii. Enhanced Diversionary Behavioral Health Activities: program to support investment in

new or enhanced diversionary levels of care that will meet the needs of patients with behavioral health needs at risk for ED boarding within the least restrictive, most clinically appropriate settings

- viii. Improved accessibility for people with disabilities and for whom English is a Second Language: programs to assist providers in delivering necessary equipment and expertise to meet the needs of person with disabilities and those for whom English is not their primary language
 - ix. Information Domains for Each Statewide Investment: The DSRIP Protocol will provide additional information for each statewide investment regarding the following domains (at a minimum):
 - 1. Eligibility for funding
 - 2. Amount of funding available
 - 3. Allowable funding uses
 - 4. Obligations for entities receiving funding support through the statewide investments
- b.) State Operations and Implementation. DSRIP expenditure authority includes necessary state operations and implementation support to help administer and provide robust oversight for the DSRIP program including state employees and vendors to provide the following support:
- i. ACO and CP administration, oversight, and operational support
 - ii. Statewide investments administration, oversight, and operational support
 - iii. DSRIP program support (e.g. project management, communications, evaluation and reporting)

67. State DSRIP Accountability to CMS

- a) At-Risk DSRIP Funding: A portion of the State’s DSRIP expenditure authority will be at-risk. If MassHealth’s DSRIP expenditure authority is reduced based on an Accountability Score that is less than 100%, then MassHealth will reduce future DSRIP payments in proportion to the reduced expenditure authority to ensure sufficient state funding to support the program. This mechanism ensures that all recipients of MassHealth DSRIP funding are accountable to the State achieving its performance commitments.
- b) The portion of the State’s DSRIP expenditure authority that is at-risk will follow the same at-risk Budget Period structure as for the ACOs and CPs. The Budget Period is January 1 through December 31. The 6 month Preparation Budget Period funds will be equal to half of the State’s allocated DSRIP Year 1 funds. Budget Period 1 funds will be equal to the sum of half of the State’s allocated DSRIP Year 1 funds, and half of DSRIP Year 2 funds. Budget Periods 2 through 4 will be sourced by the same funding pattern as Budget Period 1. Budget Period 5 funds will be equal to half of the State’s allocated DSRIP Year 5 funds. In the Preparation Budget Period and Budget Period 1, 0% of funds will be at-risk. However, in Budget Periods 2 through 5, the portion of at-risk expenditure authority follows the table below:

DSRIP Budget Period	Prep BP and BP 1 July 1, 2017 – December 31, 2018	BP 2 January 1, 2019- December 31, 2019	BP 3 January 1, 2020- December 2020	BP 4 January 1, 2021- December 31, 2021	BP 5 January 1, 2022- December 31, 2022
----------------------------	--	--	--	--	--

DSRIP Expenditure Authority	\$637.5M	\$412.5M	\$362.5M	\$275M	\$112.5M
% of Expenditure Authority At-Risk	0%	5%	10%	15%	20%
Actual Expenditure Authority At-Risk	\$0M	\$20.625M	\$36.25M	\$41.25M	\$22.5M

- c) State DSRIP Accountability Score: The State will calculate the State’s DSRIP Accountability Score. See DSRIP Protocol 10.1.1. The State DSRIP Accountability will be based on performance in the following domains:
- i. MassHealth ACO/APM Adoption Rate
 - ii. Reduction in State Spending Growth
 - iii. ACO Quality and Utilization Performance

Each domain will be assigned a domain weight for each performance year, such that the sum of the domain weights is 100% each year. State performance in each domain will be multiplied by the associated weight, and then summed together to create an aggregate score, namely the State’s DSRIP Accountability Score. The State will report its Accountability Score to CMS once it is available, and the score will then be used by the State and CMS to determine whether the State’s DSRIP expenditure authority might be reduced.

- d) Corrective Action Plan. In the event that the State does not achieve a 100% DSRIP Accountability Score, the State will provide CMS with a Corrective Action Plan including steps the State will take to regain any reduction to its DSRIP expenditure authority; and potential modification of accountability targets. The State’s Corrective Action Plan will be subject to CMS approval.
- e) MassHealth ACO/APM Adoption Rate. The State will have target percentages for the number of MassHealth ACO-eligible lives served by ACOs or who receive services from providers paid under APMs. The State will calculate the percentage of ACO-eligible lives served by ACOs or who receive services from providers paid under APMs. The State must meet or surpass its targets in order to earn a 100% score on this domain. If the State does not meet the target, then it will earn a 0% score for that Budget Period.
- f) Reduction in State Spending Growth. The State and CMS will work together to agree to a detailed methodology for calculating the State’s reduction in spending growth. In general, the State will, by CY2022, be accountable to a 2.5% reduction in PMPMs for the ACO-enrolled population, off of “trended PMPMs” (described below). The State’s trend line over the course of the DSRIP program will be 5.3% annually, which is the “without waiver” trend rate calculated by CMS based on the National Health Expenditures per capita data, this trend rate will be applied to the base PMPM rate in CY2017 (i.e. pre-ACO). The trend will be compounded over the five Budget Periods, and the

percent reduction will be determined according to the following calculation: percent reduction = (trended PMPM minus actual PMPM) / (trended PMPM). Prior to CY2022, the State will have target reductions smaller than 2.5% off of the trended PMPM.

Prior to CY2019, spending reduction targets will be adjusted to reflect CY2017 baseline performance. In the detailed methodology that CMS and the State will agree to, these measurements of PMPM spend will:

- i. Be for the ACO-enrolled population
- ii. For the population enrolled in MCO-Administered ACOs, be based on actual MCO expenditures for services to the population attributed to the ACO (categories to be agreed upon by CMS and the State), and not on the State's capitated payments to the MCO
- iii. Include reductions in DSTI supplemental payments to safety net hospitals
- iv. Exclude Hepatitis C drugs, other high-cost emerging drug therapies (such as cystic fibrosis drugs and biologics), long-term services and supports (LTSS) costs, and other potential categories agreed upon by CMS and the State
- v. Allow for adjustments based on changes in population or acuity mix
- vi. Allow for adjustments based on higher than anticipated growth in MassHealth spending due to economic conditions in the state or nationally, or other reasons as agreed upon by CMS and the State.

g) Gap to Goal Methodology. CMS and the State will agree on the detailed methodology two quarters before CY2018. The State will calculate its performance compared to the trended PMPM, and the domain score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed below:

- i. If Actual Reduction < (50% * Reduction Target), then Measure Score = 0%
- ii. If Actual Reduction ≥ (Reduction Target), then Measure Score = 100%
- iii. If Actual Reduction ≥ (50% * Reduction Target) AND < (Reduction Target), then Measure Score is equal to: (Actual Reduction - (50% * Reduction Target)) / (Reduction Target - (50% * Reduction Target))

For example, if the State achieves less than 50% of the Reduction Target, then the measure score will be equal to 0%. If the State achieves 75% of the Reduction Target, then the measure score will be equal to $(75\% - 50\%) / (100\% - 50\%) = 50\%$

h) Overall Statewide Quality and Utilization Performance. MassHealth will annually calculate the State performance score for each quality and utilization domain by aggregating the performance scores of all ACOs on a weighted basis. That is, ACOs with more members will have their domain performance scores weighted more heavily than ACOs with fewer members. See DSRIP Protocols Section 10.1.2.3 for weighted domains. Domains include:

- i. Prevention & Wellness
- ii. Chronic Disease Management
- iii. Behavioral Health/Substance Use
- iv. Long Term Services and Supports
- v. Avoidable Hospital Utilization
- vi. Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-

- Related Social Services
- vii. Member Care Experience

i) Scoring for All Domains Except Avoidable Hospital Utilization. For all domains except the Avoidable Hospital Utilization domain, the State will calculate two scores:

- i. **Aggregate domain score** – the domain score calculated by aggregating scores from all ACOs
- ii. **DSRIP domain score** – the domain score used in the calculation of the State DSRIP Accountability Score; dependent on how aggregate domain scores compare to pooled scores in all previous DSRIP Budget Periods

Using the Prevention & Wellness (P&W) domain in the second performance year (PY2) as an example:

- iii. If the P&W aggregate domain score in PY2 **is not** statistically worse (i.e. comparable or statistically better) than the P&W aggregate domain score in PY1, then the PY2 P&W DSRIP domain score is 100%
- iv. If the P&W aggregate domain score in PY2 **is** statistically worse than the P&W aggregate domain score in PY1, then the PY2 P&W DSRIP domain score is 0%

Using the Prevention & Wellness (P&W) domain in PY4 as an example:

- v. If the P&W aggregate domain score in PY4 **is not** statistically worse (i.e. comparable or statistically better) than the pooled P&W aggregate domain scores in PY1 through PY3, then the PY4 P&W DSRIP domain score is 100%
- vi. If the P&W aggregate domain score in PY4 **is** statistically worse than the pooled P&W aggregate domain scores in PY1 through PY3, then the PY4 P&W DSRIP domain score is 0%

j) Domain Scoring for Avoidable Hospital Utilization. Given the importance of reducing avoidable hospital utilization, the State will commit to specific reduction targets for ACO-enrolled members. As such, a separate domain scoring mechanism is required for this measure.

- i. Performance will be evaluated on two measures:
 - 1. Potentially preventable admissions (3M's PPA measure)
 - 2. Hospital all-cause readmissions (NQF #1789)
- ii. The reduction targets for the two measures:
 - 1. Apply to the ACO-enrolled population
 - 2. Will be with respect to baseline performance in CY2017
 - 3. Will be based not on raw admissions or readmissions events, but instead on risk-adjusted actual-to-expected event ratios
 - 4. Were determined based on state baseline performance compared to other states, and statewide reduction targets established in other states
 - 5. Will each contribute 50% to the State's performance in this domain

Prior to CY2019, these avoidable utilization reduction targets will be adjusted to reflect

CY2017 baseline performance. The State will calculate the percent reduction for each measure, and compare actual performance to the reduction targets. Each measure's score will be determined according to a gap-to-goal methodology for each Budget Period, as detailed below:

- iii. If Actual Reduction $< (50\% * \text{Reduction Target})$, then Measure Score = 0%
- iv. If Actual Reduction $\geq (\text{Reduction Target})$, then Measure Score = 100%
- v. If Actual Reduction $\geq (50\% * \text{Reduction Target})$ AND $< (\text{Reduction Target})$, then Measure Score is equal to: $(\text{Actual Reduction} - (50\% * \text{Reduction Target})) / ((\text{Reduction Target} - (50\% * \text{Reduction Target}))$ For example, if the State achieves less than 50% of the Reduction Target, then the measure score will be equal to 0%. If the State achieves 75% of the Reduction Target, then the measure score will be equal to $(75\% - 50\%) / (100\% - 50\%) = 50\%$

k) Overall Quality and Utilization Domain Score. The overall DSRIP quality and utilization domain score will be determined by calculating a weighted sum of the domain scores.

68. **State Public Outreach for ACO Expansion.** To provide and demonstrate seamless transitions for MCO and ACO enrollees, the state must (where applicable):

- a) Send sample notification letters. Existing Medicaid providers must receive sample beneficiary notification letters via widely distributed methods (mail, email, provider website, etc.) so that providers are informed of the information received by enrollees regarding their managed care transition.
- b) Provide continued comprehensive outreach, including educational tours for enrollees and providers. Education for enrollees and providers should include plan enrollment options, rights and responsibilities and other important program elements. The state must provide webinars, meeting plans, and send notices through outreach and other social media (e.g. state's website). The enrollment broker, choice counseling entities, ombudsman and any group providing enrollment support must participate.
- c) Operate a call center independent of the PCC, ACO, and MCO plans. This entity must be able to help enrollees in making independent decisions about plan choice and be able to document complaints about the plans. During the first 60 days of implementation the state must review all call center response statistics to ensure all contracted plans are meeting requirements in their contracts. After the first 60 days, if all entities are consistently meeting contractual requirements the state can decrease the frequency of the review of call center statistics, but no more than 120 days should elapse between reviews.
- d) The state will provide language assistance, including in written materials, in accordance with Section 1557 of the Affordable Care Act.
- e) Member materials sent to beneficiaries will be culturally competent, and the state will provide culturally competent and available translation and navigation services. The state will make available navigation resources upon beneficiary request.

69. **CMS Evaluation of State.**

- a) Assessment of Performance, and Interim Evaluation. A mid-point assessment of the DSRIP program will be completed by an independent evaluator that will be procured by MassHealth using DSRIP expenditure authority. The midpoint assessment will provide an independent analysis of the DSRIP program through December 2020, using both quantitative and qualitative methodologies, to evaluate whether the investments made through the DSRIP program have contributed to achieving the demonstration goals as described in STC 57. The results from the midpoint assessment will be used to develop an interim evaluation of the DSRIP program, which will be submitted to CMS by the end of June 2021.
- b) Final Evaluation. A final evaluation of the DSRIP program will be conducted by an independent evaluator. The final evaluation will provide a summative overview of the DSRIP program over the five year demonstration period, and evaluate whether the investments made through the DSRIP program made contributed to achieving the demonstration goals as described in STC 57. The final evaluation will be submitted to CMS by the end of June 2024.

70. **Independent Assessor.** The state will identify independent entities with expertise in delivery system improvement to assist with DSRIP administration, oversight and monitoring, including an independent assessor and/or evaluator. An independent assessor will review ACO and CP proposals, progress reports and other related documents, to ensure compliance with approved STCs and Protocols, provided that initial ACO and CP proposals are not subject to review from the independent assessor. The independent assessor shall make recommendations to the state regarding approvals, denials or recommended changes to plans to make them approvable. This entity (or another entity identified by the state) will also assist with the progress reports and mid-point assessment and any other ongoing reviews of DSRIP project plan; and assist with continuous quality improvement activities. Expenditures for the independent assessor are administrative costs the state incurs associated with the management of DSRIP reports and other data.

The state must describe the functions of each independent entity and their relationship with the state as part of its Quarterly report requirements.

Spending on the independent entities and other administrative cost associated within the DSRIP fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the DSRIP Fund.

71. **DSRIP Advisory Committee.** The state will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement, and clinical data used in performance improvement initiatives, quality, and best practices.

Final decision-making authority will be retained by the state and CMS, although all recommendations of the committee will be considered by the State and CMS.

Specifically, the Committee will provide feedback to the state regarding:

- i. Selection of additional metrics for providers that have reached baseline performance thresholds or exceeded performance targets
- ii. Assessing the effectiveness of cross-cutting measures, to understand how aspects of one system are effecting the other. For example, are BH/SUD/LTSS performance focus areas effecting physical health outcomes?
- iii. Alignment of measures between systems with purpose, to enable the state to assess the effectiveness in their outcomes across systems
Identify actionable new areas of priority,
- iv. Make systems-based recommendations for initiatives to improve cross-cutting performance.

a.) Composition of the Committee

The membership of the committee must consist of between nine to fifteen members with no more than three members employed by Massachusetts hospitals, ACOs or Community Partners. All members will be appointed by MassHealth based on the following composition criteria:

- i. Representation from community health centers serving the Medicaid population.
- ii. Clinical experts in each of the following specialty care areas: Behavioral Health, Substance Use Disorder, and Long Term Services & Supports. Clinical experts are physicians, physician assistants, nurse practitioners, licensed clinical social workers, licensed mental health counselors, psychologists, and registered nurses.
- iii. At least 30% of the members must have significant expertise in clinical quality measurement of hospitals, primary care providers, community health centers, clinics and managed care plans. Significant expertise is defined as not less than five years of recent full time employment in quality measurement in government service or from companies providing quality measurement services to above listed provider types and managed care plans.
- iv. Advocacy Members: Consumers or consumer representatives, including at least one representative for people with disabilities and, separately, at least one representative for people with complex medical conditions,
- v. Members must agree to recuse themselves from review of specific DSRIP matters when they have a conflict of interest. MassHealth shall develop conflict of interest guidelines.

72. **SNCP Additional Reporting Requirements.** All SNCP expenditures must be reported as specified in section XII, STC 89. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

- a) Charts A – B of Attachment E. The Commonwealth must submit to CMS for approval, updates to Charts A – B of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Years (SFYs) 2017-2022, and identify the non-federal share for each line item, no later than 45 business days after enactment of the State budget for each SFY. CMS shall approve the Commonwealth’s projected SNCP payments and expenditures within 30 business days of the Commonwealth’s submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 52.

Before it can claim FFP, the Commonwealth must notify CMS and receive CMS approval, for any SNCP payments and expenditures outlined in Charts A-B of Attachment E that are in excess of the approved projected SNCP payments and expenditures by a variance greater than 10 percent. Any variance in SNCP payments and expenditures must adhere to the SNCP expenditure limits pursuant to STC 52. The Commonwealth must submit to CMS for approval updates to Charts A – B that include these variations in projected SNCP payments and expenditures. CMS shall approve the Commonwealth’s revised projected SNCP payments and expenditures within 30 business days of the Commonwealth’s submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 52.

The Commonwealth must submit to CMS for approval updates to Charts A – B of Attachment E that reflect actual payments and expenditures for each SFY, within 180 calendar days after the close of the SFY. CMS shall approve the Commonwealth’s actual SNCP expenditures within 45 business days of the Commonwealth’s submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in STC 52.

The Commonwealth must submit to CMS for approval further updates to any or all of these charts as part of the quarterly operational report and at such other times as may be required to reflect projected or actual changes in SNCP payments and expenditures. CMS must approve the Commonwealth’s updated charts within 45 business days of the Commonwealth’s submission of the update, provided that all SNCP payments and expenditures are within the applicable limits specified in STC 51.

No demonstration amendment is required to update Charts A-B in Attachment E, with the exception of any new types of payments or expenditures in Charts A and B, or for any increase to the Public Service Hospital Safety Net Care payments.

- b) DSHP Reporting for Connector Care. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 79. This data must, at a minimum, include:
 - 1) The number of individuals served by the program;
 - 2) The size of the subsidies; and
 - 3) A comparison of projected costs with actual costs.
- c) DSRIP Reporting: DSRIP reporting is required as specified in Section X and the approved DSRIP Protocol.

IX. GENERAL REPORTING REQUIREMENTS

- 73. **Submission of Post-approval Deliverables**. The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs (“deliverables”). The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

74. **Deferral for Failure to Provide Deliverables on Time.** The state agrees that CMS may require the state to cease drawing down federal funds until such deliverables are submitted in a satisfactory form, until the amount of federal funds not drawn down would exceed \$5,000,000. Specifically:
- a. Thirty (30) calendar days after the deliverable was due, CMS is required to issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
 - b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps that the state has taken to address such issue, the estimated time for submission of the deliverable, and whether additional measures could be taken to expedite the schedule for such submission. CMS will only grant such a request if CMS finds that the state faced unforeseen circumstances, and has taken reasonable measures to submit the deliverable as soon as practicable. CMS could grant the requested extension in whole or in part. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
 - c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
 - d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
 - e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
 - f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.
75. **Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.
76. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully and timely with CMS and its contractors' evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required of the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral

being issued as outlined in STC 74.

77. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

X. MONITORING

78. **Quarterly and Annual Report Timelines.** The state must submit three Quarterly Reports and one compiled Annual Report each DY. The Quarterly Reports are due no later than 60 days following the end of each demonstration quarter. The compiled Annual Report is due no later than 90 days following the end of the DY.
79. **Quarterly and Annual Report Scope.** The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report. (Additional links not referenced in the document may be listed in a Reference/Bibliography section).
- a. **Quarterly and Annual Report Outline.** The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.
- i. **Operational Updates** – The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
 - ii. **Performance Metrics** – Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.
 - iii. **Budget Neutrality and Financial Reporting Requirements** – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

- iv. Evaluation Activities and Interim Findings – The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

80. **Additional Demonstration Annual Operational Report Requirements.** The Annual Report must include all items outlined in STC 79. In addition, the Annual Report must, at a minimum, include the requirements outlined below:

- i. All items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;
- ii. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
- iii. Total contributions, withdrawals, balances, and credits; and
- iv. Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

81. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

- a) The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration.
- b) CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
- c) The state and CMS will jointly develop the agenda for the calls.
- d) Areas to be addressed during the monitoring call include, but are not limited to:
 - i. Transition and implementation activities;
 - ii. Stakeholder concerns;
 - iii. QHP operations and performance;
 - iv. Enrollment;
 - v. Cost sharing;
 - vi. Quality of care;
 - vii. Beneficiary access;
 - viii. Benefit package and wrap around benefits;
 - ix. Audits;
 - x. Lawsuits;
 - xi. Financial reporting and budget neutrality issues;
 - xii. Progress on evaluation activities and contracts;
 - xiii. Related legislative developments in the state; and
 - xiv. Any demonstration changes or amendments the state is considering.

82. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the

planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XI. EVALUATION

83. **Independent Evaluator.** At the beginning of the demonstration period, the state must acquire an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made in advance of running any data or due to mid-course changes in the operation of the demonstration.
84. **Evaluation Design and Implementation.** The State shall submit a draft evaluation design for MassHealth 1115 Demonstration to CMS no later than 120 days after the award of the Demonstration extension. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the insert old demo name, if applicable. The state must submit a final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval. The state must implement the evaluation design and submit their evaluation implementation progress in each of the Quarterly and Annual Reports as outlined in STC 79.
- a) **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
 - b) **Cost-effectiveness.** While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the demonstration when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.
 - i. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

- ii. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the demonstration compared to what would have happened for a comparable population absent the demonstration.
 - iii. The state will compare total costs under the demonstration to costs of what would have happened without the demonstration. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.
 - iv. The State will compare changes in access and quality to associated changes in costs within the demonstration. To the extent possible, component contributions to changes in access and quality and their associated levels of investment will be determined and compared to improvement efforts undertaken in other delivery systems.
- c) **Evaluation Requirements.** The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.
- i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.
 - ii. The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.
- d) **Evaluation Design.** The Evaluation Design shall include the following core components to be approved by CMS:
- i. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

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

1. The formation of new partnerships and collaborations within the delivery system
2. The increased acceptance of TCOC risk-based payments among MassHealth providers
3. Improvements in the member experience of care, particularly through increased member engagement in the primary care setting or closer coordination among providers
4. Reductions in the growth of avoidable inpatient utilization
5. Reductions in the growth of TCOC for MassHealth’s managed care-eligible population

6. More robust EHR and other infrastructure capabilities and interconnectivity among providers
7. Increased coordination across silos of care (e.g., physical health, behavioral health, LTSS, social supports)
8. Maintenance or improvement of clinical quality
9. The enhancement of safety net providers' capacity to serve Medicaid and uninsured patients in the Commonwealth
10. The strength of aggregate provider networks in the ACO and MCO programs (excluding Primary Care ACOs) relative to the PCC Plan, in first three years of demonstration, including:
 - a) Types of providers
 - b) Breadth of providers
 - c) Quality of services
 - d) Outcomes of services

These hypotheses should be addressed in the demonstration reporting described in STC 84 with regard to progress towards the expected outcomes.

ii. Data: This discussion shall include:

1. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;
2. Method of data collection
3. Frequency and timing of data collection.

The following shall be considered and included as appropriate:

1. Medicaid encounters and claims data,
2. Enrollment data, and
3. Consumer and provider surveys

iii. Study Design: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered.

iv. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include

the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.

- v. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the State may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.
 - vi. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.
 - vii. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.
 - viii. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, and the deliverables outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.
 - ix. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.
 - x. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.
- e) **Interim Evaluation Report.** The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending June 30, 2022. The Interim Evaluation Report shall include the same core components as identified in STC 84 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 business days after receipt of CMS' comments.
- f) **Summative Evaluation Reports.**

- i. The state shall provide the summative evaluation reports described below to capture the demonstration period covered by this renewal.
 1. The state shall provide a Summative Evaluation Report (SER) for the demonstration period starting July 1, 2017 through June 30, 2022.
 - a) A preliminary draft of the SER is due within 180 calendar days of the end of this demonstration period. This report shall include documentation of outstanding assessments due to data lags to complete the interim evaluation.
 - b) The second of these is due within 500 calendar days of the end of this demonstration period. The state should respond to comments and submit the final SER within 30 calendar days after receipt of CMS' comments.

- ii. The Summative Evaluation Report shall include the following core components:
 1. **Executive Summary.** This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
 2. **Demonstration Description.** This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
 3. **Study Design.** This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.
 4. **Discussion of Findings and Conclusions.** This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
 5. **Policy Implications.** This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.
 6. **Interactions with Other State Initiatives.** This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

- g) **State Presentations for CMS.** The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 84. The State will present on its interim evaluation in conjunction with STC 84. The State will present on its summative evaluation in conjunction with STC

- h) **Public Access.** The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

XI. CLOSE OUT REPORTING

- 85. **Close out Reports.** Within 120 days prior to the end of the demonstration, the state must submit a Draft Final Operational Report and a Draft Final Evaluation to CMS for comments.
 - a) The draft final reports must comply with the most current Guidance from CMS, and include all components required in the approved Evaluation Design.
 - b) The state will present to and participate in a discussion with CMS on the Close-Out reports.
 - c) The state must take into consideration CMS' comments for incorporation into the final Close-Out Reports.
 - d) The Final Close-Out Reports are due to CMS no later than 30 days after receipt of CMS' comments.
 - e) A delay in submitting the draft or final versions of the Close-Out Reports could subject the state to penalties described above.
- 86. **Public Access.** The state shall post the final approved Annual Reports, Final Operational Report, Evaluation Design, Interim Evaluation Report(s), Summative Evaluation Report(s), and Final Evaluation Report on the state's Medicaid website within 30 days of approval by CMS.
- 87. **Presentations and Publications.** During the demonstration period, and for 24 months following the expiration of the demonstration, CMS will be provided with notification regarding the public release, presentation or publication of Interim, Summative, and/or Final Evaluations and Operational Reports.
 - 1. The state will make every effort to inform the CMS Project Officer, as far in advance as possible, of pending news articles or reports about the demonstration that are of a significant nature. A bibliographic reference of news articles and reports about the demonstration will be included in the next Quarterly Report.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

- 88. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section XII of the STCs.
- 89. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
 - a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must

report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00030/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

- b) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- c) Pharmacy Rebates. When claiming these expenditures the Commonwealth may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf>). The Commonwealth must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

Additionally, this information addresses how states must report drug rebates associated with the new adult eligibility group described at 42 CFR 435.119. States that adopt the new adult group may be eligible to claim drug expenditures at increased matching rates. Drug rebate amounts associated with these increased matching rates must be reported at the same matching rate as the original associated prescription drug expenditures.

- d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the Commonwealth under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narr by demonstration year.
- e) Demonstration year reporting. Notwithstanding the two-year filing rule, the Commonwealth may report expenditures and adjustments to particular demonstration years as described below:
 - i. Beginning July 1, 2014 (SFY 2015/DY 18), all expenditures and adjustments for demonstration years 1-14 previously reported in sections i.-viii. will be reported as demonstration year 14, all expenditures and adjustments for demonstration years 15-17

will be reported as demonstration 17, and separate schedules will be completed for demonstration years 18, 19 and 20.

- ii. Beginning July 1, 2017 (SFY 2018/DY 21), all expenditures and adjustments for demonstration years 1-17 previously reported in sections i.-ix. will be reported as demonstration year 17, all expenditures and adjustments for demonstration years 18-20 will be reported as demonstration 20, and separate schedules will be completed for demonstration years 21, 22, 23, 24, and 25.

f) Use of Waiver Forms. For each demonstration year as described in subparagraph (e) above, 29 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following EGs and the Safety Net Care Pool. Expenditures should be allocated to these forms based on the guidance found below.

- 1) **Base Families:** Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only)
- 2) **Base Disabled:** Eligible individuals with disabilities enrolled in Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only)
- 3) **1902(r)(2) Children:** Medicaid expansion children and pregnant women who are enrolled in MassHealth Standard, as well as eligible children and pregnant women enrolled in MassHealth Limited (emergency services only)
- 4) **1902(r)(2) Disabled:** Eligible individuals with disabilities enrolled in Standard with income between 114.1 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency services only)
- 5) **BCCDP:** Individuals eligible under the Breast and Cervical Cancer Demonstration Program who are enrolled in Standard
- 6) **CommonHealth:** Higher income working adults and children with disabilities enrolled in CommonHealth
- 7) **e-Family Assistance:** Eligible children receiving premium assistance or direct coverage through 200 percent of the FPL enrolled in Family Assistance.
- 8) **Base Fam XXLRO:** Title XXI-eligible AFDC children enrolled in Standard after allotment is exhausted

- 9) **1902 (r)(2) XXI RO:** Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted
- 10) **CommonHealth XXI:** Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted
- 11) **Fam Assist XXI:** Title XXI-eligible children through 200 percent of the FPL eligible for Family Assistance under the demonstration after the allotment is exhausted
- 12) **e-HIV/FA:** Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance
- 13) **SBE:** Subsidies or reimbursement for ESI made to eligible individuals
- 14) **SNCP-DSRIP:** Expenditures for Delivery System Reform Payments (DSRIP) for the period July 1, 2017 through June 30, 2022
- 15) **SNCP-PHTII:** Expenditures authorized under the Public Hospital Transformation and Incentives Initiative
- 16) **SNCP-DSH:** Expenditures authorized under the Disproportionate Share Hospital Pool
- 17) **SNCP-UCC:** Expenditures authorized under the Uncompensated Care Pool
- 18) **SNCP-OTHER:** All other expenditures authorized under the SNCP
- 19) **Asthma:** All expenditures authorized through the pediatric asthma bundled pilot program
- 20) **New Adult Group :** Report for all expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119
- 21) **Health Connector Subsidy:** Expenditures for subsidy wrap under the demonstration.
- 22) **Provisional Eligibility:** Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority
- 23) **TANF/EAEDC:** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children.

- 24) **End of Month Coverage:** Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.
- 25) **Continuous Eligibility:** Expenditures for continuous eligibility period up to 12 months for those enrolled in a student health insurance program.

90. **Reporting Expenditures under the Demonstration for Groups that are Eligible First under the Separate Title XXI Program.** The Commonwealth is entitled to claim title XXI funds for expenditures for certain children that are also eligible under this title XIX demonstration included within the Base Families EG, the 1902(r)(2) Children EG, the CommonHealth EG and the Family Assistance EG. These groups are included in the Commonwealth's title XXI state plan and therefore can be funded through the separate title XXI program up to the amount of its title XXI allotment (including any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual. If the title XXI allotment has been exhausted, including any reallocations or redistributions, these children are then eligible under this title XIX demonstration and the following reporting requirements for these EGs under the title XIX demonstration apply:

Base Families XXI RO, 1902(r)(2) RO, CommonHealth XXI, and Fam Assist XXI:

- a) **Exhaustion of Title XXI Funds.** If the Commonwealth has exhausted title XXI funds, expenditures for these optional targeted low-income children may be claimed as title XIX expenditures as approved in the Medicaid state plan. The Commonwealth shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 89 (Reporting Expenditures Under the Demonstration).
- b) **Exhaustion of Title XXI Funds Notification.** The Commonwealth must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures.
- c) If the Commonwealth chooses to claim expenditures for **Base Families XXI RO, 1902(r)(2) RO, and CommonHealth XXI** groups under title XIX, the expenditures and caseload attributable to these EGs will:
 - i. Count toward the budget neutrality expenditure limit calculated under section XI, STC 107 (Budget Neutrality Annual Expenditure Limit); and
 - ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 107, so that the Commonwealth is not at risk for caseload while claiming title XIX federal matching funds when title XXI funds are exhausted.
- d) If the Commonwealth chooses to claim expenditures for **Fam Assist XXI** under title XIX, the

expenditures and caseload attributable to this EG will be considered expenditures subject to the budget neutrality agreement as defined in STC 107. The Commonwealth is at risk for both caseload and expenditures while claiming Title XIX federal matching funds for this population when title XXI funds are exhausted.

91. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term “expenditures subject to the budget neutrality agreement” means expenditures for the EGs outlined in section IV of the STCs, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.
92. **Premium Collection Adjustment.** The Commonwealth must include demonstration premium collections as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis on the CMS-64 Summary Sheet and on the budget neutrality monitoring workbook submitted on a quarterly basis.
93. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the Commonwealth must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
94. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the Commonwealth made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.
95. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:
 - a) For the purpose of calculating the budget neutrality agreement and for other purposes, the Commonwealth must provide to CMS, as part of the quarterly report required under STC 79, the actual number of eligible member months for the EGs 1-12 and EGs 20 - 22 and 25 defined in STC 89. The Commonwealth must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
 - b) The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each

contribute two eligible member month to the total, for a total of four eligible member months.

96. Cost Settlement.

- a) Interim Reconciliation– Within 12 months of the provider’s cost report filing for each reporting year, the Commonwealth must validate cost data using the CMS-approved cost review protocol, developed jointly by Massachusetts and CMS. Interim Reconciliation will be based on the results of the Commonwealth’s review. Any increasing or decreasing adjustment identified as a result of the settlement must be reported to CMS as an adjustment to reported expenditures and reported through the CMS-64 process.
- b) Final Reconciliation – For each provider subject to cost settlement, the Commonwealth must complete final settlement within 12 months after the provider’s final and audited (as applicable) cost report become available. The Commonwealth must submit cost and payment information for that demonstration year as required by the CMS-approved cost limit protocol. Any increasing or decreasing adjustment identified as a result of the settlement must be reported to CMS as an adjustment to reported expenditures and reported through the CMS-64 process. CMS will complete its review of the costs reported using the protocol tool and send concurrence or share its findings with the Commonwealth within 120 calendar days of receipt.

97. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Massachusetts must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

98. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole for the following, subject to the limits described in section XII of the STCs:

- a) Administrative costs, including those associated with the administration of the demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
- c) Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period, including expenditures under the Safety Net Care Pool.

99. **Sources of Non-Federal Share.** The Commonwealth provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The Commonwealth further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a) CMS may review at any time the sources of the non-federal share of funding for the demonstration. The Commonwealth agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c) The Commonwealth assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

100. **State Certification of Funding Conditions.** The Commonwealth must certify that the following conditions for non-federal share of Demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
- b) To the extent, the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies as allowable under 42 C.F.R. § 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;
- d) The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from state or local monies and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e) Under all circumstances, health care providers must retain 100 percent of the claimed

expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect to the Commonwealth any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

101. **Monitoring the Demonstration.** The Commonwealth will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.
102. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

103. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning July 1, 2017.
104. **Limit on Title XIX Funding.** Massachusetts will be subject to a limit on the amount of federal title XIX funding that the Commonwealth may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual DSH allotment that would have applied to the Commonwealth absent the demonstration (DSH allotment). Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the Commonwealth using the procedures described in section XII, STC 89. The data supplied by the Commonwealth to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Commonwealth's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.
105. **Risk.** Massachusetts shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Massachusetts will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Massachusetts at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.
106. **Expenditures Excluded From Budget Neutrality Test.** Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on

behalf of enrollees under age 65 who are institutionalized in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded, or a state psychiatric hospital for other than a short-term rehabilitative stay;

- b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient, and home and community-based waiver services, except pursuant to STC 105; For demonstration years 1 and 2, LTSS costs will be excluded from budget neutrality. Over the course of the demonstration, LTSS will be included no later than DY 24 into budget neutrality if MassHealth incorporates LTSS into managed care delivery models and TCOC for ACOs.
 - i. *Exception.* Hospice services provided to individuals in the MassHealth Basic and Essential programs are subject to the budget neutrality test.
- c) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement; and
- d) Allowable administrative expenditures.

107. Budget Neutrality Annual Expenditure Limit. For each DY, two annual limits are calculated.

- a) Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the Commonwealth under section XII, STC 89 for each EG, including the hypothetical populations, times the appropriate estimated per member/per month (PMPM) costs from the table in subparagraph (v) below;
 - ii. Starting in SFY 2006, actual expenditures for the CommonHealth EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline CommonHealth costs, or actual CommonHealth per member per most cost experience for SFYs2018-2022;
 - iii. The amount of actual expenditures included will be the lower of the trended baseline costs, or actual per member per most cost experience for each eligibility group in SFYs2018-2022;
 - iv. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior demonstration periods are provided in Attachment D; and
 - v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Group (EG)	Trend Rate	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
Mandatory and Optional State Plan Groups						
Base Families	3.8%	\$753.10	\$781.72	\$811.42	\$842.25	\$874.26
Base Disabled/MCB	4.0%	\$1,647.49	\$1,713.39	\$1,781.93	\$1,853.21	\$1,927.34
1902 (r) 2 Children	3.6%	\$597.02	\$618.51	\$640.78	\$663.85	\$687.75
1902 (r) 2 Disabled	3.6%	\$1,284.97	\$1,331.23	\$1,379.15	\$1,428.80	\$1,480.24
1902 (r) 2 BCCDP	3.6%	\$4,928.56	\$5,105.99	\$5,289.81	\$5,480.24	\$5,677.53
Hypothetical Populations*						
CommonHealth	4.4%	\$776.08	\$813.33	\$852.37	\$893.28	\$936.16

108. **Supplemental Budget Neutrality Test: New Adult Group.** Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. The state will not be allowed to obtain budget neutrality “savings” from this population. Therefore, a separate expenditure cap is established for this group, to be known as Supplemental Budget Neutrality Test.

a) The EG listed in the table below is included in Supplemental Budget Neutrality Test.

Eligibility Group (EG)	Trend Rate	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
<u>New Adult Group</u>	4.3 percent	\$561.68	\$585.83	\$611.02	\$637.29	\$664.70

b) If the state’s experience of the take up rate for the New Adult Group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the New Adult Group, the state may submit an adjustment to paragraph (a) for CMS review without submitting an amendment. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than April 30 of the demonstration year for which the adjustment would take effect.

c) The Supplemental Budget Neutrality Test is calculated by taking the PMPM cost

projection for the New Adult Group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap is obtained by multiplying total computable Supplemental Cap by the Composite Federal Share described in STC 109.

- d) The Supplemental Budget Neutrality Test is a comparison between the federal share of the Supplemental Cap and total FFP reported by the State for the New Adult Group.
- e) If total FFP for the New Adult Group should exceed the federal share of the Supplemental Budget Neutrality Test after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in STC 106.
- f) The annual budget neutrality expenditure limit for the demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the demonstration is the sum of the annual budget neutrality expenditure limits. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the Commonwealth may receive for expenditures on behalf of demonstration populations as well as demonstration services described in Table B in STC 38 during the demonstration period.
- g) Limit B. The Commonwealth's annual DSH allotment.
- h) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) adjustment:

The Commonwealth must present to CMS for approval a draft evaluation plan outlining the methodology to track the following:

- 1) Baseline measurement of EPSDT service utilization prior to the EPSDT court-ordered remedial plan in *Rosie D. v Romney* (the Order) final judgment and final remedial plan established on July 16, 2007;
- 2) Increase, following entry of the Order, in utilization of :
 - a) EPSDT screenings;
 - b) Standardized behavioral health assessments utilizing the Child and Adolescent Needs and Strengths (CANS), or other standardized assessment tool in accordance with the Order; and
 - c) State plan services available prior to the entry of the Court Order.
- 3) Cost and utilization of services contained in State Plan amendments submitted by the Commonwealth in accordance with the Order and approved by CMS;

and

- 4) Methodology for tracking and identifying new EPSDT services for purposes of budget monitoring.

The draft evaluation plan with an appropriate methodology to track new EPSDT expenditures must be approved by CMS through the amendment process described in STC 7. Once an appropriate methodology to track new EPSDT expenditures is approved by CMS, these projected expenditures will be included in the expenditure limit for the Commonwealth, with an effective date beginning with the start of the new EPSDT expenditures, and reconciled to actual expenditure experience.

109. **1115A Duals Demonstration Savings.** When Massachusetts' section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the Duals demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the Duals Demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal. This evaluation of estimated and certified amounts of actual title XIX savings will reflect addendums and amendments to the 1115A Duals Demonstration contract and adjustment to the MassHealth Component of the capitation rate, including interim and final risk corridor settlements.

A. 1115A Duals Demo Rate Year/ Demo Year	B. MassHealth Component of the Capitation Rate (hypothetical)	C. Medicaid Savings Percentage Applied Per Contract (average)	D. Savings Per Month (B*C)	E. Member Months of MMEs who participated in 1115A Duals Demonstration and 1115(a) Demonstration (hypothetical)	F. Risk Corridor Payment/ (Recoupment)	G. Amount subtracted from 1115(a) BN savings/ margin (D*E)
CCY 2013/ DY 1	\$1,000 PMPM	0%	\$0 PMPM	1,000	\$15,000	[\$0 PMPM * 1,000 = \$0 =
CCY 2014 Jan. – March 2014/ DY 1	\$1,000 PMPM	0%	\$0 PMPM	1,000	\$15,000	[\$0 PMPM * 1,000 = \$0 =
CCY 2014 April to Dec. 2014/	\$1,000 PMPM	1%	\$10 PMPM	1,000	\$15,000	\$10 PMPM * 1,000 = \$10,000=

DY 1						
CCY 2015/ DY2 – Fallon Total Care (FTC)	\$1,000 PMPM	1.5%	\$15 PMPM	1,000	\$0	\$15 PMPM * 1,000 = \$15,000
CCY 2015/ DY 2 – One Care Plans other than FTC	\$1,000 PMPM	0%	\$15 PMPM	1,000	\$10,000	\$15 PMPM * 1,000 == 5,000
CCY 2016/ DY 3	\$1,000 PMPM	>40% (Per	\$40 PMPM	1,000		[\$40 PMPM 1,000 = = \$0

Specifically, OACT will estimate and certify actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration following the methodology below.

The actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration are equal to the savings percentage specified in the 1115A Duals demonstration contract multiplied by the 1115A Duals demonstration MassHealth Component of the capitation rate and the number of 1115A Duals demonstration beneficiaries enrolled in the 1115(a) demonstration. The Duals demonstration capitation rate is reviewed by CMS’s Medicare and Medicaid Coordination Office (MMCO), MMCO’s contracted actuaries and was certified by the Commonwealth’s actuaries. Per the 1115A Duals Demonstration contract, the actual Medicaid rate paid for beneficiaries enrolled in the 1115A Duals demonstration is equivalent to the state’s 1115A Duals demonstration MassHealth component minus an established savings percentage (specified in the Duals Demonstration contract), adjusted by any risk corridor payments or recoupments. The Commonwealth must track the number of member months for every Medicare-Medicaid enrollee (MME) who participates in both the 1115(a) and 1115A Duals demonstration.

The table above provides an illustrative example of how the savings attributable to populations and services provided under the 1115A demonstration is calculated. The Commonwealth may adjust the chart to account for risk corridor payment or recoupments.

In each quarterly report, the Commonwealth must provide the information in the above- named

chart (replacing estimated figures with actual data). Should rates differ by geographic area and/or rating category within the 1115A demonstration, this table should be done for each geographic area and/or rating category. In addition, the state must show the “amount subtracted from the 1115(a) BN savings” in the updated budget neutrality Excel worksheets that are submitted in each quarterly report.

Finally, in each quarterly CMS-64 submission and in each quarterly report, the state must indicate in the notes section: “For purposes of 1115(a) demonstration budget neutrality reporting purposes, the state reports the following information:

- Number of unduplicated Medicare-Medicaid enrollees served under the 1115A duals demonstration = [Insert number]
- Number of member months = [Insert number]
- PMPM savings per dual beneficiary enrolled from the 1115A duals demonstration = [Insert number]”

The Commonwealth must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A Duals demonstration. The Commonwealth may add columns to identify risk corridor payments and other adjustments in subsequent quarterly reporting. Note, the savings percentages may be updated in the Duals Demonstration contract, and the amount considered in the budget neutrality worksheets must reflect any adjustments, addendums, or amendments made in the Duals Demonstration contract.

110. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the Commonwealth on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C. with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

111. **Recognized Budget Neutrality Savings.**

- a) Beginning July 1, 2017 (SFY 2018/DY21), recognized budget neutrality savings is limited to savings realized beginning in July 1, 2011 (SFY 2012/DY 15). No deficit or savings is carried over from years prior to SFY 2012. Accordingly, the budget neutrality demonstration includes "with waiver" expenditures and "without waiver" expenditure limit calculations beginning in SFY 2012.
- b. Savings Phase-out: Beginning July 1, 2017 (SFY 2018/DY21), the net variance between the without-waiver cost and actual with-waiver cost will be reduced for selected Medicaid population based EGs. The reduced variance, to be calculated as a percentage of the total

variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) For the first five years that an eligibility group is enrolled in managed care savings are carried forward in full. For the first five years that a set of services (e.g. LTSS) is subject to managed care, savings are also carried forward in full. The formula for calculating the reduced variance is: reduced variance equals total variance times applicable percentage. The applicable percentages for each EG and DY are determined based how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer established managed care populations. The EGs affected by this provision and the applicable percentages are shown in the table below, except that if the total variance for an EG in a DY is negative, the applicable percentage is 100 percent.

EG	DY 21 PMPM (SFY 2018)	DY 22 PMPM (SFY 2019)	DY 23 PMPM (SFY 2020)	DY 24 PMPM (SFY 2021)	DY 25 PMPM (SFY 2022)
Base Families	25%	25%	25%	25%	25%
Base Disabled/MCB	25%	25%	25%	25%	25%
1902 (r) 2 Children	25%	25%	25%	25%	25%
1902 (r) 2 Disabled	25%	25%	25%	25%	25%
1902 (r) 2 BCCDP	25%	25%	25%	25%	25%

112. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the demonstration as adjusted July 1, 2008, rather than on an annual basis. However, if the Commonwealth exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the Commonwealth must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
DY 21	Cumulative budget neutrality limit plus:	2.0percent
DY 21 through DY 22	Cumulative budget neutrality limit plus:	1.5 percent
DY 21 through DY 23	Cumulative budget neutrality limit plus:	1.0 percent
DY 21 through 24	Cumulative budget neutrality limit plus:	.5 percent
DY 21 through 25	Cumulative budget neutrality limit plus:	0 percent

In addition, the Commonwealth may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the demonstration will exceed the cap during this extension.

113. **Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end

of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 110, composite federal share ratio. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

114. **Budget Neutrality Monitoring Tool.** The state and CMS will jointly develop a budget neutrality monitoring tool (using a mutually agreeable spreadsheet program) for the state to use for quarterly budget neutrality status updates and other in situations when an analysis of budget neutrality is required. The tool will incorporate the Schedule C Report for monitoring actual expenditures subject to budget neutrality. A working version of the monitoring tool will be available for the state’s first Quarterly Progress Report in 2018.

115. **Impact of Continuous Eligibility on Budget Neutrality.** Students enrolled in SHIP will receive continued benefits during any periods within a twelve month eligibility period when these individuals would be found ineligible if subject to redetermination. To this end, 97.4% of the member months will be matched at the enhanced rate, and 2.6% of the member months will be matched at the regular FMAP to account for the proportion of member months that beneficiaries would have been disenrolled due to excess income in the absence of continuous eligibility. Therefore, Massachusetts shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

116. **Treatment of DSH Allotment.** The amount of any DSH-like payments must be prorated if necessary so that DSH-like payments will not exceed the percentage of the DSH allotment corresponding to the percentage of the federal fiscal year for which payment of DSH-like payments is required).

XIV. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date – Specific	Deliverable	Section Reference
Within 120 days from the award of the demonstration	Draft Evaluation Design	Section X
Within 60 days of receipt of CMS comments	Final Evaluation Design and Implementation	Section X
Within 180 days after the expiration of the demonstration	Final Report	
Annually		

October 1 st	Draft Annual Report,	Section X
30 days of the receipt of CMS comments	Final Annual Report, including DSRIP, ACO, flexible services and expenditures.	Section X
No later than 45 days after enactment of the state budget for each SFY	Updates to Charts A-B of Attachment E that reflect projected annual SNCP expenditures and identify the non-Federal share for each line item	Section XIV, XV
No later than 45 days after enactment of the state budget for each SFY	Projected annual DSHP expenditures	Section XIV
180 days after the close of the SFY (December 31)	Updates to Charts A-B of Attachment E that reflect actual SNCP payments and expenditures	Section XIV, XV
Quarterly		
60 days following the end of the quarter	Quarterly Operational Reports, including DSRIP, ACO, Flexible Services and payments reporting and eligible member months	Section X
60 days following the end of the quarter	Quarterly Expenditure Reports	Section X

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Unborn Targeted Low Income Child	0 through 200%	Uninsured	No (through December 31, 2013) Yes (effective January 1, 2014)	Separate XXI		Healthy Start (through December 31, 2013) Standard (effective January 1, 2014)	

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

Newborn Children Under age 1	AFDC-Poverty Level Infants 0 through 185%	Any	Yes	XIX via Medicaid state plan	<u>Base Families</u> <i>Without Waiver</i>	Standard	
	185.1 through 200%	Insured	Yes	XIX via Medicaid state plan	<u>1902(r)(2) Children</u> <i>Without Waiver</i>	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI Medicaid Expansion (via Medicaid state plan and XXI state plan) Funded through title XIX if XXI is exhausted	<u>1902(r)(2) XXI RO</u> <i>Without Waiver</i> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

This chart is provided for informational purposes only.

**ATTACHMENT A
OVERVIEW OF CHILDREN’S ELIGIBILITY IN MASSHEALTH**

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Newborn Children Under Age 1 and Disabled	200.1-300%	Insured	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance with wraparound to direct coverage CommonHealth	
		Uninsured at the time of application	Yes (if XXI is exhausted)	Separate XXI Funded through XIX if XXI is exhausted via demonstration authority	<u>CommonHealth XXI</u> <i>Hypothetical</i> (member months and expenditures for these children are only reported if XXI)	CommonHealth	The CommonHealth program was in existence prior to the separate XXI Children’s Health Insurance Program and was not affected by the maintenance of effort date. The

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

					funds are exhausted)		CommonHealth program is contained in the separate title XXI state plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate title XXI program but expenditures are claimed under title XXI until the title XXI allotment is exhausted.
Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

Newborn Children Under Age 1 and Disabled (continued)	Above 300%	Any	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth or CommonHealth Premium Assistance With wraparound to direct coverage CommonHealth	
Children Ages 1 through 18 Non-disabled	AFDC-Poverty Level Children Age 1-5: 0 through 133% FPL	Any	Yes	XIX	<u>Base Families</u> <i>Without waiver</i>	Standard	

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

	Age 6 through 17: 0 through 114% Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets						
	AFDC-Poverty Level Children Age 6 through 17: 114.1% through 133% Age 18: 0 through 133%	Insured	Yes	XIX	<u>Base Families</u> <i>Without waiver</i>	Standard	
		Uninsured	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	<u>Base Fam XXI</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

Children Ages 1 through 18 Non-disabled (continued)	Medicaid Expansion Children Ages 1 through 18: 133.1 through 150%	Insured	Yes	XIX	1902(r)(2) Children <i>Without waiver</i>	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	<u>1902(r)(2) Children RO</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

	All children Age 1 through 18: 150.1 through 200%	Insured	Yes	XIX via demonstration authority only	<u>E-Family Assistance</u>	Family Assistance Premium Assistance Direct Coverage	No additional wraparound is provided to ESI
--	---	---------	-----	--------------------------------------	-----------------------------------	--	---

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
-------------------	---	--	--	-------------------------------------	---	------------------------------	-----------------

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

<p>Children Ages 1 through 18 Non-disabled (continued)</p>	<p>All children Age 1 through 18: 150.1 through 200% (continued)</p>	<p>Uninsured at the time of application</p>	<p>Yes</p>	<p>Separate XXI Funded through XIX if XXI is exhausted</p>	<p><u>Fam Assist XXI RO</u> (member months and expenditures for these children are only reported if XXI funds are exhausted)</p>	<p>Family Assistance Premium Assistance Direct Coverage</p>	<p>No additional wrap is provided to ESI Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children's Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the title XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under the 1115 demonstration and as authorized under the separate title XXI</p>
---	--	---	------------	---	--	---	---

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

							program, but expenditures are claimed under title XXI until the title XXI allotment is exhausted.
--	--	--	--	--	--	--	---

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Ages 1 through 18 Non-disabled (continued)	All children Age 1 through 18: 200.1 through 300%	Insured	Yes	XIX via demonstration authority only	<u>E-Family Assistance</u>	Family Assistance Premium Assistance	No additional wraparound provided
		Uninsured at the time of application	Yes	Separate XXI			
	0 through 150%	Any	Yes	XIX via Medicaid state plan	<u>Base Disabled Without Waiver</u>	Standard	

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

Children Aged 1 through 18 and Disabled	150.1 through 300%	Insured	Yes	XIX via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance With wrap to direct	
---	--------------------	---------	-----	--------------------------------------	---	---	--

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Aged 1 through 18 and Disabled (continued)	150.1 through 300% (continued)	Uninsured at the time of application	Yes	Separate XXI Funded through XIX if XXI is exhausted	<u>CommonHealth XXI</u> <i>Hypothetical</i> (member months and expenditures for these children are only reported if XXI funds are exhausted)	CommonHealth	The CommonHealth program was in existence prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI state plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate XXI program, but expenditures are

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

Children Aged 1 through 18 and Disabled	Above 300%	Any	Yes	XXI via demonstration authority only	<u>CommonHealth</u> <i>Hypothetical</i>	CommonHealth/ Premium Assistance With wraparound to direct coverage	
---	------------	-----	-----	--------------------------------------	---	---	--

**ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBILITY IN MASSHEALTH**

						CommonHealth	
Children Aged 19 and 20	0 through 133%	Any	Yes	XIX via Medicaid state plan	Base Childless Adults	Benchmark 1	
Non-disabled	Medicaid Expansion Children Ages 19 and 20: 133.1 through 150%	Any	Yes	XIX via Medicaid state plan	1902(r)(2) Children <i>Without waiver</i>	Standard	
Children Aged 19 and 20 and Disabled	0 through 150%	Any	Yes	XIX via Medicaid state plan	Base Disabled <i>Without Waiver</i>	Standard	

**ATTACHMENT B
Cost Sharing**

Cost-sharing currently in effect unless changed by a state plan amendment.

Cost-sharing imposed upon individuals enrolled in the demonstration may vary across delivery systems, coverage types and by FPL. However, no co-payments are charged for any benefits rendered to individuals under age 21, pregnant women, individuals living in an institution or receiving hospice, and American Indian/Alaska Natives who receive services through an IHS, tribal 638 or the IHS/tribal Purchased and Referred Care program. Additionally, no premiums are charged to any individual enrolled in the demonstration whose gross income is less than 150 percent of the FPL, or to any American Indian/Alaska Natives who receive services through an IHS, tribal 638 or the IHS/tribal Purchased and Referred Care program. In the event a family group contains at least two members who are eligible for different coverage types and who would otherwise be assessed two different premiums, the family shall be assessed only the highest applicable premium. Family group will be determined using MassHealth rules for the purposes of assessing premiums as described in STC 20.

Demonstration Program	Premiums (only for persons with family income above 150 percent of the FPL)	Co-payments
MassHealth Standard/Standard ABP	\$0	All co-payments and co-payment caps are specified in the Medicaid state plan.
MassHealth CarePlus	\$0	MassHealth Standard co-payments apply.
MassHealth Breast and Cervical Cancer Treatment Program	\$15-\$72 depending on income	MassHealth Standard co-payments apply.
MassHealth CommonHealth	\$15 and above depending on income and family group size	MassHealth Standard co-payments apply.
CommonHealth Children through 300% FPL Children with income above 300% FPL adhere to the regular CommonHealth schedule	\$12-\$84 depending on income and family group size	MassHealth Standard co-payments apply.

ATTACHMENT B
Cost Sharing

MassHealth Family Assistance: HIV/AIDS	\$15-\$35 depending on income	MassHealth Standard co-payments apply.
MassHealth Family Assistance: Premium Assistance	\$12 per child, \$36 max per family group	Member is responsible for all co-payments required under private insurance with a cost sharing limit of 5 percent of family income

ATTACHMENT C
Quarterly Operational Report Content and Format

Under section X, the Commonwealth is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration.

The reports are due to CMS 60 calendar days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the Commonwealth. A complete quarterly progress report must include an updated budget neutrality monitoring workbook as well as updated Attachment E, Charts A-C.

NARRATIVE REPORT FORMAT:

Title Line One – MassHealth
Title Line Two – Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
 Demonstration Year: 21 (7/1/2017 – 6/30/2018) Quarter 1: (7/17 – 09/17)

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval/ operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The Commonwealth should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the Commonwealth should indicate that by “0”.

Note: Enrollment counts should be person counts, not member months.

<u>Eligibility Group</u>	<u>Current Enrollees (to date)</u>
Base Families	
Base Disabled	
1902(r)(2) Children	
1902(r)(2) Disabled	
Base Childless Adults (19-20)	
Base Childless Adults (ABP1)	
Base Childless Adults (CarePlus)	
BCCTP	

ATTACHMENT C
Quarterly Operational Report Content and Format

<u>Eligibility Group</u>	<u>Current Enrollees (to date)</u>
CommonHealth	
e-Family Assistance	
e-HIV/FA	
SBE	
Basic	
DSHP- Health Connector Subsidies	
Base Fam XXI RO	
1902(r)(2) XXI RO	
CommonHealth XXI	
Fam Assist XXI	
Asthma	
TANF/EAEDC	
End of Month Coverage	
Total Demonstration	

Enrollment in Managed Care Organizations and Primary Care Clinician Plan

Comparative managed care enrollments for the previous quarter and reporting quarter are as follows:

Delivery System for MassHealth-Administered Demonstration Populations

Plan Type			Difference
MCO			
PCC			
MBHP			
FFS			
PA			
ACO			

Enrollment in Premium Assistance and Small Business Employee Premium Assistance

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Safety Net Care Pool

Provide updates on any activities or planning related to payment reform initiatives or delivery system reforms affecting demonstration population and/or undertaken in relation to the SNCP. As per Section X, include projected or actual changes in SNCP payments and expenditures within the quarterly report. Please note that

ATTACHMENT C
Quarterly Operational Report Content and Format

the annual report must also include SNCP reporting as required by Section X and XIV.

Operational/Issues

Identify all significant program developments that have occurred in the current quarter or near future, including but not limited to, approval and contracting with new plans, the operation of MassHealth and operation of the Commonwealth Health Insurance Connector Authority. Any changes to the benefits, enrollment, grievances, quality of care, access, proposed changes to payment rates, health plan financial performance that is relevant to the demonstration, cost-sharing or delivery system for demonstration populations receiving premium assistance to purchase health insurance via the Commonwealth Health Insurance Connector Authority must be reported here.

Policy Developments/Issues

Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the Commonwealth’s actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Base Families				
Base Disabled				
1902(r)(2) Children				
1902(r)(2) Disabled				
New Adult Group				
BCCDP				
CommonHealth				
TANF/EAEDC				

B. For Informational Purposes Only

ATTACHMENT C
Quarterly Operational Report Content and Format

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
e-HIV/FA				
<u>Small Business Employee Premium Assistance</u>				
<u>DSHP- Health Connector Subsidies</u>				
Base Fam XXI RO				
1902(r)(2) RO				
CommonHealth XXI				
Fam Assist XXI				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also, discuss feedback received from other consumer groups.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

**ATTACHMENT D
MassHealth Historical Per Member/Per Month Limits**

MassHealth Family Assistance: Direct Coverage	\$12 per child, \$36 max per family group	Children only-no copayments.
---	---	------------------------------

Breast and Cervical Cancer Treatment Program Premium Schedule	
Percent of FPL	Premium Cost
Above 150 to 160	\$15
Above 160 to 170	\$20
Above 170 to 180	\$25
Above 180 to 190	\$30
Above 190 to 200	\$35
Above 200 to 210	\$40
Above 210 to 220	\$48
Above 220 to 230	\$56
Above 230 to 240	\$64
Above 240 to 250	\$72

CommonHealth Full Premium Schedule		
Base Premium	Additional Premium Cost	Range of Premium Cost
Above 150% FPL—start at \$15	Add \$5 for each additional 10% FPL until 200% FPL	\$15 □ \$35
Above 200% FPL—start at \$40	Add \$8 for each additional 10% FPL until 400% FPL	\$40 □ \$192
Above 400% FPL—start at \$202	Add \$10 for each additional 10% FPL until 600% FPL	\$202 □ \$392
Above 600% FPL—start at \$404	Add \$12 for each additional 10% FPL until 800% FPL	\$404 □ \$632
Above 800% FPL—start at \$646	Add \$14 for each additional 10% FPL until 1000% FPL	\$646 □ \$912
Above 1000% FPL—start at \$928	Add \$16 for each additional 10% FPL	\$928 □ greater

*A lower premium is required of CommonHealth members who have access to other health insurance per the schedule below.

CommonHealth Supplemental Premium Schedule	
% of FPL	Premium requirement
Above 150% to 200%	60% of full premium per listed premium costs above
Above 200% to 400%	65% per above
Above 400% to 600%	70% per above

ATTACHMENT D
MassHealth Historical Per Member/Per Month Limits

Above 600% to 800%	75% per above
Above 800% to 1000%	80% above
Above 1000%	85% above

Small Business Employee Premium Assistance* (effective January 1,	% of FPL	Premium Requirement for Individual	Premium Requirement for Couples
Small Business Employee Premium Assistance* provides premium assistance to certain employees who work for a small employer	Above 150% to 200%	\$40.00	\$80.00
	Above 200% to 250%	\$78.00	\$156.00
	Above 250% to 300%	\$118.00	\$236.00

* Premium requirements for individuals participating in the Small Business Employee Premium Assistance program are tied to the state affordability schedule, as reflected in the minimum premium requirement for individuals enrolled in QHP Wrap coverage through the Health Connector. The premium amounts listed in this table reflect the 2013 state affordability schedule and are subject to change without any amendment to the demonstration.

**ATTACHMENT D
MassHealth Historical Per Member/Per Month Limits**

The table below lists the calculated per-member per-month (PMPM) figures by eligibility group (EG) used to develop the demonstration budget neutrality expenditure limits for the first 14 years of the MassHealth demonstration. All demonstration years are consistent with the Commonwealth's fiscal year (July 1 – June 30).

After DY 5, the following changes were made to the per member/per month limits:

1. MCB EG was subsumed into the Disabled EG;
2. A new EG, BCCTP, was added; and
3. the 1902(r)(2) EG was split between children and the disabled

DY	Time Period	Families		Disabled		MCB		1902(r)(2)	1902(r)(2) Disabled	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	Trend Rate	PMPM	Trend Rate
1	SFY 1998	\$199.06	7.71%	\$491.04	5.83%	\$438.39	5.83%	5.33%	\$471.87	4.40%
2	SFY 1999	\$214.41	7.71%	\$519.67	5.83%	\$463.95	5.83%	5.35%	\$497.12	4.80%
3	SFY 2000	\$230.94	7.71%	\$549.97	5.83%	\$491.00	5.83%	5.60%	\$524.96	5.50%
4	SFY 2001	\$248.74	7.71%	\$582.03	5.83%	\$519.62	5.83%	5.70%	\$554.88	5.30%
5	SFY 2002	\$267.92	7.71%	\$615.96	5.83%	\$549.91	5.83%	5.70%	\$586.51	5.70%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
6	SFY 2003	\$288.58	7.71%	\$677.56	10.0%	\$236.9	7.71%	\$645.1	10.0%	\$1,891.62	10.0%
7	SFY 2004	\$310.83	7.71%	\$745.32	10.0%	\$255.2	7.71%	\$709.6	10.0%	\$2,080.78	10.0%
8	SFY 2005	\$334.79	7.71%	\$819.85	10.0%	\$274.9	7.71%	\$780.6	10.0%	\$2,288.86	10.0%
9	SFY 2006	\$359.23	7.30%	\$824.79	7.00%	\$295.0	7.30%	\$718.1	7.00%	\$2,449.08	7.00%
10	SFY 2007	\$385.46	7.30%	\$834.71	7.00%	\$316.5	7.30%	\$660.6	7.00%	\$2,620.52	7.00%
11	SFY 2008	\$413.60	7.30%	\$901.39	7.00%	\$339.6	7.30%	\$724.3	7.00%	\$2,803.95	7.00%

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
12	SFY 2009	\$466.84	6.95%	\$1,011.95	6.86%	\$382.45	6.95%	\$791.4	6.86%	\$3,052.78	6.86%

ATTACHMENT D
MassHealth Historical Per Member/Per Month Limits

13	SFY 2010	\$499.05	6.95%	\$1,081.37	6.86%	\$407.87	6.95%	\$846.6	6.86%	\$3,265.69	6.86%
14	SFY 2011	\$533.73	6.95%	\$1,115.55	6.86%	\$436.22	6.95%	\$904.7	6.86%	\$3,489.72	6.86%

ATTACHMENT D
MassHealth Historical Per Member/Per Month Limits

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCDP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
15	SFY 2012	\$562.02	5.3%	\$1,224.88	6.0%	\$457.59	4.9%	\$959.04	6.0%	5.3%	\$3,674.67
16	SFY 2013	\$591.81	5.3%	\$1,298.38	6.0%	\$480.02	4.9%	\$1,016.59	6.0%	5.3%	\$3,869.43
17	SFY 2014	\$623.17	5.3%	\$1,376.28	6.0%	\$503.54	4.9%	\$1,077.58	6.0%	5.3%	\$4,074.51

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC53(a).

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (projected and rounded in millions).

#	Payment Type	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per SFY					Total SFY 2018-2022	Applicable footnotes
					SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
<i>System Transformation Incentive Based Pools</i>											
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC57, STC 60	\$425.0	\$425.0	\$400.0	\$325.0	\$225.0	\$1,800.0	(1)
2	Public Hospital Transformation and Incentive Initiatives (PHTII)	n/a		Cambridge Health Alliance	\$309.0	\$243.0	\$100.0	\$100.0	\$100.0	\$852.0	
<i>System Transformation Incentive Based Pools Subtotal</i>					<i>\$734.0</i>	<i>\$668.0</i>	<i>\$500.0</i>	<i>\$425.0</i>	<i>\$325.0</i>	<i>\$2,652.0</i>	
<i>Disproportionate Share Hospital (DSH) Pool</i>											
3	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	\$20.0	\$20.0	\$20.0	\$20.0	\$20.0	\$100.0	(2)
		DSH									
4	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101CMR 613.00, 614.00	All acute hospitals and CHCs	\$287.0	\$287.0	\$288.0	\$288.0	\$290.0	\$1,440.0	(3)
5	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	\$32.0	\$32.0	\$32.0	\$32.0	\$32.0	\$160.0	(4)

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (projected and rounded in millions).

6	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	\$51.0	\$52.0	\$52.0	\$52.0	\$52.0	\$259.0	(5)
7	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	\$105.0	\$107.0	\$107.0	\$107.0	\$107.0	\$533.0	(5)
8	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	\$180.0	\$177.0	\$176.0	\$176.0	\$174.0	\$883.0	
	<i>Disproportionate Share Hospital (DSH) Pool Subtotal:</i>				<i>\$675.0</i>	<i>\$675.0</i>	<i>\$675.0</i>	<i>\$675.0</i>	<i>\$675.0</i>	<i>\$3,375.0</i>	
	<i>Uncompensated Care (UCC) Pool</i>										

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC53(a).

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (projected and rounded in millions).

9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals	\$0.0	\$10.0	\$10.0	\$10.0	\$10.0	\$40.0	(3)
10	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	\$65.0	\$15.0	\$15.0	\$0150	\$150	\$125.0	(5)
11	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	\$147.0	\$75.0	\$75.0	\$75.0	\$75.0	\$447.0	(5)
Uncompensated Care (UCC) Pool Subtotal:					\$212.0	\$100.0	\$100.0	\$100.0	\$100.0	\$612.0	
ConnectorCare Subsidies											

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (projected and rounded in millions).

12	DSHP – Health Connector Subsidies	n/a		n/a	\$250.0	\$250.0	\$250.0	\$250.0	\$250.0	\$1,250.0	(6)
	<i>DSHP – Health Connector Subtotal</i>				\$250.0	\$250.0	\$250.0	\$250.0	\$250.0	\$1,250.0	
	Total				\$1,871.0	\$1,693.0	\$1,525.0	\$1,450.0	\$1,350.0	\$7,889.0	

*Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.

The following notes are incorporated by reference into Chart A

- (1) The Delivery System Reform Incentive Payments will be distributed to participating ACOs, CPs and for other approved uses pursuant to STC57 and STC 60 and the DSRIP Protocol
- (2) The provider-specific Public Service Hospital Safety Net Care payments are approved by CMS. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. The Commonwealth may decrease these payment amounts based on available funding without a demonstration amendment; any increase will require a demonstration amendment.
- (3) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Only payments for care provided to eligible uninsured patients may be claimed in line 9, under the UC Pool.
- (4) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD category: inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC53(a).

Chart A: Approved SNCP Payments for the period from July 1, 2017 through June 30, 2022, unless otherwise specified in STCs 50 and 51 (projected and rounded in millions).
centers.

- (5) Expenditures for DPH and DMH hospitals in chart A are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis. Annual payments are for dates of service beginning July 1 and ending June 30 for each fiscal year. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth. Only uninsured costs may be claimed in lines 10-11 under the UC Pool.
- (6) Expenditures for DSHP - Health Connector Premium and Cost Sharing Subsidies are approved based on actual enrollment and premium assistance and cost sharing subsidy costs, and HSN Health Connector gap coverage subsidies are approved based on actual enrollment and gap coverage costs. Consequently, the amount of total expenditures may vary. Health Connector Subsidies are not subject to the aggregate SNCP cap or any sub-cap.

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

#	Payment Type	Applicable Caps	State law or regulation	Eligible Providers	Total SNCP Payments per SFY					Total SFY 2018-2022	Source of non-federal share
					SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022		
<i>System Transformation Incentive Based Pools</i>											
1	Delivery System Reform Incentive Payments (DSRIP)	n/a		Participating ACOs, CPs and other uses as specified in STC 57 and STC 60.	\$425.0	\$425.0	\$400.0	\$325.0	\$225.0	\$1,800.0	General Fund, including provider assessment funding in the DSRIP Trust Fund
2	Public Hospital Transformation and Incentive Initiatives (PHTII)	n/a		Cambridge Health Alliance	\$309.0	\$243.0	\$100.0	\$100.0	\$100.0	\$852.0	Inter-Governmental Transfer
<i>System Transformation Incentive Based Pools Subtotal</i>					\$734.0	\$668.0	\$500.0	\$425.0	\$325.0	\$2,652.0	
<i>Disproportionate Share Hospital (DSH) Pool</i>											

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

3	Public Service Hospital Safety Net Care Payment	DSH		Boston Medical Center	\$20.0	\$20.0	\$20.0	\$20.0	\$20.0	\$100.0	General Fund
		DSH									
4	Health Safety Net Trust Fund Safety Net Care Payment	DSH	101CMR 613.00, 614.00	All acute hospitals and CHCs	\$287.0	\$287.0	\$288.0	\$288.0	\$290.0	\$1,440.0	General Fund, including provider assessment funding in the Health Safety Net Trust Fund
5	Institutions for Mental Disease (IMD)	DSH	130 CMR 425.408, 101CMR 346.004	Psychiatric inpatient hospitals Community-based detoxification centers	\$32.0	\$32.0	\$32.0	\$32.0	\$32.0	\$160.0	Certified Public Expenditure
6	Special Population State-Owned Non-Acute Hospitals	DSH		Shattuck Hospital Tewksbury Hospital Massachusetts	\$51.0	\$52.0	\$52.0	\$52.0	\$52.0	\$259.0	Certified Public Expenditure

**ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B**

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

	Operated by the Department of Public Health			Hospital School Western Massachusetts Hospital							
7	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	DSH		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital	\$105.0	\$107.0	\$107.0	\$107.0	\$107.0	\$533.0	Certified Public Expenditure

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

				Worcester Recovery Center and Hospital							
8	Safety Net Provider Payments	DSH		Eligible hospitals outlined in Attachment N	\$180.0	\$177.0	\$176.0	\$176.0	\$174.0	\$883.0	General Fund
	<i>Disproportionate Share Hospital (DSH) Pool Subtotal:</i>				\$675.0	\$675.0	\$675.0	\$675.0	\$675.0	\$3,375.0	
	<i>Uncompensated Care (UCC) Pool</i>										
9	Health Safety Net Trust Fund Safety Net Care Payment	UCC	101CMR 613.00, 614.00	All acute hospitals	\$0.0	\$10.0	\$10.0	\$10.0	\$10.0	\$40.0	General Fund, including provider assessment funding transferred to the HSN Trust
10	Special Population State-Owned Non-Acute Hospitals Operated by the Department	UCC		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western	\$65.0	\$15.0	\$15.0	\$15.0	\$15.0	\$125.0	Certified Public Expenditure

**ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B**

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

	Department of Public Health			Massachusetts Hospital							
11	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	UCC		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Worcester Recovery Center and Hospital	\$147.0	\$75.0	\$75.0	\$75.0	\$75.0	\$447.0	Certified Public Expenditure

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS:
CHART B

Safety Net Care Pool. The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2017, unless otherwise specified in STCs 49 and 50, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2022, unless otherwise specified in STCs 49 and 50 (projected and rounded)

	<i>Uncompensated Care (UCC) Pool Subtotal:</i>			<i>\$212.0</i>	<i>\$100.0</i>	<i>\$100.0</i>	<i>\$100.0</i>	<i>\$100.0</i>	<i>\$612.0</i>		
	<i>ConnectorCare Subsidies</i>										
12	DSHP – Health Connector Premium and Cost Sharing Subsidies	n/a		n/a	\$250.0	\$250.0	\$250.0	\$250.0	\$250.0	\$1,250.0	Certified Public Expenditure and General Fund, including provider assessment funding in the Health Safety Net Trust Fund
	<i>DSHP – Health Connector Subtotal</i>			<i>\$250.0</i>	<i>\$250.0</i>	<i>\$250.0</i>	<i>\$250.0</i>	<i>\$250.0</i>	<i>\$1250.0</i>		
	Total			\$1,871.0	\$1,693.0	\$1,525.0	\$1,450.0	\$1,350.0	\$7,889.0		

*Under section 1902(a)(13)(A)(iv) of the Social Security Act, states are required to make payments that take into account the situation of disproportionate share hospital (DSH) providers. As part of this Demonstration project, CMS has waived the requirements of section 1902(a)(13) and has provided in the STCs that Massachusetts will not make such DSH payments but instead will make provider support payments under the SNCP.

Designated State Health Programs (DSHP). The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit. No demonstration amendment is required for CMS approval of updates to Chart C of Attachment E to include additional DSHP programs. This chart shall be updated pursuant to the process described in STC 53(b).

Chart C: Approved Designated State Health Programs (DSHP)

These DSHPs are not subject to the overall SNCP cap.

Agency	Program Name
Health Connector	Health Connector Premium Assistance and Cost Sharing Subsidies, and HSN- Health Connector Gap Coverage Subsidies

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

INTRODUCTION

The Pediatric Asthma Pilot Program will utilize an integrated delivery system for preventive and treatment services through methodologies that may include a payment such as a per member/per month (PMPM) payment to participating providers for asthma-related services, equipment and supports for management of pediatric asthma for high-risk patients, to improve health outcomes, reduce asthma-related emergency department utilization and asthma-related hospitalizations, and to reduce associated Medicaid costs. These methodologies are subject to CMS approval of this pilot program protocol.

This protocol describes Phase 1 of the Pediatric Asthma Pilot Program. In accordance with STC 39(e), the Commonwealth will not expand the pilot program or implement a Phase 2 until after Phase 1 has been implemented, evaluated, and CMS has issued its approval of an expansion or Phase 2. The Commonwealth must operate Phase 1 of the demonstration for at least one (1) full year before beginning to evaluate the pilot program (see STC Protocol Requirements 8 below for additional information regarding the timing of the evaluation of Phase 1). Phase 1 may last for up to three years to ensure a seamless transition to Phase 2, if approved by CMS.

In accordance with STC 39(g) “Required Protocols Prior to Claiming Federal Financial Participation (FFP)”, this protocol describes how the Commonwealth plans to meet the milestones required before enrolling beneficiaries and claiming FFP under this pilot program.

To develop these protocols, the Commonwealth established an internal program design team, which includes three physicians, a nurse, a pharmacist, several policy experts, data analysts, and a legal counsel. MassHealth also convened an external Advisory Committee with 20 members, each of whom has expertise in treating high-risk pediatric asthma patients, designing and implementing clinical programs to prevent and manage high-risk pediatric asthma, and/or designing and implementing global or bundled payment structures. Advisory Committee members include physicians, nurses, pharmacists, researchers, representatives of professional organizations, and health care administrators.

This section sets forth the Commonwealth’s proposal for establishing eligibility criteria for member participation in the pilot and the process for enrolling members in the pilot. Because the proposed intervention is intensive, it can only be implemented in a cost neutral way if it is targeted to the patients who are most likely to require hospital treatment for asthma in the absence of intervention. In order to target these children, the advisory committee recommended restricting eligibility to members with poorly controlled asthma, as described in section A.6. below.

The advisory committee also recommended enabling Participating Practices to enroll eligible members into the pilot through the process described in section B below, in order to enroll eligible members at the time that they most need the intervention. Participating practices may have documentation supporting a member’s eligibility that is not available or not yet available through MassHealth claims data. For example, a member may have been hospitalized for asthma prior to his or her enrollment in MassHealth.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

A. **Eligibility.** Patients who meet the criteria in section A1 through 6 below may be enrolled in the Children's High-Risk Asthma Bundled Payment Pilot (CHABP) as CHABP Enrollees:

1. Are between the ages of 2 and 18 years at the time of CHABP enrollment;
2. Are a MassHealth member;
3. Are enrolled in the MassHealth Primary Care Clinician (PCC) plan , as described in STC 41a, and on the PCC panel of the participating practice, as identified by its provider identification and service location number (PID/SL);
4. Have a clinical diagnosis of asthma;
5. Meet the clinical criteria for high-risk asthma, as demonstrated by meeting at least one of the following criteria within the 12 months prior to the date of CHABP enrollment:
 - a. Inpatient hospital admission for asthma;
 - b. Hospital observation stay for asthma;
 - c. Hospital emergency department visit for asthma; or
 - d. Oral systemic corticosteroid prescription for asthma; and,
6. Have poorly controlled asthma, as evidenced by a score of 19 or lower on Quality Metric's asthma control test (ACT) (see attachment A) at least twice within any 2 month period in the 12 months prior to the date of enrollment, based on responses by the patient if the patient is at least 12 years old or else by the patient's caregiver. The ACT may be completed in person or by telephone.

B. **Enrollment Process.** Patients who meet the eligibility criteria described in section A will be enrolled in the CHAPB through one of the following two pathways.

1. Members identified by MassHealth:
 - a. The Executive Office of Health and Human Services (EOHHS) will, within 10 working days of the contract start-date and every 90 calendar days thereafter, give the participating practice a list of the members on the participating practice's PCC panel who, based on MassHealth claims data, meet the clinical criteria for high-risk asthma set forth in section A.1 through A.5 above.
 - b. The participating practice must make and document its best efforts to schedule each eligible member in its practice for an office visit within 90 days of the date of the list described in paragraph 1.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

- c. At the office visit described in paragraph 2, the participating practice must assess each member on the list described in paragraph 1 above for poorly controlled asthma in accordance with section A.6 above and list members who meet all eligibility criteria specified in section A on the patient enrollment report (see attachment B). The practice must report to the state on the patient enrollment report the reason for not enrolling any member on the list.
2. Members identified by the participating practice.
The participating practice may also enroll on its panel PCC plan members who meet all eligibility criteria (listed in section A), but were not included on the list described in paragraph 1 above, by documenting their eligibility for the CHABP using the patient enrollment report. EOHHS will verify Member eligibility using MassHealth eligibility and claims data, to the extent it is available.
3. The participating practice must submit an initial patient enrollment report within 75 days of the contract start-date. The participating practice may submit changes to this enrollment report by the second Friday of each month for enrollment in the CHABP for the following month. Enrollment is effective as of the first of the month following submission of the enrollment report.
4. The participating practice must send a letter, approved by EOHHS, notifying each PCC plan member enrolled in the CHABP of the CHABP and the services available through the CHABP.

C. Disenrollment

1. A parent or guardian who does not wish their child to receive services through the CHABP may notify the Participating Practice in writing and request to be disenrolled from the CHABP. If the Participating Practice receives such a request, it will report the Member as “disenrolled” on the next Patient Enrollment Report it files.
2. Members who, according to the monthly enrollment roster available through the MassHealth provider online service center (POSC), (1) lose MassHealth coverage, (2) are disenrolled from the PCC plan, or (3) are enrolled with a different PCC site location, will be simultaneously disenrolled from the CHABP. If a member is disenrolled for one of these reasons and the member subsequently is (1) re-enrolled in MassHealth, and (2) re-enrolled in the PCC plan, and (3) reenrolled with the previous participating practice PCC site location, then the participating practice must re-enroll the member in the CHABP; in this case prior eligibility for the CHABP will serve as sufficient documentation of eligibility on the patient enrollment report.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

3. Members will be not be disenrolled during Phase 1 of the CHABP, as further described below, for turning age 18 after being enrolled in the CHABP, nor for failing to continue to meet the clinical criteria for high-risk asthma described in section A.1 through A.5, nor for having an ACT test that fails to meet the criterion in section A.6 above, nor for any reason other than those listed in C.1 and C.2 above.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

STC PROTOCOL REQUIREMENTS

1. **A description and listing of the program specific asthma-related benefit package that will be provided to the pilot participants.**

A. **Traditional MassHealth Covered Services**

The Participating Practice will continue to provide or arrange for all medically necessary services for the effective treatment and management of pediatric asthma for Children's High-risk Asthma Bundled Payment Demonstration Program (CHABP) enrollees, in addition to providing required CHABP services (listed in section B) and contingent CHABP services (listed in section C). The participating practice must monitor and manage high-risk asthma services for CHABP enrollees according to their needs and based on national asthma guidelines contained in expert panel report 3 (EPR 3): "Guidelines for the diagnosis and management of asthma" (see <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>¹, as those guidelines may be periodically updated). The participating practice may bill MassHealth for any such medically necessary traditional MassHealth covered services it provides on a fee-for-service basis. Payment for traditional MassHealth covered services is *not* included in the Phase 1 bundled payment.

In particular, the participating practice must:

1. Assess the member's PCC plan enrollment status at each visit.
2. Assess and monitor asthma control, impairment, and risk, and classify asthma as described in EPR 3, as part of a physician office visit;
3. Administer the asthma control test (ACT) at every well-child and asthma-related visit;
4. Provide or arrange for all medically necessary MassHealth-covered services for the effective treatment and management of pediatric asthma;
5. Ensure that the CHABP Enrollee has a written asthma action plan, in a patient-friendly format, listing the enrollee's primary care provider's and parents' contact information, triggers that exacerbate the CHABP enrollee's symptoms, symptoms to watch for, the names and doses of medications the CHABP Enrollee needs and when to use them, and instructions on when to call the primary care provider and when to see a doctor immediately. The primary care provider must review the asthma action plan at least annually and update it as necessary;
6. Provide asthma self-management education to the CHABP Enrollee and family in the office, including education on the asthma action plan;

¹ Accessed as of February 1, 2012

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

7. Provide or arrange for the CHABP enrollee to receive an inactivated flu vaccine when seasonally appropriate;
8. Provide care coordination by a case manager or clinician, to help CHABP enrollees access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma; and,
9. Provide clinical care management of multiple co-morbidities by a licensed clinician, including communication with all clinicians treating the patient, as well as medication review, reconciliation and adjustment.

B. Required CHABP Services

For each CHABP enrollee, the participating practice must:

1. At least once per month, review available data for each CHABP Enrollee to identify the need for follow-up. This review shall include:
 - a. Identifying Enrollees who are due for an office visit, phone call, or other service; and
 - b. Identifying cases for review and discussion by the Interdisciplinary Care Team. The ICT shall at minimum review cases for Enrollees:
 - i. who had an unscheduled office visit, emergency department visit, observation stay and/or inpatient admission for asthma;
 - ii. whose most recent ACT score was 19 or lower; or
 - c. who were recommended for review by a clinician or a member of the ICT.
2. Contact families of CHABP enrollees within three months of enrollment and at least once every six months thereafter:
 - a. To schedule office visits. The participating practice must make every effort to ensure each CHABP enrollee has an office visit within three months of enrollment into the CHABP and at least once every six months thereafter. The participating practice must help families, as needed, to arrange transportation and to avoid missing appointments and document this assistance in the CHABP enrollee's record; and,
 - b. To administer the Asthma Control Test (ACT), as well as the following two additional questions:

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

- 1) During the past 4 weeks, how many days of school/daycare/summer program did the CHABP Enrollee miss because of his/her asthma?
- 2) During the past 4 weeks, how many days was a CHABP Enrollee's caregiver unable to work or carry out usual activities because of the Enrollee's asthma?
3. Offer and encourage families of CHABP enrollees to accept a home visit by a community health worker (CHW) or nurse to provide supplemental family education and conduct an initial environmental assessment to identify potential asthma triggers in the home; if a family declines a home visit, then the participating practice must offer supplemental family education and care coordination in the office or by telephone and document this in the CHABP enrollee's record;
4. Request permission from the CHABP enrollee's parent or guardian to contact the CHABP enrollee's school and any childcare provider. With written permission, the Participating Practice must share the CHABP Enrollee's Asthma Action Plan with the school and childcare provider and offer to explain the plan; and,
5. Contact families of CHABP Enrollees each August, either by phone or during an pre-scheduled office visit as needed, in order to:
 - a. Review medications that the CHABP Enrollee currently takes or may need to re-start after the summer; and,
 - b. Request updated school and childcare contact information and, with permission, share the CHABP Enrollee's Asthma Action Plan with new school and childcare personnel.

C. CHABP Services to be provided on an as needed basis

The participating practice must effectively manage their use of CHABP funds to meet individual CHABP enrollees' and families' needs in addition to the minimum requirements listed in section B above. The participating practice must provide additional services and supplies, based on the enrollee's assessed needs, which include, but are not limited to the following:

1. Additional home visits by a CHW or nurse to provide supplemental family education and a full home environmental assessment to identify and document the presence of environmental asthma triggers in the home;
2. Supplies to mitigate environmental triggers, such as hypoallergenic mattress and pillow covers, vacuums, HEPA filters, air conditioner units, and pest management supplies and services, as well as training by a CHW to use these supplies correctly;

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

3. Support by CHWs for families' advocacy with landlords and property managers to promote healthy environmental conditions in the home;
4. Care coordination, provided by a CHW, as a supplement to traditional care coordination provided by a case manager or clinician, to help CHABP enrollees and their caregivers access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma; and,
6. Contacting families of CHABP Enrollees each May, either by phone or during an office visit, in order to:
 - a. Review medications that the CHABP enrollee currently takes and adjust as necessary for the summer; and,
 - b. Request contact information for any summer programs that the CHABP enrollee may be enrolled in and, with permission, share the CHABP enrollee's asthma action plan with new school and childcare personnel. Clinical data indicates that many patients experience improvement in asthma symptoms during the summer; Participating Practices should focus their efforts to coordinate with summer programs on CHABP enrollees who have not demonstrated such improvement.
7. Delivering an Enrollee's prescribed medications to a school or childcare, along with the Enrollee's Asthma Action Plan, with written consent from a parent or guardian.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

2. **Rationale for the inclusion of each benefit in the asthma-related benefit package that will be provided to the pilot participants**

The CHABP is intended to allow primary care practitioners to use a variety of evidence-based innovations in care delivery and decision-making to control asthma in children and adolescents at high risk of serious complications or death in a culturally competent and clinically relevant manner.

The recommendations of this benefit package are based on the structure provided in the latest report of the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (2007)ⁱ, but with evidence-based content designed to accommodate new and emerging best practices in the field.

The NAEPP Guidelines structures asthma management into four components:

- (1) Measures of Asthma Assessment and Monitoring;
- (2) Education for a Partnership in Asthma Care;
- (3) Control of Environmental Factors and Co-morbid Conditions That Affect Asthma; and,
- (4) Medications.

Traditional care for asthma generally focuses on medication and education in the office setting. Phase 1 of the pilot covers currently unreimbursed services, allowing flexible use of funds to support community-based interventions. According to the NAEPP guideline, individual interventions alone are often ineffective unless they are part of a comprehensive and holistic approach to medical care. Transportation, money, and time limit traditional asthma education programs set in clinic or school settings and often cause difficulty attracting and retaining participantsⁱⁱ. The benefit package review will thus largely focus on home and community-based interventions for improved asthma outcomes.

Healthy People 2020 outlines select goals and objectives related to home interventions with an environmental focus to reduce asthma morbidity.ⁱⁱⁱ

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol
Approved: July 24, 2014

Table 1: Select HealthyPeople 2020 Objectives relating to environmental strategies to reduce asthma morbidity	
Objective Description	
EH-13	Reduce indoor allergen levels
RD-1	Reduce asthma deaths
RD-2	Reduce hospitalizations for asthma
RD-3	Reduce hospital emergency department visits for asthma
RD-4	Reduce activity limitations among persons with current asthma
RD-5	Reduce the proportion of persons with asthma who miss school or work days
RD-6	Increase the proportion of persons with current asthma who receive formal patient education
RD-7	Increase the proportion of persons with current asthma who receive appropriate asthma care according to National Asthma Education and Prevention Program (NAEPP) guidelines

Potential CHABP Evidence-based Interventions

Recommendations from numerous advisory groups concur that a comprehensive, multi-faceted approach to asthma management is necessary.

Table 2: Advisory group recommendations regarding a comprehensive approach to asthma management	
Publication & Advisory Group	Findings
<i>Guidelines for the Diagnosis and Management of Asthma</i> The National Asthma Education and Prevention Program (NAEPP) Expert Panel Report 2007	This report states that patients who have asthma at any level of severity should reduce, if possible, exposure to allergens to which the patient is sensitized and exposed, and that effective allergen avoidance requires a multifaceted, comprehensive approach; individual steps alone are generally ineffective.
<i>Characteristics of successful asthma programs: Asthma Health Outcomes Project^{iv} (AHOP)</i> U.S. Environmental Protection Agency	Presents quantitative and qualitative data on 223 asthma programs throughout the world that include at least one environmental component. The report findings indicated that programs were more likely to report a positive impact on health outcomes if they (1) were community based, (2) engaged the participation of community-based organizations, (3) provided program components in a clinical

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

<p>2009</p>	<p>setting, (4) provided asthma training to health-care providers, (5) collaborated with other organizations and institutions and with government agencies, (6) designed a program for a specific racial/ethnic group, (7) tailored content or delivery based on individual health or educational needs, and (8) conducted environmental assessments and tailored interventions based on these assessments.</p>
<p><i>Global Strategy for Asthma Management and Prevention</i>^v</p> <p>Global Initiative for Asthma (GINA)</p> <p><i>Updated 2011</i></p>	<p>GINA works with health care professionals and public health officials around the world to reduce asthma prevalence, morbidity, and mortality. The organization published asthma guidelines that state “. . . among inner-city children with atopic asthma, an individualized home-based, comprehensive environmental intervention decreased exposure to indoor allergens and resulted in reduced asthma-associated morbidity.”</p>
<p><i>Housing Interventions and Health: a Review of the Evidence</i></p> <p>National Center for Healthy Housing & CDC</p> <p>2007</p>	<p>Published the conclusions of an expert panel convened by the National Center for Healthy Housing and the CDC in December 2007 to weigh the strength of a variety of housing interventions. Home-based environmental interventions to reduce asthma triggers were among the interventions discussed. After reviewing the evidence, the panel found that interventions such as multifaceted, tailored, home-based environmental interventions and integrated pest management for asthma were effective and appropriate for implementation.</p>
<p><i>Effectiveness of Home-Based, Multi-Trigger, Multi-component Interventions with an Environmental Focus for Reducing Asthma Morbidity: A Community Guide Systematic Review</i></p> <p>Taskforce on Community Preventive Services: A collaboration between USDHHS and CDC with public and private partners</p> <p>2011</p>	<p>The Task Force recommends the use of home-based, multi-trigger, multi-component interventions with an environmental focus for children and adolescents with asthma, on the basis of strong evidence of effectiveness in reducing symptom-days, improving quality of life scores or symptom scores, and reducing the number of school days missed. The evidence was considered strong on the basis of findings from 23 studies in the effectiveness review.</p>

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Home Environment Strategy: Decrease Triggers & Housing Resources

Exposure to allergens and irritants within the home can trigger or exacerbate episodes of asthma. The most common asthma triggers within the home include allergens from house dust mites, pets, cockroaches, rodents, and mold as well as irritants such as environmental tobacco smoke (ETS) and indoor air pollutants. Targeting these triggers can decrease the number and severity of asthma exacerbations. Poor housing quality has been shown to be strongly associated with poor asthma control even after controlling for potentially confounding factors such as income, smoking, overcrowding, and unemployment^{vi}. Moisture from leaky plumbing, high humidity, and cracks in floors and walls can contribute to mold growth; provide water for cockroaches, mice, and dust mites; and provide avenues through which cockroaches and mice can enter the home.

INTERVENTION: CHABP will address the environmental asthma triggers through an environmental assessment of the home by a specially trained community health worker (CHW). Based on the results of the home assessment, a determination of an appropriate mitigation plan would be developed. Supplies that could contribute to asthma control include HEPA vacuums, air conditioning units, allergenic covers would be available to qualifying households based on specific triggers, patient sensitization, and need. CHWs will also be trained to support families' advocacy with landlords and property managers to promote healthy environmental conditions in the home; CHWs can educate families as to landlords' legal responsibilities for maintaining their property and help families to articulate requests for corrective action.

Home-based Education Strategy:

The NAEPP recommends asthma self-management education at multiple points of care. There is evidence that using multiple approaches to address environmental triggers, specifically approaches that use both education and remediation, could be more effective than interventions that use either alone^{vii}.

INTERVENTION: The CHABP pilot would provide funding for CHWs who have specialized training in asthma and environmental mitigation to the high risk asthma patients and their families. The cost effectiveness of CHWs for asthma education has been established in numerous settings.^{viii,ix,x,xi} The CHW training will result from a collaboration with DPH and community partners and includes a core competency training as well as additional asthma environmental mitigation training.

The education that could be supplemented by the CHW assessment and follow-up include the following:

- asthma education for caregivers
- self-management skills to promote control
- allergen control interventions
- tobacco cessation and/or avoidance for household members
- asthma action plan review
- advocacy training around housing rights

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Importantly, the education is to be tailored to patient and caregiver level of literacy, will test understanding, and will be provided in a culturally and linguistically competent manner.

Office-based Strategy

In addition to the normal standard of care provided in the office setting, the CHABP is designed to allow practices the flexibility to enhance a care coordination strategy for the high risk patients identified by training CHWs to provide care coordination services for both CHABP enrollees and their caregivers. CHABP establishes a mechanism for linking office and home-based strategies for valuable information regarding the home environment, reinforcement of asthma management education concepts, and feedback to the practices regarding the patient's control. The office would also be able to offer other significant benefits to appropriate families including supplies to mitigate environmental triggers (as mentioned above) to households that qualify. The goal is to decrease asthma exacerbations and improve function by providing enhanced services that yield more timely and actionable information to prevent costly asthma exacerbations and best serve the needs of the child.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

3. Eligibility, qualifications and selection criteria for participating providers, including the RFP for preapproval;

The following eligibility, qualification, and selection criteria will be used to assess provider applications for the CHABP program, and will be reflected in procurement documents. EOHHS may also consider any relevant information about the practice known to EOHHS.

A. Minimum Qualifications

To be considered for selection as a participating provider, applicants, in addition to all other requirements specified herein, must:

1. Participate as a PCC in the MassHealth PCC plan;
2. Have a MassHealth PCC plan provider identification and service location number (PID/SL) for the applicant site;
3. Have high-risk asthma patients ages 2-18 enrolled in the PCC panel, as evidenced by MassHealth claims data;
4. Possess secure broadband Internet access; and,
5. Not participate in the MDPH Reducing Ethnic/Racial Asthma Disparities in Youth (READY) study or another initiative that pays for similar services for pediatric patients with high-risk asthma at this practice site location identified by its PID/SL.

B. Participating Practice Evaluation Criteria

1. In order to be considered for participation in the CHABP, an applicant must:
 - i. Demonstrate that it meets the minimum practice qualifications identified in section A;
 - ii. Not receive payment or funding from any other source for services, activities, or expenses that will be funded through the CHABP; and,
 - iii. Submit a complete and timely application.
2. The quality of the responses to the questions in the application will be evaluated in accordance with the following criteria: comprehensiveness, feasibility, appropriateness, clarity, effectiveness, innovation, and responsiveness to the needs of EOHHS and the goals of the CHABP;
3. EOHHS will also evaluate responses from each applicant based on the following criteria:

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

- i. The extent to which the practice demonstrates commitment to participate in the CHABP for at least contingent on CMS approval:
- ii. The number of high-risk asthma patients ages 2 through 18 enrolled in the applicant's PCC plan panel based on MassHealth claims data;
- iii. The extent to which the applicant demonstrates its ability to manage high-risk asthma in a coordinated fashion as demonstrated by the applicant's responses to the questions in the application;
- iv. The extent to which EOHHS determines that the applicant satisfies EOHHS' goals of selecting a group of pediatric primary care practices which, taken together, are diverse in terms of:
 - Practice structure (e.g., solo, group, community health center);
 - Practice affiliation (e.g., independent, hospital-owned);
 - Geographic location;
 - Bilingual and multilingual capability; and,
 - Patient mix, as defined by racial and ethnic composition.

EOHHS may consider any relevant information about the practice known to EOHHS.

C. Contract Requirements for Participating Practice Staffing

The Participating Practice must:

1. Designate a financial/operational project leader. The financial/operational project leader must manage the financial resources required to manage and treat CHABP Enrollees. During Phase 1, the financial/operational project leader will participate in monthly meetings, in person or by phone, with EOHHS-designated staff to discuss development of the Phase 2 Bundled Payment;
2. Designate a clinical project leader for the CHABP demonstration program. The clinical project leader must ensure that each Interdisciplinary Care Team (ICT), as described below, manages CHABP Enrollees' asthma according to their needs, with a goal of preventing asthma-related hospital admissions and emergency department utilization and improving health outcomes. The clinical project leader must be a licensed clinician on staff at the Participating Practice and will act as the clinical director for the CHABP within the Participating Practice;
3. Designate a group of health care professionals within the Participating Practice that must comprise an ICT for each CHABP Enrollee which must collectively provide, coordinate and supervise the provision of asthma care, services and supplies in a continuous, accessible, comprehensive and coordinated manner. The ICT must

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

include, at a minimum, the member's primary care provider, a Community Health Worker (CHW), and the clinical supervisor for the CHW. The ICT must include CHABP Enrollees' specialty providers who offer treatment for asthma, if any, and establish a standard procedure for communicating with specialists;

4. Employ or contract for the services of at least one full-time or part-time Community Health Worker (CHW) or train an existing staff member to become a CHW (if training an existing staff member, training must be completed prior to the provision of CHABP services). CHWs must be culturally competent in the cultures, and preferably languages, of a Participating Practice's CHABP Enrollees and must:
 - a) Demonstrate their knowledge, skill and ability in the following core competencies:
 - i. Knowledge and identification of environmental asthma triggers;
 - ii. Environmental intervention and treatment;
 - iii. Ability to counsel caregivers and pediatric asthma patients on the reduction of environmental asthma triggers and self-management; and
 - iv. Effective communication and patient follow-up skills;
 - b) Complete a seven (7) day CHW core competency training, sponsored by the Massachusetts Department of Public Health (DPH), an Area Health Education Center (AHEC), or a Massachusetts Community College. The core competency curriculum includes leadership skills, assessment techniques, public health, outreach, cross cultural communication, community organizing, special focus on specific diseases groups and health issues, techniques for connecting families with community services, and techniques for talking about smoking cessation. If the Participating Practice is unable to access the DPH training free of charge, the cost of training will be the responsibility of the Participating Practice;
 - c) Complete a four (4) day asthma mitigation training, sponsored by DPH or provided by the Participating Practice using a curriculum approved by DPH. The asthma mitigation curriculum includes recognizing uncontrolled asthma, how to read an action plan, how to reinforce messages, environmental assessment and mitigation, and a discussion of housing law and tenants rights. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for training the CHW;
 - d) Complete a two day refresher asthma mitigation and core competency training, sponsored by DPH, each year the practice is participating in the CHABP. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for the cost of the training for the CHW;
 - e) Participate in quarterly CHW trainings or collaborative learning sessions organized by DPH. If the Participating Practice is unable to access the DPH training free of charge, the Participating Practice will be responsible for the cost of the training for the CHW; and

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

- f) Obtain CHW certification through DPH within one year of the date that such certification becomes available.
- 5. Assign a clinical supervisor for the CHW. The clinical supervisor may be any clinical member of the Participating Practice who participates in the ICT(s). The clinical supervisor must participate in a half-day training, sponsored by DPH, on how best to utilize the CHW and how to integrate the CHW into the care team.
- 6. Designate or contract for the services of at least one individual to provide care coordination to help CHABP Enrollees and caregivers access needed health care and community-based services, such as: allergen testing, flu vaccines, dietary modifications, smoking cessation services, and services needed for other physical and behavioral health conditions that affect the child's asthma. Care coordination may be provided by a CHW, case manager, or clinician.
- 7. Designate or contract for the services of at least one licensed clinician to provide clinical care management of multiple co-morbidities, including communication with all clinicians treating the patient, as well as medication review, reconciliation and adjustment.

D. Preapproval of RFP

The Commonwealth must submit the Request for Proposals (RFP) to the CMS Regional and Central Offices for review and preapproval prior to public release. The RFP must be submitted to CMS for review and preapproval at least 45 business days prior to the expected release date.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

4. **A plan outlining how this pilot may interact with other federal grants, such as for related research (e.g. NIH, HUD, etc.) and programmatic work (e.g. CHIPRA grant related to pediatric health care practices in multi-payer medical homes, etc.). This plan should ensure no duplication of federal funds and outline the state's coordination activities across the various federal support for related programmatic activities to address potential overlap in practice site selection, patient population, etc.**

If a practice participates in the Patient Centered Medical Home Initiative (PCMHI) as a Technical Assistance Plus Practice and participates in the CHABP, the Commonwealth will reduce the CHABP payment by the amount of the PCMHI payment. The PCMHI Medical Home Activity Fee and the PCMHI Clinical Care Management Fee will be deducted from the PMPM CHABP Phase 1 bundled payment amount.

If a Practice participates, either on its own or as part of a PCC, in the Primary Care Payment Reform (PCPR) initiative, the PCPR participants' PMPM payment for medical home services will be deducted from the \$50.00 PMPM CHABP Phase 1 Bundled Payment Amount. The PCPR PMPM payment for medical home services will be calculated by multiplying the PCPR medical home load by the risk score by the expected external service provision adjustment.

Applicants to participate in the CHABP must certify that they do not receive payment or funding from any other source for services, activities, or expenses that will be funded through the CHABP at this practice site. The application form requires applicants to respond to a number of questions regarding other related programmatic activities which may be federally funded.

In evaluating the CHABP, the Commonwealth will attempt to match Participating Practices with other practices that are participating in the same set of related programmatic activities in order to discern interactions among these activities.

Application to Participate in the Massachusetts Children's High-risk Asthma Bundled Payment (CHABP) Demonstration Program Sample Questions

- a. Indicate whether the practice is participating in any of these initiatives. (Participation in these initiatives is not a prerequisite to participation in the CHABP. The Practice may participate in both the CHABP and one or more of these initiatives as long as they do not provide payment or funding for services, activities, or expenses that will be funded through the CHABP at this practice site.) Check all that apply.
- (1) ___ Massachusetts CHIPRA Medical Home Demonstration Project
 - (2) ___ Safety Net Medical Home Initiative
 - (3) ___ Medicare Care Management for High-cost Beneficiaries Demonstration
 - (4) ___ Medicare Federally Qualified Health Center Advanced Primary Care Practice (FQHC ACP) Demonstration
 - (5) ___ State Demonstration to Integrate Care for Dual Eligible Individuals
 - (6) ___ Patient Centered Medical Home Initiative (PCMHI)
 - (7) ___ Other medical home initiative (describe)
 - (8) ___ None of the above

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

b. If the practice is participating in one or more of the initiatives listed above, are the staff committed to providing time and effort to the other initiative(s)? Explain the practice's plan to complete all initiatives successfully.

c. Is the PCC plan provider participating in the MDPH Reducing Ethnic/Racial Asthma Disparities in Youth (READY) study or another initiative that pays for similar services for pediatric patients with high-risk asthma at a different practice site?

Yes No

If yes, please provide the name of the initiative and the participating practice site.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

5. **A plan for the purchase and dissemination of supplies within the pilot specific benefit package, including procurement methods, by the state and/or providers including volume discounts;**

During Phase 1, CHABP providers will be responsible for the purchase and dissemination of the environmental mitigation supplies provided as necessary to CHABP beneficiaries. Providers are required to submit a plan to procure, store and disseminate environmental mitigation supplies under this pilot during the application process; this plan must also address the delivery, installation, and ease of consumer use for each supply. This plan should also address how the provider will utilize volume discounts (either its own or the Commonwealth's) in its procurement of mitigation supplies, and how the practice will instruct the CHABP parent/guardian in the use of the supplies.

The Commonwealth is responsible for the oversight of providers' environmental mitigation supply purchasing and dissemination procedures to ensure that supplies are comparable in the areas of patient outcome, safety and relative costs. The Commonwealth must also assure standardized equipment pricing, the availability of items to all CHABP enrollees, and must provide any beneficiary supports necessary to access provider-distributed environmental mitigation supplies.

Participating providers will be required to report the type, make, model, cost and quantity for each supply procured and disseminated to CHABP members on the CHABP Expenditure Report. The Commonwealth will evaluate this information on a quarterly basis to ensure consistency and quality of purchased supplies for each practice. The state will ensure there is a process to disseminate supplies as needed to best meet individual CHABP enrollees' needs. If the Commonwealth finds that a provider(s) is unable to purchase or disseminate mitigation environmental supplies where medically necessary to support the goals of the pilot, the Commonwealth must immediately notify CMS and provide a mitigation strategy that begins with the Commonwealth intervening in order to ensure needs are met.

As part of the evaluation of Phase 1 and as a condition of approval for Phase 2, the Commonwealth will conduct a value analysis to assess the environmental mitigation supplies purchased and disseminated in terms of patient outcome, safety, and relative costs to develop product selection and standardization guidelines to be used during Phase 2 of the Pilot. The purpose of this analysis will be to determine how the bundled payment model and products provided under this contingent service correlate with costs, outcomes, and safety.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

6. Payment rate setting methodology outlining the per member per month (PMPM) payment for the pilot services and supplies, consideration of risk adjustment and the estimated/expected cost of the pilot.

Providers who contract with the MassHealth PCC Plan will be reimbursed on fee for service (FFS) basis. Under Phase 1 of CHABP, participating PCCs will receive a prospective, monthly PMPM payment to cover the CHABP asthma mitigation services not currently reimbursed by MassHealth for members with high risk asthma (services include home visits by CHW, supplies and services to mitigate environmental asthma triggers). The data used to develop the Phase 1 PMPM is included in the tables below.

The PMPM payment is built up from an estimated cost of the covered benefits and an estimate of how many members will receive each supply or service. Supply costs were estimated based on actual costs incurred by Massachusetts health care providers who are currently distributing these supplies through their practices.

The budget table below includes an estimate of the percent of CHABP Enrollees that will receive a specific supply or service during a given year. Not all Enrollees will require each supply on an annual basis (for example, a family may already own a vacuum cleaner with a HEPA filter). Participating providers may distribute supplies to CHABP members in subsequent years of Phase 1 for a number of reasons, including for example:

- The member was newly eligible for CHABP because the member recently turned 2 years of age, enrolled in MassHealth, enrolled in the PCC Plan, was assigned to the Participating Practice's PCC Panel, met the clinical criteria for high-risk asthma, and/or met the criteria for poorly controlled asthma.
- The family had previously declined a home visit, but accepted a home visit in the second year. The environmental assessment identified the need for supplies that had not been identified previously through conversations with the family in the office and by telephone.
- The supply is no longer operational and required replacement.
- The family moved to a new housing situation and was unable to bring the supply with them.

The estimated percentage of members that will receive a supply during a year takes these contingencies into account. The estimates were based on the experience of existing programs, where for example, 30% of members declined a home visit where supplies were provided, as well as a consensus of the pilot advisors.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Estimated cost of Community Health Worker Visits and Phone Calls

	Visit	Phone Calls
CHW salary/hour	\$ 15.00	\$ 15.00
Hours per visit, including prep	4	0.25
Salary cost/visit	\$ 60.00	\$ 3.75
Supervision cost (10%)	\$ 6.00	\$ 0.38
Fringe, travel, indirect (45%)	\$ 29.70	\$ 1.86
Cost/visit	\$ 95.70	\$ 5.98

Budget for an average panel of high-risk asthma Members

Supply	Average Cost Each	Number	Price per Member	% of Members Receiving Supply	Cost per Member
Vacuum	\$200.00	1	\$200.00	70%	\$140.00
Filters	\$40.00	1	\$40.00	70%	\$28.00
Bedding	\$90.00	1	\$90.00	70%	\$63.00
Pillows	\$14.00	2	\$28.00	70%	\$19.60
Environmental Kits	\$55.00	1	\$55.00	45%	\$24.75
Educational Materials	\$20.00	1	\$20.00	100%	\$20.00
A/C Units	\$115.00	1	\$115.00	10%	\$11.50
Pest Management	\$135.00	1	\$135.00	50%	\$67.50
Total Supplies Cost					\$374.35
CHW initial visit/education	\$95.70	1	\$95.70	70%	\$66.99
CHW 2nd & 3rd visit, environmental mitigation	\$95.70	2	\$191.40	50%	\$95.70
CHW 4th & 5th visit follow-up education	\$95.70	2	\$191.40	30%	\$57.42
Total home visit cost					\$220.11
Phone calls	\$5.98	9	\$53.83	100%	\$53.83
Total cost per member per year					\$648.29
Cost per member per month					\$54.02

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol
Approved: July 24, 2014

Supply Item	Required Features
Vacuum	High Efficiency Particulate Air (HEPA) filter that removes 99.97% of particles at least 0.3 microns in size; double bag
Vacuum bags	Fits vacuum
Mattress cover	Allergen-impermeable, allergen-proof, zippered, waterproof
Pillow	Allergen-impermeable, allergen-proof
Air conditioner	High Efficiency Particulate Air (HEPA) filter that removes 99.97% of particles at least 0.3 microns in size

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

7. Payment methodology outlining cost and reconciliation for the infrastructure payments to participating provider sites, and the eligibility and reporting requirements associated with the infrastructure payments.

The Commonwealth will not make infrastructure payments as part of the CHABP initiative to participating provider sites during Phase 1 of the pilot. The Commonwealth must request CMS approval in order to implement infrastructure payments during Phase 2. During Phase I, the Commonwealth must work with stakeholders, including providers and an advisory committee, to develop the cost and reconciliation methodology for infrastructure payments, which will be submitted as a condition for approval Phase 2.

During Phase 1, the financial/operational project leader will participate in monthly meetings, in person or by phone, with EOHHS-designated staff and/or with the project Advisory Committee to discuss development of the Phase 2 Infrastructure Payment and Reconciliation Methodology.

During Phase 1, the Participating Practice will develop, or contract with another entity to provide, any additional infrastructure necessary to meet the specifications that EOHHS ultimately establishes for managing the Phase 2 Bundled Payment. This infrastructure may include, but is not limited to:

- a. Systems to coordinate ambulatory services provided by other health care providers, including specialists;
- b. Contracts and other documentation necessary to make payments to these other providers;
- c. Financial systems to accept Bundled Payments from EOHHS and to use them to pay for services provided by these other health care providers; and
- d. Information technology systems to track Bundled Payments received from EOHHS and payments made to these other providers.

During Phase 2, Participating Provider sites may be eligible for up to \$10,000 per practice site for infrastructure changes. The amount of infrastructure support is variable up to this maximum; actual awards will vary depending on the provider's readiness, EOHHS's review and finding of such readiness, and CMS' concurrence on the use of the proposed funding for the Participating Practice. A description of the award, distribution, and reconciliation process for these funds must receive CMS approval prior to implementation during Phase 2. Infrastructure payments are subject to the spending limitation of the infrastructure and capacity-building (ICB) component of the Safety Net Care Pool (SNCP), and are further contingent on continued CMS approval of the SNCP and the ICB.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

8. Evaluation Design

The Commonwealth must develop an evaluation design for the CHABP pilot program which will be incorporated into the evaluation design required per STC 84 following CMS review and approval. The Commonwealth must submit the evaluation design to CMS no later than 60 calendar days after the approval of this Pediatric Asthma Pilot Program Protocol.

The objective of the evaluation is to determine the benefits and savings of the pilot as well as design viability and inform broader implementation of the design. The evaluation design must include an evaluation of programmatic outcomes for purposes of supporting any future expansion of the pilot project, including Phase 2. As part of the evaluation, the state at a minimum must include the following requirements:

- i. Collect both baseline and post-intervention data on the service utilization and cost savings achieved through reduction in hospital services and related provider services for the population enrolled in the pilot. This data collection should include the quality measure on annual asthma-related emergency room visits outlined in the initial core set of children's health care quality measures authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA) beginning with a baseline set at the onset of the pilot, adjusted for the age range enrolled in the pilot program;
- ii. A detailed analysis of how the pilot program affects the utilization of acute health services, such as asthma-related emergency department visits and hospitalizations by high risk pediatric asthma patients, and how the pilot program reduces or shifts Medicaid costs associated with treatment and management of pediatric asthma;
- iii. A detailed analysis of the provision of mandatory and optional CHABP services provided to enrollees, which must include an analysis of purchasing strategies, supply costs, and stratification of distribution and provision of CHABP services by enrollee age, as well as an analysis of any optional services provided to enrollees that differ from those specified in this protocol;
- iv. An assessment of whether the cost projections for the provider payment were appropriate given the actual cost of rendering the benefits through the pilot program; and,
- v. A detailed analysis of how the effects of the pilot interact with other related initiatives occurring in the state.

The goal of the evaluation is to assess the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation as demonstrated by changed practices in asthma care and improved health outcomes at the same or lower cost. The Phase 1 hypotheses are that:

1. There will be a lower rate of asthma-related hospitalization and emergency department visits among enrollees compared to the comparison group.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

2. Enrollees will attain better asthma control as measured by lower numbers of days absent from school/work/summer program as compared to the comparison group.
3. Total expenditures for the pilot including bundles payments for optional services for enrollees will be equal to or less than overall expenditures for the comparison group.

Specifically, the Commonwealth will examine changes in: 1) the way providers deliver services to CHABP Enrollees; 2) CHABP Enrollees' self-management of asthma; 3) CHABP Enrollees' health service use (i.e. emergency department use); 4) CHABP Enrollees' healthcare expenditures; and 5) CHABP Enrollees' quality of asthma care. This will include a cost-effectiveness analysis to examine the relative value between the pilot and the usual care.

Additionally, the Commonwealth will conduct a value analysis to assess the impact of environmental mitigation supplies purchased and disseminated in terms of patient outcome, safety, and relative costs. The purpose is to determine how the bundled payment model and products provided under this optional service correlate with costs, outcomes and safety.

The evaluation will use a mix of qualitative and quantitative methods. Data will be collected from Participating Practices and CHABP Enrollees, and extracted from Medicaid claims data and the MassHealth program office. Individuals with characteristics comparable to participating members will be identified for comparisons. The Commonwealth must submit its evaluation of the first full year of Phase 1 to CMS within 180 days of the end of the pilot year. To the extent that Phase 1 remains in place while the Commonwealth is conducting the evaluation and awaiting approval of its Phase 2 proposal, it will conduct an evaluation of each subsequent full pilot year on an annual and cumulative basis. Year one Phase 1 evaluation data will be a component of CMS' review of the Commonwealth's Phase 2 proposal. If CMS' review of the Commonwealth's Phase 2 proposal begins after the end of a subsequent full pilot year of Phase 1, then CMS may also include data from the Commonwealth's evaluation of that subsequent year in its review of the Commonwealth's Phase 2 proposal.

Data Sources

Data will be collected from Participating Practices to evaluate changes in the practice at 1 year intervals following implementation of Phase 1 of the pilot. The Commonwealth will also collect data from CHABP Enrollees at the pilot enrollment and 1 year after the enrollment to assess changes in asthma control and the number of days absent from school/work. Medicaid claims data will be used to evaluate changes in service use and healthcare expenditures. Additionally, data collected from participating members, healthcare expenditures paid by Medicaid, and program operation costs from the pilot management office will be used for the cost-effectiveness analysis.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Comparison Group

To mitigate the potential bias that any observed changes in outcomes are resulting from high service utilization or poor asthma control prior to the pilot participation or from concurrent changes in healthcare environment, the Commonwealth will identify a matched comparison group. To the extent available and comparable, the Commonwealth will include practices that applied for the pilot but were not chosen for the 1st phase in this comparison group. Both practice and member characteristics will be considered in the matching algorithm. Exact matching on important characteristics and propensity score matching techniques will be used to ensure the comparability of characteristics between Participating Practices/members and the comparison group. Considering these practice characteristics in the matching algorithm and subsequent statistical analysis are intended to isolate the effect of the pilot from other initiatives. This approach also addresses requirements set forth by STC 84.

Measures

Measures used in this evaluation are organized into three groups: changes in provider practice, changes in self-management of asthma, changes in service use (i.e. emergency department use), number of days missed from school/work/summer program due to asthma, healthcare expenditures, and quality of care. The initial core set of children's healthcare quality measured authorized by the Children's Health Insurance program Reauthorization Act (CHIPRA) will serve as the guide for service use and quality of care measures (see Measures: changes in service use, healthcare expenditures, and quality of care). Also, healthcare expenditures and program operation costs will be included in the analysis to assess the viability of the pilot and to develop a payment rate for the program (see Measures: measures for the cost-effectiveness analysis).

Changes in provider practice

Qualitative semi-structured key informant interviews with members of the interdisciplinary care team in each Participating Practice will be conducted at 1 year intervals after implementation of Phase 1 of the pilot. These interviews will assess changes in the way providers deliver services by identifying key components of changes in the practice and potential barriers in implementing the pilot.

Changes in self-management on asthma

Telephone and/or mail surveys will be used to evaluate changes in asthma management and the effect of the pilot. The survey instrument includes the asthma control test (ACT) measure and questions on the number of days absent from school for children/teens and from work for parents. These measures will also represent the effects in the cost-effectiveness analysis. The Commonwealth will conduct the surveys on all participating members and individuals in the comparison group at the baseline and at 12 month after baseline as budget permits.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Changes in service use, healthcare expenditures, and quality of care

MassHealth claims data will be used to derive healthcare service utilization, healthcare expenditures, and quality of care measures before the pilot enrollment and through the first year of the pilot participation. Key healthcare service utilization measures include asthma-related emergency department (ED) visits and asthma-related hospitalizations. Other types of service use also will be analyzed to examine possible shifting in services. Quality of care will be evaluated based on Healthcare Effectiveness Data and Information Set (HEDIS) specifications for asthma care and on the use of asthma-control medications following NQF 1799 Medication Management for People with Asthma.

Measures for cost-effectiveness analysis

In addition to healthcare expenditures from claims data, cost data will include program operation costs. Healthcare expenditures are MassHealth payment amounts for providers which are reported in claims. Program operation costs include the per-capita bundled payments for participating members and program-related administrative costs; and costs of environmental mitigation supplies purchased by providers. The MassHealth PCC plan staff will provide information on program operation costs. These cost data will represent the cost to Medicaid in the cost-effectiveness analysis.

Data Analysis

Qualitative data collected from staff in Participating Practices will be analyzed to identify common themes of changes in service delivery across Participating Practices. Innovative approaches and barriers for service delivery related to the pilot implementation will be summarized by the practice.

A difference-in-differences analytical framework will be used to analyze outcomes from claims data and data collected from Participating Members. The Commonwealth will compare changes in services use, healthcare expenditures, asthma control, and number of days absent from school/work for participating members to those for individuals in the matched comparison group. Outcome measures will be available for each individual for two or more times before and during the first year of the pilot. Measures for an individual at different time points are likely to be correlated. The Commonwealth will apply generalized estimating equations to account for the within-subject correlations. Given the usual time lag of claims data and the seasonal nature of acute events associated with asthma, quantitative analysis using claims data will begin at 1 year after the pilot implementation.

The Commonwealth will develop a measure of total cost based on health care expenditures, adjusted for case mix, plus program operations costs. The Commonwealth will conduct cost-effectiveness analysis to estimate the relative value between the pilot and the usual care. The ACT score and the number of days being absent from school/work measures the effect of the pilot, which is independent from the costs included in the analysis. Results will show the incremental costs associated with each day not absent from school or work.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Notice of Opportunity to Participate in Pediatric Asthma Advisory Committee

Published on the Commonwealth Procurement Access and Solicitation Site (Comm-PASS) April 6, 2011.

The Executive Office of Health and Human Services (EOHHS), Office of Medicaid seeks individuals to serve on the Pediatric Asthma Bundled Payment Pilot Advisory Committee.

St.2011, C.131, S.154 directs EOHHS to “develop a global or bundled payment system for high-risk pediatric asthma patients enrolled in the MassHealth program, designed to prevent unnecessary hospital admissions and emergency room utilization.” This legislation also provides for EOHHS to consult with relevant providers in designing and implementing the pediatric asthma project. The University of Massachusetts Medical School (UMMS) is working with EOHHS to help develop this initiative.

EOHHS wishes to establish and consult an Advisory Committee on designing and implementing the high-risk pediatric asthma global or bundled payment demonstration program. The Advisory Committee may make recommendations on issues such as specifying the target patient population to be included in the initial demonstration, the basket of services to be included in the bundled payment, the risk adjustment methodology, the infrastructure required to manage the bundled payment, the evaluation metrics, and potential strategies for sharing savings between the MassHealth program and participating providers. EOHHS anticipates that this Advisory Committee will meet approximately once or twice per month or as EOHHS determines necessary beginning in or around April, 2011 through approximately December, 2012.

EOHHS seeks individuals, including representatives of providers who wish to participate in the high-risk pediatric asthma global or bundled payment demonstration program, to serve on this Advisory Committee. To be eligible to participate in the Advisory Committee, such individuals must have expertise (1) treating high-risk pediatric asthma patients, and/or (2) designing and implementing clinical programs to prevent and manage high-risk pediatric asthma, and/or (3) designing and implementing global or bundled payment structures. EOHHS will not compensate individuals for serving on this Advisory Committee. Participation in this Advisory Committee is not a pre-requisite for participation in the global or bundled payment demonstration program.

Interested individuals should submit an up-to-date resume or Curriculum Vitae and a letter of interest highlighting their relevant experience and expertise by April 13, 2011.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

EOHHS and UMMS will review the responses and select individuals who bring the greatest breadth and depth of relevant knowledge and expertise to serve on the Advisory Committee. EOHHS reserves the right to request additional information from potential participants, solicit additional individuals for participation, and reject applicants for participation as it determines appropriate to assure that the Advisory Committee meets the agency's needs.

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Advisory Committee Members

Name	Title	Institution/ Employer	Qualifications
Gary Adamkiewicz, PhD, MPH	Research Scientist	Harvard School of Public Health	<ul style="list-style-type: none"> • Research on the studies of indoor environmental conditions • Member of the Healthy Public Housing initiative – a community-centered asthma intervention project • Member of the Asthma Regional Council • Provide training on healthy homes issues • Several publications and research on asthma
Stacey Chacker	Director of Environmental Health and Asthma Regional Council	Health Resources in Action, Inc.	<ul style="list-style-type: none"> • Member Steering Committee Massachusetts Asthma Action Partnership • ARC and UMass developed tools – Investing in Best Practices for Asthma and Insurance Coverage for Asthma: A Value and Quality Checklist • November 2010 – Symposium leader for Improving Asthma Management in a Changing Healthcare System
May Chin, RN, MS, MBA	Project Director Asthma Prevention and Management Initiative	Floating Hospital for Children at Tufts Medical Center	<ul style="list-style-type: none"> • Registered Nurse for over 40 years • Designed and implemented the Asthma Prevention and Management Initiative at Tufts • Cardiac Care demonstration project which resulted in full implementation as a reimbursable standard of care
Patricia Edraos, JD	Health Resources Policy Director	Massachusetts League of Community Health Center	<ul style="list-style-type: none"> • Assisted Medicaid agency in CHIP expansion • Educational programs for global payment
Jim Glauber, MD, MPH	Senior Medical Director	Neighborhood Health Plan	<ul style="list-style-type: none"> • Pediatrician in practice for 19 years • Management of children with special healthcare needs i.e. asthma, prenatal diabetes • Developed asthma disease management program • Received grant for Implementation of an Enhanced Asthma Home Environmental Program
Polly Hoppin, ScD	Research Professor and Program Director	School of Health and Environment University of Massachusetts, Lowell	<ul style="list-style-type: none"> • Senior advisor to the Regional Director of DHHS • Principal Investigator on project to better understand how health insurance plans make decisions to cover preventive measures • Designing a coordinated asthma home visit system for the city of Boston • Several publications on the subject of Asthma • Secretary’s Award for Distinguished Service in 1998 for developing five-year strategic plan to combat Asthma

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Name	Title	Institution/ Employer	Qualifications
Lara Khouri, MBA, MPH	Director, Integrated Care	Children's Hospital	<ul style="list-style-type: none"> • Business Perspective – Accounting & Management • Managed Care Contracting on behalf of large academic medical centers • Developed innovative payment structures – pay for performance
Ted Kremer, MD	Director, Pediatric Sleep Medicine	UMass Memorial Medical Center	<ul style="list-style-type: none"> • Pediatrician in practice for over 12 years • Board certified in Pediatric Pulmonology • Member of the Division of the Pediatric Pulmonary, Asthma, Sleep and Cystic Fibrosis Center at UMass Memorial
Kimberly Lenz, Pharm.D.	Clinical Consultant Pharmacist	UMass Medical School – Commonwealth Medicine	<ul style="list-style-type: none"> • Registered pharmacist 8 years • Participated in an asthma outreach program while a student at St. Louis Children's Hospital • Member of the Pediatric Pharmacy Advocate Group
William Minkle, MS	Executive Director	ESAC (Ecumenical Social Action Committee, Inc.)	<ul style="list-style-type: none"> • Supervise ESAC's Boston Asthma Initiative (BAI) for 4 years • 30 years non-profit experience with community programs • Member Boston Community Asthma Initiative Steering Committee
Neil Minkoff, MD	Chief Medical Officer	1776 Healthcare	<ul style="list-style-type: none"> • Has been practicing medicine for 15 years • Currently clinical lead for creating bundled payment • Extensive medical management experience
Shari Nethersole, MD	Medical Director for Community Health	Children's Hospital, Boston	<ul style="list-style-type: none"> • Pediatrician in practice for over 25 years • Drafted the MA Provider Consensus Statement in conjunction with the Asthma Regional Council • Oversaw the design and establishment of the Community Asthma Initiative at Children's.
Dorothy Page, MSN, FNP	Pediatric Nurse Practitioner	UMass Memorial Medical Center	<ul style="list-style-type: none"> • Registered Nurse for 40 years • Member of the Pediatric Pulmonary, Asthma, Sleep and Cystic Fibrosis Center – UMass Memorial • Developed the clinical asthma program working with school nurses for the high risk and poorly controlled asthmatics
Margaret Reid, RN, BA	Director, Division of Healthy Homes and Community Supports	Boston Public Health Commission	<ul style="list-style-type: none"> • Registered Nurse for 17 years – currently working on Master's • Convened the Boston Asthma Home Visit Stakeholders Group • 2009 –EPA National Environment Leadership Award in Asthma Management • Member Massachusetts Asthma Action Partnership

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol

Approved: July 24, 2014

Name	Title	Institution/ Employer	Qualifications
Elaine Erenrich Rosenburg, MS	Executive Director	Asthma & Allergy Foundation of America/New England Chapter, Inc.	<ul style="list-style-type: none"> • Member of the Steering Committees for the Boston Urban Asthma Coalition and the Massachusetts Asthma Action Program and the Health Access Resource Network • Work closely with parents of asthma patients • Help to manage children's asthma to reduce asthma incidents especially those requiring ER visits
Matthew Sadof, MD, FAAP	Director, Medical Home and Primary Care Asthma Intervention Programs	Baystate Medical Center	<ul style="list-style-type: none"> • Pediatrician in practice for 25 years • Received numerous grants for Asthma research • Directs a program that utilizes CHW's to extend care to children with asthma • Cares for a high-risk pediatric population with asthma at a local clinic
Megan Sandel MD, MPH, FAAP	Director & Co- Founder	Doc4kids project	<ul style="list-style-type: none"> • Pediatrician in practice for 15 years focused solely on care for low income children • Member Asthma Regional Coordinating Council • Ongoing research on How Much is Too Much to Wheeze: Asthma • Co-authored with Jean Zotter a publication on How substandard Housing affects children's health
Winthrop Whitcomb, MD, MHM	Medical Director, Healthcare Quality	Baystate Medical Center	<ul style="list-style-type: none"> • Physician for over 20 years • Chair of the total hip replacement bundled payment program pilot at Baystate
Elizabeth Woods, MD, MPH	Director of the Children's Hospital Boston's Community Asthma Initiative	Children's Hospital, Boston	<ul style="list-style-type: none"> • Pediatrician in practice for over 25 years • April 12, 2007 Elizabeth Woods Day in Boston for community asthma efforts • Principal investigator on a grant providing coordination of asthma care at home • Principal investigator on a grant addressing health disparities for children living in Jamaica Plain, Roxbury and Dorchester dealing with asthma

Attachment F - Pediatric Asthma Pilot Program Phase 1 Protocol
Approved: July 24, 2014

References

ⁱNational Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma
<http://www.nhlbi.nih.gov/guidelines/asthma/asthdln.htm>

ⁱⁱ Krieger J, Takaro T, Song L, Beaudet N, Edwards K. A randomized controlled trial of asthma self-management support comparing clinic-based nurses and in-home community health workers: the Seattle–King County Healthy Homes II Project. *Arch Pediatr Adolesc Med* 2009;163(2):141–9.

ⁱⁱⁱ From HealthyPeople 2020:
<http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=36>

^{iv} Clark, N.M., Lachance, L., Milanovich, A.F., Stoll, S., Awad, D., [Characteristics of Successful Asthma Programs](#), *Public Health Reports*. 2009 Nov;124(6). 3-17.

^v *From the Global Strategy for Asthma Management and Prevention*, Global Initiative for Asthma (GINA) 2011. Available from: <http://www.ginasthma.org/>.

^{vi} Krieger J, Takaro T, Allen C, et al. The Seattle–King County Healthy Homes Project: Implementation of a comprehensive approach to improving indoor air environmental quality for low-income children with asthma. *Environ Health Perspect*. 2002 Apr;110 Suppl 2:311-22.

^{vii} Wu F, Takaro TK. Childhood asthma and environmental interventions. *Environ Health Perspect* 2007;115(6):971–5.

^{viii} Described in more detail in the Massachusetts DPH Community Health Worker Advisory Council Report, *Community Health Workers in Massachusetts: Improving Health Care and Public Health* (Boston, MA: Massachusetts Department of Public Health, 2010).
http://www.mass.gov/Eeohhs2/docs/dph/com_health/com_health_workers/legislature_report.pdf

^{ix} Fedder DO, et al. The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. *Ethnicity and Disease*. 2003;13(1):22-7.

^x Whitley EM, et al. Measuring return on investment of outreach by community health workers. *J Health Care Poor Underserved*. 2006;17(1):6-15.

^{xi} Krieger, JW et al. The Seattle-King County Healthy Homes Project: a randomized, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. *Am J of Pub Hlth*. 2005;95 (4):652- 659.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Introduction

This cost limit protocol will meet the required protocol specifications pursuant to Massachusetts 1115 Demonstration Special Terms and Conditions (STC) 50(f). According to this protocol:

- 1) The cost limit must be calculated on a provider-specific basis.
- 2) Only the providers receiving SNCP payments for uncompensated care pursuant to STC 49(c) will be subject to the protocol.
 - a. All Medicaid Fee-for-Service payments for services and managed care payments, including any supplemental or enhanced Medicaid payments made under the State plan¹, SNCP payments subject to the Provider Cap pursuant to STC 50(c), and any other revenue received by the providers by or on behalf of Medicaid-eligible individuals or uninsured patients are offset against the eligible cost. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance- and incentive-based payments and grants and awards both currently in existence and those that may be implemented during future demonstration renewal periods, such as those listed below.
 - b. Performance- and incentive-based payments, including but not limited to:
 - i. Pay-for-performance payments made under the Medicaid state plan;
 - ii. Quality incentive payments associated with an alternative payment arrangement authorized under the Medicaid state plan or the section 1115 demonstration;
 - iii. Delivery System Transformation Initiative payments made under the 1115 demonstration;
 - iv. Patient Centered Medical Home Initiative payments, including care management and coordination payments, made under the 1115 demonstration;
 - v. Shared savings and other risk-based payments under an alternative payment arrangement (e.g., Primary Care Payment Reform, subject to CMS approval), authorized under the Medicaid state plan or the section 1115 demonstration;

¹ State Plan supplemental payments include, but may not be limited to, Essential MassHealth Hospital Payments, Freestanding Pediatric Acute Hospital Payments, Acute Hospitals with High Medicaid Discharges Payments, and Infant and Pediatric Outlier Payment Adjustments. Safety Net Care Pool supplemental payments under the 1115 demonstration include Public Service Hospital Payments.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- vi. Medicaid EHR incentive payments, including eligible provider and hospital Electronic Health Record (EHR) incentive payments, made in accordance with the CMS-approved state Medicaid Plan and CMS regulations.

- c. Grants and awards:
 - i. Infrastructure and Capacity Building grants and any other grants or awards awarded by the Commonwealth of Massachusetts or any of its agencies;
 - ii. Any grants or awards through the CMS Innovation Center or other federal programs;
 - iii. Any grants or awards by a private foundation or other entity.

Acute Inpatient and Outpatient Hospital Protocol for Medicaid and Uncompensated Care Cost

Determination of Allowable Medicaid and Uninsured Costs

- a. Disproportionate Share Hospital (DSH) Allowable Costs
 - i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” per Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
 - i. Massachusetts will use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan,

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by acute inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).

1. Inpatient acute hospital services: Medical services provided to a member admitted to an acute inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 2. Outpatient acute hospital services: Outpatient Hospital Services include medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services. Outpatient Services include medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, hospital-based physicians' offices, hospital-based nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by acute hospitals for providing Medicaid state plan services to members eligible for Medicaid through the 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the Medicaid state plan and are provided by acute hospitals under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
 1. The Commonwealth must not claim costs for the Pediatric Asthma Pilot Program until receiving CMS approval of the Pediatric Asthma Program payment protocol as described in Special Term and Condition 40(h).
 2. Intensive Early Intervention Services for Children with Autism Spectrum Disorder. The Commonwealth must not claim costs for the Intensive Early Intervention Services for Children with Autism Spectrum disorder until CMS approves the Intensive

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Early Intervention Services for Children with Autism Spectrum Disorder the Pediatric Asthma Pilot Program payment protocol as specified in STC 40(h).

3. Diversionary Behavioral Health Services.
 - d. Medicaid Managed Care Costs: Costs incurred by acute hospitals for providing services to members enrolled in Medicaid managed care organizations including Senior Care Organizations (SCOs) and Integrated Care Organization (ICOs), prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
 - e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
 - f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

I. Summary of 2552-10 Cost Report (CMS 2552 cost report)

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts hospitals because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth will use the CMS 2552² and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the CMS 2552 cost report, hospitals subject to the cost limit protocol will file the UCCR to allocate allowable 2552 costs to Medicaid

² Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Acute hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid- and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid- eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.” Additionally, costs associated with the Medicaid- eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		
Administrative costs of the hospital’s billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionsary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

UCCR Instructions

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

Column 1 – Reported Costs

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 2 – Reclassification of Observation Costs and inclusion of Post-Stepdown Costs

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

Column 3 – Total Costs

Sum of costs from column 1 and column 2. [This column will auto-populate.]

Column 4 – Charges

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

Column 5 – Hospital Cost-to-Charge Ratios

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Inpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- MassHealth FFS Inpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

Column 7 – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

Column 8 – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204; and
 - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan); or

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- Charges associated with the professional component of hospital-based physician services.

Column 9 – MassHealth Fee-for-Service Outpatient Costs

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

Column 1 – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

Column 2 – Total Inpatient Days

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

Column 3 – Per Diem

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

Column 4 – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

Column 5 – Total MassHealth FFS Inpatient Costs

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

Column 6 – Medicaid Managed Care Inpatient Days

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 7 – Total Medicaid Managed Care Inpatient Costs

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

Column 8 – HSN and Uninsured Care Inpatient Days

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 9 – Total HSN and Uninsured Care Inpatient Costs

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).

- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

Column 6 – Total Massachusetts Medicaid Managed Care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 7 – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

Column 8 – HSN and Uninsured Care Inpatient Costs

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

Column 9 – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

Column 10 – HSN and Uninsured Care Outpatient Costs

Uncompensated care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

Column 11 – Total HSN and Uninsured Care Costs

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- MassHealth FFS Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
 - Charges associated with the professional component of hospital-based physicians services.

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
 - Charges associated with professional component of hospital-based physician services.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).

- HSN and Uninsured Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- Individuals with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of a particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 12 – Total Massachusetts Medicaid Fee-for-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee-for-service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

Column 1 – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

III. Reconciliation

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552³ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund payments, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation

³ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

**Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient
Hospital Protocol for Medicaid and Uncompensated Care Cost**

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
 - i. Per STC 50(f), the cost limit protocol will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
 - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid state plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
 - 1. Inpatient chronic disease and rehabilitation hospital services: Inpatient services are routine and ancillary services that are provided to recipients admitted as patients to a chronic disease or rehabilitation hospital. Such services

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
2. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 3. Outpatient chronic disease and rehabilitation hospital services: Rehabilitative and medical services provided to a member in a chronic disease or rehabilitation outpatient setting including but not limited to chronic disease or rehabilitation hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services include, but are not limited to, radiology, laboratory, diagnostic testing, therapy services (i.e., physical, speech, occupational and respiratory) and Day surgery services. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 4. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members eligible for Medicaid through the section 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
 1. Diversionary Behavioral Health Services.
- d. Medicaid Managed Care Costs: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
- f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

I. Certified Public Expenditures – Determination of Allowable Safety Net Care Pool Costs

In accordance with the approved MassHealth Section 1115 demonstration, beginning July 1, 2014, the estimated fiscal year expenditures will be based on the actual fiscal year CMS 2552 and UCCR cost reports.

General Description of Methodology

The certified public expenditures (CPEs) for special population State-Owned Non-Acute hospitals operated by the Department of Public Health (DPH) and Department of Mental Health (DMH) are claimed annually under the Safety Net Care Pool (SNCP) based upon the unreimbursed Medicaid and uninsured. The CPE interim payments made under the SNCP will follow the same methodology as contained in the Commonwealth's Medicaid State Plan.

II. Summary of 2552-10 Cost Report

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

(determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

III. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

The Commonwealth will use the CMS 2552⁴ and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient Hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth based on the 2552 and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.”

⁴ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the Medicare 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		
Administrative costs of the hospital’s billing activities	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
associated with physician services who are employees of the hospital billed and received by the hospital								
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and	X	X	X	X	X	X	X	X

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
uninsured patients								
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

UCCR Instructions

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

Column 1 – Reported Costs

Enter costs from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

Column 3 – Total Costs

Sum of costs from column 1 and column 2. [This column will auto-populate.]

Column 4 – Charges

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

Column 5 – Hospital Cost-to-Charge Ratios

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

- MassHealth FFS Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

Column 7 – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

Column 8 – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

Column 9 – MassHealth Fee-for-Service Outpatient Costs

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 11. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C.

Column 1 – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 2 – Total Inpatient Days

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

Column 3 – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

Column 4 – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

Column 5 – Total MassHealth FFS Inpatient Costs

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

Column 6 – Medicaid Managed Care Inpatient Days

Enter total MassHealth managed care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 7 – Total Medicaid Managed Care Inpatient Costs

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

Column 8 – HSN and Uninsured Care Inpatient Days

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 9 – Total HSN and Uninsured Care Inpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with patients eligible for another state’s Medicaid program;
 - Charges reported as HSN and Uninsured Care (below).

- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

Column 7 – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

Column 8 – HSN and Uninsured Care Inpatient Costs

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

Column 9 – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

Column 10 – HSN and Uninsured Care Outpatient Costs

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

Column 11 – Total HSN and Uninsured Care Inpatient and Outpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
 - Charges associated with the professional component of hospital-based physician services.

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians' costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Total Massachusetts Medicaid Fee For Service Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee for service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

Column 1 – Total SNHCS Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay for Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since following payments are not payments for the provision of medical care,

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

IV. Reconciliation

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552⁵ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not

⁵ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the Medicare cost report(s).

Final Reconciliation

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

**Institutions for Mental Diseases – Psychiatric Hospitals and Community Based
Detoxification Centers (CBDCs) Protocol for Medicaid and Uncompensated Care
Cost**

The Commonwealth will use the reports described below to collect data from these providers.

Psychiatric hospitals will fill out the CMS 2552 and UCCR, as required of other hospitals in the cost limit protocol. CBDCs are non-hospital human and social services contractors that do not file a CMS 2552 cost report; therefore, for the purposes of the protocol, the Commonwealth will use only the Massachusetts **Uniform Financial Statements and Independent Auditor’s Report (UFR)** to determine costs and revenues. The UFR is the set of financial statements and schedules required of human and social service contracting with state departments. For the calculation of provider-specific cost limits, psychiatric hospitals and CBDCs will fill out the necessary reports with the information that is relevant to the services they provide to the Medicaid-eligible and HSN and uninsured populations.

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
 - i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable psychiatric hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - ii. Pharmacy service costs are separately identified on the CMS 2552 10 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
 - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

b. Medicaid State Plan Allowable Costs

- i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by institutions for mental disease. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
 1. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 2. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 3. Community Based Detoxification Center (CBDC): CBDCs are eligible to receive Safety Net Care Pool payments as Institutions for Mental Diseases (IMDs) under the section 1115 demonstration. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
 - a. Acute Inpatient Substance Abuse Treatment Services: Short-term medical treatment for substance withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling, and post detoxification referrals provided by an inpatient unit, either freestanding or hospital-based, licensed as an acute inpatient substance abuse treatment service by the Massachusetts Department of Public Health under its regulations at 105 CMR 160.000 and 161.000. These services are delivered in a three-tiered system consisting of Levels III-A through III-C that must conform with the standards and patient placement criteria issued and enforced by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services.
 - b. Substance Abuse Outpatient Counseling Service: An outpatient counseling service that is a

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

rehabilitative treatment service for individuals and their families experiencing the dysfunctional effects of the use of substances.

- ii. 1115 Demonstration Population Expenditures: Costs incurred by psychiatric hospitals and CBDCs for providing IMD services to members eligible for Medicaid through the State plan and section 1115 demonstration will be counted as allowable costs. Allowable costs for psychiatric hospital services and CBDC services provided under the 1115 demonstration include service-related expenditures (please note that all services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs). The list of allowable services is contained in the Cost Element table.

1. Diversionary Behavioral Health Services

- c. Medicaid Managed Care Costs: Costs incurred by IMDs for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
- d. Other Allowable Costs, Approved 1915(c) Waivers. The list of allowable services is contained in the Cost Element table.
- e. Additional Allowable Costs – The list of allowable services is contained in the Cost Element table.

I. Summary of 2552-10 Cost Report (Psychiatric Hospitals Only)

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) (Psychiatric Hospitals Only)

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth must use the CMS 2552⁶ and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Psychiatric hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.”

⁶ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Medicare cost principles								
Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day		X				X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Treatment Program Services								
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

UCCR Instructions

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

Column 1 – Reported Costs

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

Column 3 – Total Costs

Sum of costs from column 1 and column 2. [This column will auto-populate.]

Column 4 – Charges

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

Column 5 – Hospital Cost-to-Charge Ratios

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

- MassHealth FFS Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- Charges associated with the professional component of hospital-based physician services.

Column 7 – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

Column 8 – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges associated with the professional component of hospital-based physician services.

Column 9 – MassHealth Fee-for-Service Outpatient Costs

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

Column 1 – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

Column 2 – Total Inpatient Days

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

Column 3 – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

Column 4 – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

Column 5 – Total MassHealth FFS Inpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

Column 6 – Medicaid Managed Care Inpatient Days

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 7 – Total Medicaid Managed Care Inpatient Costs

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

Column 8 – HSN and Uninsured Care Inpatient Days

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

Column 9 – Total HSN and Uninsured Care Inpatient Costs

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.

- Medicaid Managed Care Charges may not include:

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
 - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
 - HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

Column 1 – Hospital Cost-to-Charge Ratios

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

Column 7 – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

Column 8 – HSN and Uninsured Care Inpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

Column 9 – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured patients.

Column 10 – HSN and Uninsured Care Outpatient Costs

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

Column 11 – Total HSN and Uninsured Care Costs

Total uncompensated care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Care Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
 - Charges associated with the professional component of hospital-based physicians services.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204;
 - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
 - Charges associated with professional component of hospital-based physician services.

- Medicaid Managed Care Charges may not include:
 - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
 - Charges associated with claims that have been final denied for payment by the MMCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
 - Charges reported as HSN and Uninsured Care (below).

- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Individuals with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Total Massachusetts Medicaid Fee-For-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Total Massachusetts Medicaid Fee-For-Service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document. .

Column 1 – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

Line 8 – Other Revenue

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate.]

Lines 10-15 Physician Revenue

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

Column 6 – Total Revenue

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

III. Uniform Financial Report (UFR)

CBDCs are entities that provide health care services for substance abuse that contract with the MassHealth agency, Medicaid Managed Care Entities and the Bureau of Substance Abuse Services, the latter providing services to the uninsured. Each CBDC is licensed by the Bureau of Substance Abuse Services under the requirements set forth in 105 CMR 164.000. Because CBDCs are not a hospital, they do not fill out the Medicare CMS-2552 cost report and instead fill out the Uniform Financial Report (UFR).

UFR reports are filed with the Massachusetts Operational Services Division (OSD) on an annual basis. This report captures administration and support costs, as defined in 808 CMR 1.00, which includes expenditures for the overall direction of the organization, e.g., general record keeping, budgeting, etc., but also the salaries and expenses of the organization's staff. The report will also capture expenditures for health care services, as defined in M.G.L. c. 118 § 2 (b), the pricing of which is set by the Center for Health Information and Analysis

The CBDCs are required to keep necessary data on file to satisfy the UFR reporting requirements, and books and records must be maintained in accordance with generally accepted accounting principles set forth by the American Institute of Certified Public Accountants (AICPA).

The UFR must be submitted on or before the 15th day of the fifth month after the end of the contractor's fiscal year.

The UFR reports the following data elements:

1. Net Assets
2. Total Current Assets
3. Total Assets
4. Total Current Liabilities
5. Total Liabilities
6. Total Liabilities and Net Assets
7. Total Revenue, Gains, and Other Support
8. Total Expenses and Losses
9. Indirect / Direct Method
10. Cash from Operating Activities
11. Cash from Investing Activities
12. Cash from Financing Activities
13. Total Expenses – Programs
14. Total Expenses – Supporting Services
15. Surplus Percentage
16. Surplus Retention Liability

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

The UFR allows for revenue to be reported from Medicaid Direct Payments, Medicaid Massachusetts behavioral Health Partnership (MBHP) Subcontracts, Department of Mental Health, Department of Public Health, and other human and social service agencies.

The CBDC's program expense is broken down by provider type for Psychiatric Day Treatment and Substance Abuse Class Rate Services, including:

1. Psychiatrist
2. N.P., Psych N., N.A., R.N.-Masters
3. R.N.-Non Masters
4. L.P.N.
5. Occupational Therapist
6. Psychologist – Doctorate
7. Clinician (formerly Psych. Masters)
8. Social Worker – L.I.C.S.W.
9. Social Worker – L.C.S.W., L.S.W.
10. Licensed Counselor
11. Cert. Voc. Rehab. Counselor
12. Counselor
13. Case Worker/Manager – Masters
14. Case Worker/Manager
15. Direct Care/Program Staff Supervisor
16. Direct Care/Program Staff

Per unit cost from UFR. The provider will calculate a per unit cost from the UFR for inpatient detoxification programs, who do not submit the Medicare 2552 cost report, by dividing the total reimbursable program expense (Schedule B line 53E) by line 6SS (number of service units delivered). The per diem cost will be reported by the CBDC on the CBDC Protocol Form.

Allowable Costs

- i. From the MMIS paid claims database, the State will obtain the number of units of care, including administrative units, provided to all Medicaid patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS that reports the number of units, days of care, including administrative days, for services provided to Medicaid MCO and other uninsured patients.⁷
- iii. The state will calculate costs by multiplying the per unit cost with the number of MassHealth, Medicaid MCO, and uninsured units described above.

⁷ This is not currently available on the UFR report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

Payments

- i. From the MMIS paid claims database, the state will obtain payments made to programs for services, including administrative days, provided to MassHealth patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS reporting payments received from all sources for services provided to Medicaid MCO and uninsured patients.

Determination of Provider-Specific SNCP Limit for CBDCs

The State will calculate a provider-specific SNCP limit for each CBDC as by subtracting all applicable payments from the allowable costs

IV. Reconciliation

Interim Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552⁸ cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three after months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of

⁸ Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

Interim Reconciliation for UFR Method

Each provider's uncompensated care costs must be computed based on the provider's as-filed Uniform Financial Report (UFR) and for the actual service period. The UFR is filed five months after the close of the cost reporting period. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service period. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The interim reconciliation described above will be performed and completed within twelve months after the filing of the provider's UFR.

Final Reconciliation for the UFR Method

Each provider's uncompensated care costs must be recomputed based on the provider's audited UFR for the actual service period. The UFR is audited and settled by the Commonwealth to determine final allowable costs and reimbursement amounts as recognized by the Commonwealth based on this cost limit protocol. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool
Uncompensated Care Cost Limit Protocol
December 11, 2013**

period. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government. Settlement of any over- or underpayment to a provider will be treated as a separate transaction rather an adjustment to the following year's interim payment.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The final reconciliation described above will be performed and completed within twelve months after the audited provider UFR is made available.

**ATTACHMENT K
PUBLIC HOSPITAL TRANSFORMATION AND INCENTIVE INITIATIVE PROTOCOL**

I. PREFACE

1. MassHealth Medicaid Section 1115 Demonstration Waiver

This Attachment K, Public Hospital Transformation and Incentive Initiatives (PHTII) Protocol, applies to the extension period of the Centers for Medicare & Medicaid Services (CMS) approved section 1115 demonstration waiver, entitled MassHealth (11-W-00030/1) (demonstration) from July 1, 2017 through June 30, 2022 (DY 21 through DY 25), as set forth in Attachment E and STC 56.

2. Public Hospital Transformation and Incentive Initiatives (PHTII)

STC 56 of the demonstration authorizes the Commonwealth to implement the Public Hospital Transformation and Incentive Initiatives (PHTII) funded through the Safety Net Care Pool (SNCP).

PHTII payments are intended to support the public hospital system for improvements in delivery systems and payment models that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

The Public Hospital will be required to develop and implement initiatives and activities, and to achieve performance metrics, as described and approved in this PHTII Protocol in order to receive the incentive payments.

In concert with the Commonwealth of Massachusetts' MassHealth transition from fee-for-service models into integrated accountable, total cost of care models in this demonstration, a defined portion of PHTII funding will be aligned with accountability for Medicaid Accountable Care Organization (ACO) performance accountability for the public hospital's MassHealth patient panel utilizing the Delivery System Reform Incentive Program (DSRIP) measures.

In addition, PHTII transformation initiatives will include a focus on behavioral health integration initiatives as well as other approved initiatives that support the public hospital's ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations it serves. These initiatives may include:

- a) Integration of Behavioral Health and Primary Care;
- b) Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions;
- c) Referral Management and Integrated Care Management;
- d) Evidence-Based Practices for Medical Management of Chronic Conditions; and/or
- e) Community Empowered Population Health Initiative (Not Selected).

These initiatives may complement or enhance other federal initiatives in which a hospital may be participating, but they must not duplicate the exact same activities for which the public hospital receives specific funding by the U.S Department of Health and Human Services or any other state or federal funding source.

Pursuant to STC 56, PHTII payments are not direct reimbursement or payment for services, should not be considered patient care revenue, will not be offset against other Medicaid reimbursements to a hospital system, and will not be counted as payments when calculating hospital-specific cost limits under the Safety Net Care Pool Uncompensated Care Cost Limit Protocol.

3. PHTII Eligibility

STC 56 describes the eligibility for PHTII. Cambridge Public Health Commission d/b/a Cambridge Health Alliance (CHA) (hereby referred to as Public Hospital) is the only acute-care, non-federal, non-state Public Hospital in the Commonwealth and is eligible to earn PHTII payments outlined in Attachment E.

4. PHTII Protocol

In accordance with STC 56, Attachment K governs PHTII initiatives, guidelines, structure, and evaluation processes for reporting for payment, as outlined in Section V.

Following approval of the PHTII protocol by CMS and throughout the demonstration renewal period, the Massachusetts Executive Office of Health and Human Services (EOHHS) may propose revisions to the PHTII protocol, in collaboration with the Public Hospital, to reflect modifications to any component of the final approved protocol, including but not limited to initiatives, measures, metrics, and data sources or to account for other unforeseen circumstances in the implementation of the PHTII program. CMS must render a decision on proposed PHTII protocol revisions within 30 business days of submission by EOHHS. Such revisions must not require a waiver amendment, provided that they comport with all applicable STC requirements.

II. DESCRIPTION OF PHTII TRANSFORMATION FOCUS AREAS

5. PHTII Focus Areas

A defined portion of PHTII funding will be aligned with accountability for Medicaid Accountable Care Organization (ACO) performance accountability for the Public Hospital’s MassHealth patient panel utilizing the DSRIP measures. Because the Public Hospital relies on PHTII as an important component of its overall MassHealth funding structure, linking a portion of PHTII funding with these DSRIP performance measures will ensure full alignment across payment streams and focus on improving these outcomes.

Other PHTII transformation initiatives will include a focus on behavioral health integration initiatives as well as other approved initiatives that support the Public Hospital system’s ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations it serves.

Additional PHTII initiatives may include the following:

- a) Integration of Behavioral Health and Primary Care;
- b) Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions;
- c) Referral Management and Integrated Care Management;
- d) Evidence-Based Practices for Medical Management of Chronic Conditions; and/or
- e) Community Empowered Population Health Initiative (Not Selected).

Integration of Behavioral Health and Primary Care

To continue the advancement in integrated medical and behavioral health care in the context of population health management and alternative payment models, this initiative will leverage evidence-based practices to advance screening, treatment and improved access to behavioral health care based in the primary care setting for adults, children and adolescents. This suite of initiatives will include a focus on population health, quality outcomes, patient engagement and experience of care improvements, coordinated, cross continuum care, and effective care management and follow-up on targeted conditions including depression, anxiety, and substance use disorders. This will be enabled through the optimization of screening and follow-up workflows, expansion of evidence-based

treatment options, provider and staff training and engagement, building relationships among staff and providers across the system, and building community connections to support patient care.

Collaborative care, an evidence based delivery model involving a greater role of non-medical specialists to augment primary care and provide care management, has been shown to support the Triple Aim among patients with depression, the most prevalent mental disorder.^{1,2} The key elements of collaborative care models include: the use of a mental health registry, stepped care approach to depression management (i.e. intensifying treatments when needed), use of validated instruments (such as the Patient Health Questionnaire (PHQ-2 or PHQ-9) for depression, Generalized Anxiety Disorder scale (GAD-7) for anxiety, National Institute on Alcohol Abuse and Alcoholism single item screening tool (NIAAA-1), Alcohol Use Disorders Test (AUDIT), National Institute on Drug Abuse quick screen test (NIDA-1) and the Drug Abuse Screening Test (DAST), and regular caseload consultations by the psychiatrist and the behavioral care manager. Additional elements of integration include the co-location of behavioral health staff (such as therapists and psychiatrists) into primary care, meetings held by primary care and behavioral health team members to discuss cases, training of primary care and behavioral health staff on effective screening and collaborative care, and strategies to address substance use disorder (such as SBIRT) in primary care.³

Findings from more than 80 studies demonstrated that collaborative care increased adherence to evidence-based depression treatment by twofold and improved outcomes, including in low-income populations.⁴ Studies have also revealed value in terms of cost-effectiveness, cost-benefit analysis, and improved patient satisfaction with care.⁵ Substance use and addiction are significant challenges for society and for public payer populations. Unidentified mental health and substance use treatment needs contribute to higher costs and poor health outcomes. A recent publication released by the Substance Abuse and Mental Health Services Administration reported that in Massachusetts, only 53.8 % of adults with any mental illness (approximately 522,000 individuals per year in 2010-2014) actually received mental health treatment within the prior year, and only 7.5% of those with alcohol abuse or dependence received treatment in the prior year.⁶ Furthermore, the national problem of opioid use disorder and overdose is increasing year by year in Massachusetts.⁷

According to the American Academy of Pediatrics (AAP), behavioral and emotional problems during childhood are common, often undetected, and frequently untreated despite. Approximately 11% to 20% of children in the United States have a behavioral or emotional disorder at any given time.^{8,9} Developmental and behavioral health disorders are now the top 5 chronic pediatric conditions causing

¹ Institute for Clinical and Economic Review. March, 2015. Integrating Behavioral Health into Primary Care.

² Unützer J, Katon WJ, Williams JW, Callahan CM, Harpole L, Hunkeler EM, Hopping M, Areán PA, Hegel MT, Schoenbaum M, Oishi SM, Langston CA. Improving primary care for depression in late life: the design of a multi-center randomized trial. *Medical Care*. 2001; 39:785-799.

³ The Diamond Model is based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT Study by Jurgen Unutzer, MD as well as numerous other controlled trials from Institute for Clinical Systems Improvement and Minnesota Family Health Services presentation to the Institute for HealthCare Improvement Annual Forum, Dec 2010.

⁴ Archer, Janine, et al. "Collaborative care for depression and anxiety problems." *The Cochrane Library* (2012).

⁵ Katon WJ. "Collaborative Depression Care Models: From Development to Dissemination." *American Journal of Preventive Medicine*, 012;42(5):550–552.

⁶ Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Massachusetts, 2015*. HHS Publication No. SMA-16-BARO-2015-MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

⁷ <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf>

⁸ Costello EJ, Mustillo S, Erkanli A, Keeler G, Angold A. Prevalence and development of psychiatric disorders in childhood and adolescence. *Arch Gen Psychiatry*. 2003;60(8):837–844

⁹ *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

functional impairment.^{10,11,12} The AAP urges clinicians to screen for developmental and behavioral problems at all health supervision visits using quality tools.¹³ There is an opportunity to update routine, comprehensive screening for behavioral and developmental conditions in the child and adolescent population, using validated screening instruments such as the Survey of Wellbeing of Young Children (SWYC) for developmental screening, the Pediatric Symptom Checklist (PSC) and PHQ-9 for depression, and CRAFFT, a short clinical assessment tool for substance related risks and problems, and to develop the associated registries, analyze utilization patterns and service gaps, and optimize follow-up care according to the evidence base.¹⁴

Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions

Poor access to appropriate levels of care is a leading barrier to recovery for individuals with mental health and substance use (MHSU) conditions.¹⁵ A comprehensive system for MHSU treatment – offering the right care to the right people at the right time – requires a wide range of services and delivery methods to meet the unique needs of individuals and families. Among others, these services include outpatient counseling (including primary care integration), intermediate care (intensive outpatient, partial hospital), residential and inpatient facilities, support for care transitions, and triage and emergency services. A robust continuum of care helps people access services when they need and want them, improving patient experience and the value of care (quality/cost). A comprehensive treatment system allows individuals and their providers to develop an optimal care plan most likely to help them stay connected to their communities, succeed in daily activities, such as work or school, and engage in family and community supports toward recovery. Individuals who do receive appropriate treatment early in their onset of illness may require less intensive care, experience fewer relapses,¹⁶ and have better long-term health outcomes.¹⁷ New programs offering integrated, person-centered MHSU care show promising results – greater use of community-based outpatient care, fewer hospital and emergency department (ED) admissions, and better health outcomes.¹⁸⁻¹⁹

However, left untreated, behavioral health disorders and co-occurring health conditions have harmful economic, interpersonal, and social impacts for the population as a whole.²⁰ This troubling impact is most evident in the 20 to 30 year gap in life expectancy among people living with serious mental

¹⁰Slomski, A. Chronic Mental Health Issues in Children Now Loom Larger Than Physical Problems *JAMA*. 2012;308(3):223-225.

¹¹Halfon N, Houtrow A, Larson K, Newacheck PW. The changing landscape of disability in childhood. *Future Child*. 2012;22(1):13-42

¹²Promoting Optimal Development: Screening for Behavioral and Emotional Problems. Carol Weitzman, Lynn Wegner, the Section on Developmental and Behavioral Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, Council on Early Childhood and Society for Developmental and Behavioral Pediatrics. *Pediatrics* Feb 2015, 135 (2) 384-395.

¹³Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, Medical Home Initiatives for Children With Special Needs Project Advisory Committee *Pediatrics* Jul 2006, 118 (1) 405-420.

¹⁴Massachusetts Department of Public Health Bureau of Substance Abuse Services. Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment Using the CRAFFT Screening Tool. Boston, MA. Massachusetts Department of Public Health, 2009.

¹⁵American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>.

¹⁶Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. *Managing Managed Care: Quality Improvement in Behavioral Health*. Washington (DC): National Academies Press (US); 1997. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK233235/>

¹⁷Kane JM, Robinson DG, Schooler NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *Am J Psychiatry* 2016; 173:362-372.

¹⁸Krupski A, West II, Scharf DM, et al. Integrating primary care into community mental health centers: Impact on utilization and costs of health care. *Psychiatric Services in Advance*. 2016:1-7. doi: 10.1176/appi.ps.201500424.

¹⁹Gilmer TP, Henwood BF, Goode M, et al. Implementation of integrated health homes and health outcomes for persons with serious mental illness in Los Angeles County. *Psychiatric Services in Advance*. 2016:1-6. doi: 10.1176/appi.ps.201500092.

²⁰American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>.

illnesses (SMI).²¹⁻²² This disparity is driven by higher rates of chronic disease (e.g. diabetes, hypertension, hyperlipidemia, and obesity), delayed diagnosis and treatment of medical conditions,²³ fragmented delivery of care, medication side effects,²⁴ and higher rates of modifiable risk factors.²⁵ On average, 4.2 percent of Massachusetts residents are living with SMI and 10 percent have a SUD.²⁶ Among adults who access mental health care, 30 percent still report unmet needs, and more than one-third of those treated in the state’s public mental health system say it has not improved their functioning.²⁷

Massachusetts’ MHSU service gaps are due in part to shortages across the entire care continuum, from outpatient care to emergency services, inpatient beds, partial hospital programs, crisis stabilization units, detoxification, residential programs, and so on. This can result in sub-optimal wait times for outpatient therapy; extended hospitalizations due to lack of community-based services; and “boarding” in emergency departments (ED) as people await transfer to intermediate or acute care. Massachusetts faces an opioid use epidemic that has doubled the rate of overdose deaths from 2012 to 2015²⁸, and the need is growing exponentially for expanded Medication-Assisted Treatment (MAT) and evidence-based outpatient care for SUD. Expansion of services in areas that are most lacking, particularly in the intermediate care levels that provide step-down and diversionary services, will assist in shifting care away from more intensive levels and providing care at the appropriate level. Enhancement of treatment modalities will be explored that promote greater efficiency and create capacity within existing services, such as shorter term evidence-based treatments and technology-based services such as telemedicine consultations. Patient care teams may be redefined to include clinicians, paraprofessionals, peer specialists/coaches, community-based providers, social support providers, etc., with the patient at the center of the team.

A substantial portion of the public care system for individuals with the most disabling conditions extends beyond health care services to rehabilitative and support services, including housing, job counseling, literacy, and other programs. Poor linkage and fractured funding impedes the ability to provide access to these services in a coordinated and integrated way.²⁹ One strategy is the formalization of agreements between healthcare providers and community-based providers who offer complementary services, and providing integrated population case management. A focus on health promotion is essential to impact health outcomes for this population, as a national study estimated 85 percent of the life expectancy gap for people living with schizophrenia was attributable to “natural” causes, such as cardiovascular disease, cancers, pneumonia, and diabetes.³⁰ Early screening and

²¹Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med. Care.* Jun 2011;49(6):599-604.

²²Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease.* 2006;3(2):1-14.

²³Nasrallah HA, Meyer JM, Goff DC, et al. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: Data from the CATIE schizophrenia trial sample at baseline. *Schizophrenia Research.* 2006;86(1-3):15-2.

²⁴Meyer JM, Davis VG, Goff DC, et al. Change in Metabolic Syndrome Parameters with Antipsychotic Treatment in the CATIE Schizophrenia Trial: Prospective Data from Phase 1. *Schizophr. Res.* 2008;101(1-3):273-286.

²⁵SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010.

²⁶Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral Health Barometer: Massachusetts, 2015. HHS Publication No. SMA-16-Baro-2015-MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

²⁷Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease.* 2006;3(2):1-14.

²⁸Massachusetts Department of Public Health. Data Brief: Opioid-related Overdose Deaths Among Massachusetts Residents. May 2016. Available at: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf>.

²⁹Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. *Managing Managed Care: Quality Improvement in Behavioral Health.* Washington (DC): National Academies Press (US); 1997. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK233235/>

³⁰Kane JM, Robinson DG, Schooler NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *Am J Psychiatry* 2016; 173:362–372.

intervention for medical conditions is essential, particularly for patients taking antipsychotic medications that increase the risk for certain medical conditions, most notably metabolic syndrome. Modifiable factors such as smoking, diet, physical activity, substance use, and social needs are key drivers that can be addressed through promoting healthy living through education, skills training, and behavioral therapy.³¹⁻³²

Referral Management and Integrated Care Management

Toward the goals of better health and optimal, more coordinated and cost-effective care, this suite of initiatives is aimed at increasing patient access to high-quality care, promote appropriate referrals and access (i.e. the right provider in the right setting) based on the complexity of the patient's needs. Providing integrated care across the continuum of care through effective referral management and care coordination is foundational to the accountable care model and alternative payment arrangements with quality, cost and health care utilization accountability. This is particularly important for Medicaid and other vulnerable patient populations that often face barriers to care and care fragmentation. This initiative builds and supports systems to maintain a preferred, high value network and simultaneously provide highly coordinated and quality care in four ways: focus on public hospital system access and effective operational improvements in primary care and medical, surgical and behavioral health specialties, encourage public hospital referrals and the use of care within the public hospital system and with clearly defined high value preferred provider networks enabled to coordinate care and redirect referrals from higher cost, lower-value external referrals, build relationships with key community-based partners such as visiting nurse associations (VNAs), skilled nursing facilities (SNFs), and detoxification facilities, and leverage proven technology to improve access and convenience for the patient panel to specialty opinions and care. The Massachusetts Office of the Attorney General's report published in September 2015 found wide variation in the prices health insurance companies pay providers for similar services, unexplained by differences in quality, complexity of services, or other common measures of consumer value. The report found that higher priced providers are drawing patient volume from lower priced providers, which increases costs as care is shifted from less expensive settings to more expensive settings. Referral networks comprised of high value providers are an opportunity to address this.

In addition, this initiative will refine emergency department (ED) and inpatient case management capabilities to offer alternative treatment modalities and community-based care to patients. This initiative will expand e-consults beyond tele-dermatology in order to increase access to consultations with specialists, reducing cost and enabling more capacity for face-to-face visits when appropriate. This initiative may focus on facilitating transportation to in-network care providers for patients who lack transportation by utilizing a non-medical transportation support service. Convenience and effectiveness also drives efforts to examine text-messaging in care management.

Evidence-Based Practices for Medical Management of Chronic Conditions

Evidence based medicine (EBM) is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The goal is to improve outcomes, quality, and cost by reducing the variation of care for key conditions and integrate EBM into the health care delivery system across the continuum. Variation of care was outlined in the 2010 Dartmouth Institute's reflections on geographic variations; however, similar variations in care may also be observed within health care systems and practices, acknowledging natural differences between patients. Safer, higher-quality care, redesigned systems of care that integrate the use of

³¹Bartels S, Desilets R. Health Promotion Programs for People with Serious Mental Illness (Prepared by the Dartmouth Health Promotion Research Team). Washington, DC. SAMHSA-HRSA Center for Integrated Health Solutions. Jan 2012.

³²Bruins J, Jorg F, Bruggeman R, Slooff C, Corpeleijn E, et al. (2014) The Effects of Lifestyle Interventions on (Long-Term) Weight Management, Cardiometabolic Risk and Depressive Symptoms in People with Psychotic Disorders: A MetaAnalysis. PLoS ONE, 2014; 9(12); 1-20.

information technology can best support clinical and administrative processes to adopt EBM and improve patient outcomes.

Efforts to change the culture of medical practice to adopt EBM include education on recommendations from peer-reviewed groups such as Cochrane or the U.S. Preventive Services Task Force (USPTF), integration of EBM into clinical activities via clinical decision support (CDS) for chronic conditions and prevention, and the application of population health data to prioritize and subsequently develop systems to close quality gaps. Planned future initiatives build on capabilities to develop and use population health databases, risk stratify patients, and help connect the most costly and vulnerable patients with complex care management, transitional facilitators, and palliative care services. Medical management programs aim to develop and implement evidence-based clinical guidelines for populations of patients with particular conditions to ensure the right care at the right time in the right context and produce optimal outcomes for quality, safety, cost, and experience. Efforts may focus on improving care and reducing cost for populations of patients with five conditions: chronic obstructive pulmonary disease; congestive heart failure; hypertension; diabetes; and pediatric asthma.

Evidence-based patient engagement strategies may include those such as motivational interviewing in chronic health conditions and for substance use disorders, expansion of nursing, pharmacist, and other care team member roles in chronic disease management, and mental health team integration within primary care. Initiatives may include refining tools, frameworks, analytics, and clinical workforce development in the use of evidence-based guidelines across the care continuum.

Community Empowered Population Health Initiative

In recognition that social, behavioral, and environmental factors account for 70% of what it takes to stay healthy while only 10% are attributable to direct medical care, this initiative will build and support systems to address social determinants of health (SDH) and address health disparities in patients with chronic conditions.³³ According to the Institute of Medicine, “an aligned system with a strong interface among public health, health care, and the community and non-health sectors could produce better prevention and treatment outcomes for populations living with chronic illness.”³⁴ Healthy People 2020 highlights the importance of addressing the social determinants of health by including “create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.³⁵ Based on emerging evidence that addressing social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs, CMS has prioritized addressing SDH through the Accountable Health Communities model to address critical gaps between clinical care and community services.³⁶ The initiative also recognizes that health disparities have persisted for families and communities that have systematically experienced social and economic disadvantage and consequently face greater obstacles to optimal health.^{37,38}

Improving SDH and health disparities requires supporting communities in addressing their health needs, implementing screening and referral processes to social service agencies and building programs that identify and address health disparities. Community health improvement teams will work with community based organizations and governmental entities to support their efforts to improve community health. Clinical and community health improvement teams will work together

³³McGinnis et al. The Case for More Active Policy Attention to Health Promotion. *Health Affairs* 2002; 21(2); 78-93

³⁴IOM. *Living well with chronic illness: a call for public health action*. Washington, DC: The National Academies Press; 2012

³⁵Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

³⁶Alley DE, et al. Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid. *N Engl J Med* 2016; 374:8-11.

³⁷CMS. CMS Equity Plan for Improving Quality in Medicare. Sept 2015. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

³⁸CMS. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-health-disparities.html>

to screen for SDH, refer patients with social needs to existing community services, and rescreen patients with social needs. Clinical and community health improvement teams will also work closely to identify populations with disproportionately higher rates of poor control of chronic health conditions, monitor and improve their care through ensuring they receive interventions such as education, outreach, and linkage to primary, specialty and other ambulatory care services.

III. PROPOSED PUBLIC HOSPITAL TRANSFORMATION AND INCENTIVE INITIATIVES

6. Public Hospital Transformation and Incentive Initiatives

The Public Hospital must implement PHTII initiatives approved by EOHHS and CMS that are outlined within this protocol and that meet all requirements pursuant to STC 56, and all requirements set forth in Section III.

7. Minimum Number of Initiatives

The Public Hospital must select a minimum of four initiatives and no more than five initiatives in total for PHTII, in addition to the portion of PHTII funding linked to DSRIP performance accountability for the Public Hospital's attributed primary care panel within an ACO. Cambridge Health Alliance has selected four initiative areas 1 – 4 and corresponding Measure Slates 1 – 4 and 6.

8. Public Hospital PHTII Initiative Toolkit

Section VIII, paragraph 23 includes the menu of PHTII Initiatives and corresponding outcomes and improvement Measure Slates from which an eligible public hospital may select. Each initiative description includes:

- a. Rationale for the proposed initiative (evidence base and reasoning behind initiative idea);
- b. Goals and objectives for the initiative (initiative-specific Triple Aim goals and expected initiative outcomes);
- c. Core components or key activities to guide initiative development and implementation;
 - i. The core components for the initiatives are not required. However, most will be necessary to achieve the required results. The core components provide a guide for how the initiatives are implemented by the public hospital.
- d. Measure Slates required for the initiative, including clinical event outcomes and other specified outcomes and improvement measures.
 - i. The PHTII funding at risk for improved performance on outcomes and improvement indicators will be spread among four (4) Measure Slates associated with ongoing transformation efforts to ensure high-quality health care services for the Medicaid and safety net populations. Each Measure Slate is a list of outcomes and improvement indicators for which the Public Hospital must successfully achieve defined metrics for a specified number of the indicators on the list within each specified demonstration year.
 - ii. Each Measure Slate is designed specifically for a PHTII initiative. For the purposes of the at-risk funding for improved performance on outcomes and improvement indicators, the Measure Slates for PHTII initiatives are as follows:
 - (a) Measure Slate 1 – Integration of Behavioral Health (BH) and Primary Care Initiatives
 - (b) Measure Slate 2 – Comprehensive Systems for Treating Mental Health and Substance Use Conditions
 - (c) Measure Slate 3 – Referral Management Initiatives and Integrated Care Management
 - (d) Measure Slate 4 – Evidence-Based Practices for Medical Management of Chronic Conditions
 - (e) Measure Slate 5 – Community Empowered Population Health Initiative (Not Selected).

- iii. A specified number of outcomes and improvement indicators will need to be achieved in each DY, according to the table below.

The Public Hospital receives payment when a measure is individually achieved and reported, up to the established number of outcomes and improvement indicators assigned funding in a given demonstration year. For example in Measure Slate 2 in DY 22, if the Public Hospital achieves 4 indicators (out of the defined number for that year which is set at 5 indicators), the public hospital will be paid for those 4 indicators during that demonstration year. However, if the Public Hospital achieves a greater number than the defined number of improvement indicators established for a given year (for example, 6 indicators compared to the defined number established at 5 indicators), the Public Hospital will only be paid for the first 5 indicators that it achieves on that Measure Slate during that demonstration year.

	DY21	DY22	DY23	DY24	DY25
Measure Slate 1	Achieve 2 of 4 Indicator Goals	Achieve 4 of 11 Indicator Goals	Achieve 5 of 11 Indicator Goals	Achieve 6 of 11 Indicator Goals	Achieve 7 of 11 Indicator Goals
Measure Slate 2	Achieve 2 of 5 Indicator Goals	Achieve 5 of 13 Indicator Goals	Achieve 7 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals
Measure Slate 3	Achieve 2 of 5 Indicator Goals	Achieve 4 of 10 Indicator Goals	Achieve 7 of 13 Indicator Goals	Achieve 6 of 10 Indicator Goals	Achieve 8 of 13 Indicator Goals
Measure Slate 4	Achieve 2 of 3 Indicator Goals	Achieve 4 of 13 Indicator Goals	Achieve 7 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals	Achieve 8 of 13 Indicator Goals
Measure Slate 5	N/A (Not Selected)	Achieve 3 of 9 Indicator Goals (Not Selected)	Achieve 5 of 9 Indicator Goals (Not Selected)	Achieve 5 of 9 Indicator Goals (Not Selected)	Achieve 6 of 9 Indicator Goals (Not Selected)

- iv. The Public Hospital is not required to pre-determine which outcomes and improvement indicators will be achieved in terms of performance goals in each year; instead, the Public Hospital must achieve the established performance goals for the specified number of outcomes and improvement indicators applicable to a demonstration year, which are individually payable when an indicator is individually achieved and reported up to the established number of outcomes and improvement indicators assigned funding in that demonstration year. Beginning in DY23, for each of the Measure Slates 1 – 5, at least 2 measures are required to continue achievement from the year immediately previous. A description of the funding allocation for the at-risk outcomes and improvement indicators can be found in Section VI, paragraph 18. Updates to technical specifications of outcomes and improvement measures in Measures Slates 1 – 5 shall not require a protocol modification and can be implemented by the Commonwealth without further approval.
- e. Pay-for-Reporting Measure Slate
Measure Slate 6 reflects Population-Wide Public Health Measures. Measure Slate 6 will be Pay-for-Reporting for DYs 21 – 25.

	DY21	DY22	DY23	DY24	DY25
Measure Slate 6	Pay-for-Reporting	Pay-for-Reporting	Pay-for-Reporting	Pay-for-Reporting	Pay-for-Reporting

A description of the funding allocation for the pay-for-reporting measure slate can be found in Section VI, paragraph 18.

9. Medicaid ACO Performance Accountability for Public Hospital’s MassHealth Panel

The public hospital will report on measures associated with Medicaid Accountable Care Organization (ACO) performance accountability for the Public Hospital’s MassHealth patient panel utilizing the DSRIP measures.

IV. NON-FEDERAL SHARE OF PHTII PAYMENTS AND ALIGNED MASSHEALTH ACO PERFORMANCE ACCOUNTABILITY FUNDS INCORPORATED INTO PHTII FUNDING STREAM

11. Identification of Allowable Funding Sources

a. Allowable Funding Sources

Allowable funding sources for the non-federal share of PHTII payments must include all sources authorized under Title XIX and federal regulations promulgated thereunder.

- i. The source of non-federal share of DYs 21 – 25 PHTII payments to the Public Hospital will be an intergovernmental funds transfer. The Executive Office of Health and Human Services (EOHHS) will issue a request to the Public Hospital for an intergovernmental transfer in the amount of the non-federal share of the applicable incentive payment amounts at least 15 days prior to the scheduled date of payment. The Public Hospital will make an intergovernmental transfer of its funds to EOHHS in the amount specified by a mutually agreed timeline determined by EOHHS in consultation with the Public Hospital, and in accordance with the terms of an executed payment and funding agreement, and all applicable laws. Upon receipt of the intergovernmental transfer, EOHHS will draw the federal funding and pay both the nonfederal and federal shares of the applicable DYs 21 – 25 payment(s) to the Public Hospital according to a mutually agreed upon timeline determined by EOHHS in the consultation with the Public Hospital, and subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals.

b. Change in Funding Source

If the source of non-federal share of PHTII payments changes during the renewal period, EOHHS must notify CMS and seek CMS’ approval of such change prior to claiming FFP for any payment utilizing such funding source. No waiver amendment is required.

V. PHTII REPORTING AND PAYMENT IN DYs 21 – 25

12. PHTII Initiatives and Measure Slate 1 – 6

Three times per year, the Public Hospital seeking payment under PHTII must submit reports to the Commonwealth demonstrating progress on PHTII initiatives that the Public Hospital has selected pursuant to paragraph 7. The Commonwealth must provide such reports to the assigned independent assessor. The reports must be submitted using the standardized reporting form approved by EOHHS. The reports must include the incentive payment amount being requested for the progress achieved on PHTII initiative activities in accordance with payment mechanics (see Section VI). The report must include data on the progress with the initiative and must provide a narrative description of the progress made. The reports must contain sufficient data and documentation to allow CMS, the state, and the independent assessor to determine if the hospital is achieving progress with the initiative. The hospital system must have available for review by the Commonwealth or CMS, upon request, all

supporting data and back-up documentation. These reports will be due as indicated below after the end of each reporting period:

- a. Reporting period of July 1 through October 31: the report and request for payment is due November 30.
- b. Reporting period of November 1 through February 28/29: the report and request for payment is due March 31.
- c. Reporting period of March 1 to June 30: the report and request for payment is due July 31. The Commonwealth may permit the reporting for payment of specified outcomes measures subsequent to the July 31 reports for each demonstration year in recognition that additional time may be needed for necessary data to be available.

These reports will serve as the basis for authorizing incentive payments to the Public Hospital. The actual payment amounts will be determined by EOHHS in accordance with the provisions of Section VI. EOHHS will schedule the payment transaction for the hospital within 30 days following EOHHS approval of the hospital report, subject to state legislative appropriation and availability of funding, execution of a payment agreement provided by EOHHS, and all necessary approvals. The state must inform CMS of the funding of PHTII payments to the provider through a quarterly payment report to be submitted to CMS within 60 days after the end of each quarter.

An independent assessor will review each report, to ensure accurate reporting of the hospital's achievement, and make recommendations to the state regarding approvals, denials or recommended changes in order to approve payment. EOHHS will provide final approval of all PHTII payments. The hospital must be allowed an opportunity to respond to, and correct, any recommendation for denial of payment, for a metric that the hospital believes it achieved, through the resubmission of required clarifications and/or data.

13. MassHealth DSRIP Performance Accountability for Public Hospital's MassHealth Panel

The public hospital will also follow the reporting process as defined by EOHHS for the Medicaid DSRIP performance accountability measures for the Public Hospital's MassHealth panel.

Generally, EOHHS will make payments to the Public Hospital for the DSRIP performance measures at the same time as it makes payments associated with the Public Hospital's third annual reporting cycle, as described in paragraph 12c above. However, if any DSRIP performance measures or domains are completed and approved by EOHHS pursuant to the DSRIP process at another time during the year, EOHHS shall make payments to the Public Hospital in the most proximate report for payment. For DSRIP performance measures that may rely on claims and/or other lagged sources of data administered by MassHealth, EOHHS shall make estimated payments to the Public Hospital, which shall be subject to final reconciliation outlined in this paragraph and paragraph 14 below. If it is determined that the progress by the Public Hospital had not been achieved as calculated in the estimated payment and that such progress would have resulted in a lower payment amount, the Public Hospital will be required to re-pay the federal portion of the overpayment amount. If the review determines that actual progress exceeded the estimate and the estimated payment amount, then the Public Hospital will be able to receive the appropriate additional payment in conjunction with the intergovernmental transfer process outlined in Section IV, paragraph 11.

14. Year-end Payment Reconciliation

Based on its review and verification of the Public Hospital's third annual report for payment, EOHHS will perform reconciliation as an additional check to verify that all PHTII payments made to the hospital were correct. If, after the reconciliation process EOHHS determines that the hospital was overpaid, the overpayment will be properly credited to the Commonwealth and the federal government or will be withheld from the next PHTII payment for the hospital, as determined by

EOHHS. If, after the reconciliation process EOHHS determines that the hospital was underpaid, then subject to state legislative appropriation and availability of funds, the terms of a payment and funding agreement, and all necessary approvals, EOHHS will schedule necessary payment transaction(s), or will add the additional amount to the next PHTII payment for the hospital, as determined by EOHHS.

15. Commonwealth Reporting to CMS in DYs 21 – 25

PHTII will be a component of the Commonwealth’s quarterly operational reports and annual reports related to the demonstration. These reports will include:

- a. All PHTII payments made to the specific hospital that occurred in the quarter;
- b. Expenditure projections reflecting the expected pace of future disbursements for the participating hospital;
- c. An assessment by summarizing the hospital’s PHTII activities during the given period; and
- d. Evaluation activities and interim findings of the evaluation design.

16. Claiming Federal Financial Participation

The Commonwealth will claim federal financial participation (FFP) for PHTII incentive payments on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set up exclusively for PHTII payments. FFP will be available only for PHTII payments made in accordance with all pertinent STCs and the stipulations of this master PHTII plan, including Section VI. The Commonwealth and the hospital system receiving PHTII payment must have available for review by CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in the approved PHTII protocol.

VI. DISBURSEMENT OF PHTII FUNDS

17. PHTII Incentive Payments

a. Eligibility for PHTII Incentive Payments

PHTII payments for the Public Hospital are contingent on that provider reporting progress on the PHTII initiatives and achieving performance for at risk outcomes and improvement measures as defined in the approved protocol. As outlined in Sections V and VI of the PHTII protocol, the hospital will be able to receive PHTII incentive payments related to approval of the required reports for payment. PHTII incentive payments may equal but not exceed the allotment outlined in Attachment E.

b. DYs 21 – 25 PHTII Payments

In DYs 21 – 25, PHTII funds will be available as incentive payments to the Public Hospital based on successfully executing and reporting on approved PHTII initiatives. The Public Hospital shall be eligible to receive the full amount of PHTII Initiatives Progress Reporting and Measure Slate 6 Reporting funding for successful completion of the progress reporting requirements during the first and second reports for payment, as specified in paragraph 12.

c. Funding At Risk for Outcomes and Improvement

Inclusive of the funding allotted to PHTII Outcomes and Improvement Measure Slates and MassHealth DSRIP performance accountability measures, the percentage of PHTII funding at risk for improved performance on outcomes and improvement indicators will gradually increase from 15 percent in DY 21 to 30 percent in DY 25.

18. PHTII Funding Allocation Formula

The following chart depicts the percentage and dollar amount of total PHTII funds available per demonstration year for PHTII initiatives and the at-risk amounts for performance on the outcome and quality indicators.

	MassHealth DSRIP Performance Accountability for Public Hospital's MassHealth Panel		PHTII At-Risk Measure Slates 1 – 4 Outcomes and Improvement Indicators		PHTII Initiatives Progress Reporting and Measure Slate 6 Reporting		Total
DY 21	5%	\$15.45M	10%	\$30.9M	85%	\$262.65M	\$309M
DY 22	5%	\$12.15M	10%	\$24.3M	85%	\$206.55M	\$243M
DY 23	10%	\$10M	10%	\$10M	80%	\$80M	\$100M
DY 24	15%	\$15M	10%	\$10M	75%	\$75M	\$100M
DY 25	20%	\$20M	10%	\$10M	70%	\$70M	\$100M

a. Funding for MassHealth DSRIP Performance Accountability for Public Hospital's MassHealth Panel

In DY 21, 5% of total PHTII funds are available as incentive payments for meeting all qualification criteria for and participating in one of MassHealth's ACO models for the Public Hospital's MassHealth primary care patient panel. The funding allocation available for successful performance on MassHealth DSRIP performance accountability measures for the Public Hospital's MassHealth primary care patient panel members is 5% in DY 22, 10% in DY 23, 15% in DY 24, and 20% in DY 25.

b. Funding Allocation for PHTII At Risk Outcomes and Improvement Indicators

The amount of funding at risk for performance on the outcome and improvement indicators will be 10% of the total annual PHTII funding in DYs 21 – 25. Payment for performance on these outcome milestones will be based on an objective demonstration of improvement using a valid, standardized method, outlined in Section VI, paragraph 19. The defined number of outcome and improvement indicators targeted for achievement in a given demonstration year have an annual base value that is uniform across all indicators within a specific Measure Slate 1 – 5 during a given demonstration year. The annual outcomes and improvement indicator value related to each of the applicable initiatives (Measure Slates 1 – 5) is calculated by dividing the annual total available amount of PHTII outcomes and improvement indicator funds by the number of applicable initiatives for a given year.

	DY 21	DY 22	DY 23	DY 24	DY 25
Measure Slate 1	\$7.725M	\$6.075M	\$2.5M	\$2.5M	\$2.5M
Measure Slate 2	\$7.725M	\$6.075M	\$2.5M	\$2.5M	\$2.5M
Measure Slate 3	\$7.725M	\$6.075M	\$2.5M	\$2.5M	\$2.5M
Measure Slate 4	\$7.725M	\$6.075M	\$2.5M	\$2.5M	\$2.5M
Measure Slate 5	Not Selected	Not Selected	Not Selected	Not Selected	Not Selected

Total	\$30.90M	\$24.30M	\$10.00M	\$10.00M	\$10.00M
--------------	----------	----------	----------	----------	----------

The PHTII at-risk outcomes and improvement indicator funds will be earned by Measure Slate based on the individual achievement of established performance goals for the specified number of indicators for each respective measure slate as outlined in Section III, paragraph 8. For each Measure Slate, the available funds are divided by the established number of measures specified for achievement during a given demonstration year. Payment will be made to the Public Hospital when a measure is individually achieved and reported, up to the established number of measures assigned funding in a given demonstration year.

c. Funding Allocation for PHTII Initiatives and Measure Slate 6

In DY 21, 85% of total PHTII funds are available as incentive payments for successful achievement of progress reporting on PHTII initiative activities as described in Section V, paragraph 12. The funding allocation available for PHTII initiatives is 85% in DY 22, 80% in DY 23, 75% in DY 24, and 70% in DY 25.

Of such annual PHTII funds available for successful achievement of reporting initiative activities in DYs 21 – 25, five percent of such annual initiative metric funding is associated with Measure Slate 6 (Population-Wide Public Health Measures), which is pay-for-reporting throughout the demonstration. The table below specifies the annual base values for PHTII initiatives and Measure Slate 6.

	DY 21	DY 22	DY 23	DY 24	DY 25
PHTII Initiatives Progress Reporting	\$249.52M	\$196.22M	\$76.00M	\$71.25M	\$66.50M
Measure Slate 6	\$13.1325M	\$10.3275M	\$4.00M	\$3.75M	\$3.50M
Total PHTII Initiatives Progress Reporting and Measure Slate 6	\$262.65M	\$206.55M	\$80.00M	\$75.00M	\$70.00M

19. PHTII Improvement Measurement Approach

As stated in Section V, paragraph 12 of this attachment, the Public Hospital will report outcomes and improvement indicators related to PHTII Initiatives (Measure Slates 1 – 4). The public hospital will also follow the reporting process as defined by EOHHS for the Medicaid DSRIP performance accountability measures for the Public Hospital’s attributed panel, outlined in paragraph 13.

a. PHTII Measure Slates 1 – 5

In order to receive funding for Measure Slates 1 – 5, the Public Hospital must achieve established performance goals for a specified number of indicators which are individually payable when an indicator is individually achieved and reported up to the established number of outcomes and improvement indicators assigned funding in a given demonstration year, as described in Section III, paragraph 8. Payment-for-performance on the outcomes and improvement indicators on the Measure Slates will be based on an objective demonstration of improvement over baseline or achievement of established performance thresholds using a valid, standardized method, as described below.

The following is the PHTII Measure Slate 1 – 5 payment framework for outcomes and improvement indicators.

- i. DY 21 - 25 – This is pay-for-performance for designated measures.
 - (a) The Public Hospital must achieve established performance goals for the specified number of indicators for the demonstration year, as outlined in Section III, paragraph 8.
 - (b) Baselines will also be reported for designated measures in specified demonstration years.
- ii. In the event that the Public Hospital meets the specified performance benchmark in a particular demonstration year, the organization must maintain performance at or above the benchmark in the remaining demonstration years. Variation in performance is acceptable as long as the performance for each demonstration year is at or better than benchmark in this case. Beginning in DY22, the Public Hospital would also be required to achieve at least one measure in each measure slate for which it did not meet or exceed the benchmark in the previous year.
- iii. The Public Hospital must have a target for outcome and quality improvement indicators in Measure Slates 1 – 5. The specified targets will be used to determine whether or not success is achieved on the associated outcomes or improvement indicator. Measure Slate 6 is pay-for-reporting only on population-wide public health measures, and is not included in the at-risk funding for outcomes and improvement indicators, as described in Section VI, paragraph 18.
- iv. The following is a guiding hierarchy for the selection of improvement benchmarks or targets for outcomes and improvement indicators on Measure Slates 1 – 5. All performance targets are set forward in this protocol for Measure Slates 1 – 5 and will be in place for the entire demonstration period.
 - (a) Select the latest available 90th percentile Massachusetts Medicaid at the time of protocol development. For CMS core inpatient measures and other inpatient measures, utilize available Massachusetts performance data.
 - (b) If above is not available, select the latest available 90th percentile National Medicaid data at the time of protocol development. For CMS core inpatient measures and other inpatient measures, utilize available National performance data.
 - (c) If above is not available, select other available benchmark (such as other latest available National benchmark) or hospital-defined target at the time of protocol development. If above is not available or if the specific measure is more appropriate to improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures), any improvement over DY21/SFY18 hospital baseline will be the improvement measurement method or as specified.
- v. Outcomes and Improvement Indicators Classifications for Measure Slates 1 – 5
 - (a) Outcomes and improvement indicators will be classified into the following groups: (i) Clinical care delivery improvement measures; (ii) Clinical outcomes measures; and (iii) other delivery/outcomes measures where there is not a standardized benchmark and/or if the specific measure is more appropriate to improvement over hospital baseline.
 - (i) Clinical care delivery improvement measures quantify a performance exhibited by clinical care practices, such as health screenings, and therefore are usually directly observable and can be directly impacted. In general, these metrics fit with a gap-to-goal methodology. All metrics classified as clinical care delivery measures must have an acceptable benchmark. To meet the threshold for success, the Public Hospital must achieve closure of 10% of the difference between the Public Hospital's baseline performance and the established benchmark or maintain at or above the benchmark. Each subsequent year would continue to be set with a target using the most recent year's data, unless otherwise specified.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 10\%$$

An example of a clinical care delivery measure is influenza immunization (NQF 0041).

- (ii) Clinical outcome measures are metrics influenced by patient case mix, multiple processes, and environmental factors. In general, these metrics fit with a gap-to-goal methodology, depending on the availability of performance benchmarks. Since improvement on outcomes measures requires considerable amounts of resources and time and is dependent on foundational care delivery improvements and patient factors, closure of 10% of the difference between the Public Hospital's baseline performance and the established benchmark is included, unless otherwise specified. To meet the threshold for success, the Public Hospital must meet the 10% gap to goal, where the Public Hospital must achieve a closure of a minimum of 10% of the difference between the benchmark and the baseline performance or maintain at or above the benchmark. Each subsequent year would continue to be set with a target using the most recent year's data, unless otherwise specified.

$$\text{Performance Year} - \text{Baseline} \geq (\text{Benchmark} - \text{Baseline}) * 10\%$$

Examples of clinical outcome measures are Controlling High Blood Pressure (NQF 0018) and Comprehensive Diabetes Care: Hemoglobin A1c Control (NQF 0575).

- (iii) Non-standardized benchmark delivery/outcomes measures are metrics that do not have an available or acceptable benchmark and/or are specific measures that are more appropriate for improvement over hospital baseline (such as non-risk adjusted or utilization improvement measures). For example, to meet the threshold for success, for pay-for-performance measures applicable to DY 22, the Public Hospital must show improvement from baseline (DY 21) to performance year (DY 22). To meet the threshold for success, for pay-for-performance measures applicable to DY 23, the Public Hospital must show improvement from baseline (DY 21) to performance year (DY 23) or as specified.

Examples of a non-standardized benchmark delivery/outcomes measure are emergency department utilization rates and reducing the proportion of out-of-network referrals, thereby improving patient continuity of care. These measures are influenced by many factors (which may include patient case mix, multiple processes, and environmental factors). Given that these measures are not risk-adjusted approach, the use of the Public Hospital's historical performance is a pragmatic approach to PHTII. Other examples of a non-standardized benchmark delivery/outcomes measures are the CMS Inpatient Psychiatric Facility Quality Reporting Screening for Metabolic Disorders in Inpatient Psychiatric Care, which is a new measure for which a benchmark is unavailable.

- b. MassHealth DSRIP Performance Accountability Funds Incorporated into PHTII Funding Stream
The Public Hospital will follow the reporting process established for the MassHealth DSRIP accountability measures. A DSRIP Accountability Score will be calculated for the Public Hospital using the methodology as described in the DSRIP Protocol, except that the Accountability Score will be calculated based specifically on performance for MassHealth members related to the Public Hospital's primary care panel (versus the whole ACO's primary care panel, if the ACO includes other primary care providers in addition to the Public Hospital). The amount of these at-risk funds the Public Hospital earns will be determined as outlined in the DSRIP Protocol. The DSRIP domains and measures, and the methodology for calculating accountability scores, are further defined in the DSRIP Protocol.

VII. INITIATIVE MODIFICATION, GRACE PERIODS, AND CARRY FORWARD AND RECLAMATION

20. Initiative Modification Process

- a. Consistent with the recognized need to provide the Public Hospital some flexibility to evolve its initiatives over time and take into account evidence and learning from experience and from the field, as well as for unforeseen circumstances or other good cause, the hospital may request modifications to the PHTII Toolkit for an initiative or to its portfolio of selected PHTII initiatives, with the exception of ACO performance accountability, which may not be modified except at EOHHS' direction and as applicable to the broader DSRIP program. The hospital must submit a request for modification to EOHHS. Requests for initiative modification must be in writing and must describe the basis for the proposed modification. Updates to technical specifications of outcomes and improvement measures in the Measure Slates (1 – 6) shall not require a plan modification and can be implemented by the Commonwealth without further approval.
- b. Initiative modifications include proposed changes to core components of the initiative, replacement metrics on the improvement and outcome measure slates (Measure Slates 1 – 5), replacement measures to Measure Slate 6, or a change to the overall portfolio of selected PHTII initiatives. Acceptable reasons to approve an initiative modification request are:
 - i. Learning and knowledge acquired from initiative experience and/or external sources indicate that revising or reorienting initiative components or metrics would improve and/or enhance the initiative;
 - ii. Information that was believed to be available to achieve or report on a metric or measure is unavailable or unusable, necessitating a modification to the hospital initiative to revise or replace the metric or measure;
 - iii. The hospital identifies superior information to demonstrate achievement of a metric and requests a modification to incorporate that data source;
 - iv. External issues occur outside of the hospital's control that require the hospital to modify or replace a metric, measure, or core component of an initiative;
 - v. New federal or state policies are implemented, or changes in Massachusetts market dynamics occur, that impact a PHTII initiative and the hospital seeks to update the affected initiative to reflect the new environment;
 - vi. The hospital encounters an unforeseen operational or budgetary change in circumstances that impacts initiative components or metrics; and
 - vii. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the PHTII program.
- c. The Public Hospital may request initiative modifications during DYs 21 – 25. Initiative modification requests must be submitted to EOHHS a minimum of 75 days prior to the end of the Demonstration Year. EOHHS must take action on the initiative modification request and submit recommended requests to CMS for approval within 15 days of receiving a modification request. CMS must take action on the initiative modification request within 30 days of receipt from EOHHS. Any CMS approved initiative modification must be considered an approved modification to the PHTII protocol.
- d. Plan modifications associated with grace period requests, including EOHHS and CMS review timeframes, are further addressed in paragraph below.

21. Grace Periods

- a. If the Public Hospital needs additional time to achieve a metric beyond the demonstration year, a grace period may be granted for up to 180 days from the end of the demonstration year if it requests. However, no grace period is available for DY 25 beyond June 30, 2022, with the exception of specified outcomes and improvement measures where there is state and federal approval for a later reporting date in recognition that the data will not be available for reporting until after the July 31, 2022 report for payment. The hospital must have a valid reason, as determined by the Commonwealth and CMS, why it should be granted a grace period and demonstrate that the hospital is able to achieve the metric within the timeframe specified in the request. Grace periods will not be granted for ACO performance accountability. Acceptable reasons to approve a grace period request include:
 - i. Additional time is needed to collect and prepare data necessary to report on a metric;
 - ii. Unexpected delays by third parties outside of hospital's control (e.g., vendors) impact the timing of a metric achievement date;
 - iii. An approved plan modification delays the timing for completing an approved metric; and
 - iv. Other acceptable reasons, subject to review and approval by EOHHS and CMS that are reasonable and support the goals of the PHTII program.
- b. The Public Hospital may submit a grace period request in writing to EOHHS accompanied by a proposed initiative modification if the initiative modification is deemed necessary by the Public Hospital, pursuant to paragraph 21 above. The hospital must submit the request 75 days prior to the end of the Demonstration year for which the grace period is being sought. EOHHS must determine its recommended action on a grace period request and initiative modification, if the grace period request is accompanied by an initiative modification, and submit the request to CMS, with its recommendation, within 15 days. CMS must take action on the request within 30 days of receipt from EOHHS. The grace period request and any associated initiative modification must be decided by the Commonwealth and CMS 30 days prior to the end of the Demonstration year.
- c. The Public Hospital that requests a grace period related to a metric is not precluded from alternatively claiming the incentive payment associated with the same metric under the carry-forward policy described in paragraph 22 below.
- d. If after submitting the grace period request, a hospital achieves the metric before June 30, the hospital may withdraw the grace period request and claim the incentive payment associated with the metric under the regular PHTII reporting process described in Section V.
- e. Allowable Time Periods for Grace Period Requests: the allowable time period for a grace period is 180 days from June 30 for DYs 21 – 24. No grace period is available for DY 25 beyond June 30, 2022 except as expressly described in paragraph 21(a) above.

22. Carry Forward and Reclamation

The Public Hospital may carry forward unclaimed incentive payments applicable to PHTII initiative reports and PHTII Measure Slates 1 – 6 for up to 12 months from the end of the demonstration year and be eligible to claim reimbursement for the incentive payment according to the rules below. No carry-forward is available for DY 25 or for DSRIP performance accountability.

- a. If the Public Hospital does not achieve improvement on a measure that was specified for achievement in a particular year, it will be able to carry forward the available incentive funding associated with that measure for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the corresponding

measure associated with the year in which the payment is made. For purposes of carry-forward in this paragraph, a corresponding measure is a measure that is a continuation of a prior year measure and is readily quantifiable. An example of corresponding measures includes a metric that shows a number or percentage increase in the same specific activity from the previous year.

- b. If there is no corresponding measure associated with the year in which the payment is made, the hospital will be able to carry forward the available incentive funding associated with the missed measure for up to 12 months and receive full payment if EOHHS determines, based on documentation provided by the hospital, that the hospital meets the missed measure in addition to at least 25 percent of measures associated with that initiative in the year in which the payment is made. If at the end of that subsequent demonstration year, an eligible safety net hospital has not fully achieved a measure, it will no longer be able to claim that funding related to its completion of that measure.

VIII. MENU OF PHTII INITIATIVES AND CORRESPONDING OUTCOMES AND IMPROVEMENT MEASURE SLATES

23. PHTII Initiatives and Measure Slates

This section presents a menu of PHTII Initiatives and corresponding outcomes and improvement Measure Slates from which an eligible public hospital may select. Cambridge Health Alliance has selected PHTII Initiatives 1 – 4 and corresponding Measure Slates 1 – 4 and 6.

Initiative Title	1. Integration of Behavioral Health and Primary Care
Description/Rationale	
<p>To continue the advancement in integrated medical and behavioral health care in the context of population health management and alternative payment models, this initiative will leverage evidence-based practices to advance screening, treatment and improved access to behavioral health care based in the primary care setting for adults, children and adolescents.</p> <p>This suite of initiatives will include a focus on population health, quality outcomes, patient engagement and experience of care improvements, coordinated, cross continuum care, and effective care management and follow-up on targeted conditions including depression, anxiety, and substance use disorders. This will be enabled through the optimization of screening and follow-up workflows, expansion of evidence-based treatment options, provider and staff training and engagement, building relationships among staff and providers across the system, and building community connections to support patient care.</p> <p>Collaborative care, an evidence based delivery model, has been shown to support the Triple Aim among patients with depression, the most prevalent mental disorder.^{39 40} The key elements of collaborative care models include: the use of a mental health registry, stepped care approach to depression management (i.e. intensifying treatments when needed), use of validated instruments (such as the Patient Health Questionnaire (PHQ-2 or PHQ-9) for depression, Generalized Anxiety Disorder scale (GAD-7) for anxiety, National Institute on Alcohol Abuse and Alcoholism single item screening tool (NIAAA-1), Alcohol Use Disorders Test (AUDIT), National Institute on Drug Abuse quick screen test (NIDA-1) and the Drug Abuse Screening Test (DAST), and regular caseload consultations by the psychiatrist and the behavioral care manager. Additional elements of integration include the co-location of behavioral health staff (such as therapists and psychiatrists) into primary care settings, meetings held by primary care and behavioral health team members to discuss cases, training of primary care and behavioral health staff on effective screening and collaborative care, and strategies to address substance use disorder (such as SBIRT) in primary care.⁴¹</p> <p>Collaborative care models, structured care involving a greater role of non-medical specialists to augment primary care and provide care management, have been shown to be more effective than standard care in improving depression outcomes in the short- and long-term.⁴² There is strong evidence supporting benefits of care management for depression.⁴³ Findings from more than 80 studies demonstrated that collaborative care increased adherence to evidence-based depression treatment by twofold and improved outcomes, including in low-income populations.⁴⁴ Studies have also revealed value in terms of cost-effectiveness, cost-benefit analysis, and improved patient satisfaction with care.⁴⁵ The Agency for Healthcare Research and Quality has found in their research that the integration of mental health/substance abuse and primary care has</p>	

³⁹Institute for Clinical and Economic Review. March, 2015. Integrating Behavioral Health into Primary Care.

⁴⁰Unützer J, Katon WJ, Williams JW, Callahan CM, Harpole L, Hunkeler EM, Hoffing M, Areán PA, Hegel MT, Schoenbaum M, Oishi SM, Langston CA. Improving primary care for depression in late life: the design of a multi-center randomized trial. *Medical Care*. 2001; 39:785-799.

⁴¹The Diamond Model is based on the Collaborative Care Model for depression by Wayne Katon, MD and the IMPACT Study by Jurgen Unutzer, MD as well as numerous other controlled trials from Institute for Clinical Systems Improvement and Minnesota Family Health Services presentation to the Institute for HealthCare Improvement Annual Forum, Dec 2010.

⁴²Gilbody S, Bower P, Fletcher J, Richards D, Sutton A. "Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes." *ARCH INTERN MED/VOL 166, NOV 27, 2006*

⁴³Williams J et.al. "Systematic review of multifaceted interventions to improve depression care." *General Hospital Psychiatry*, 29 (2007) 91–116.

⁴⁴Archer, Janine, et al. "Collaborative care for depression and anxiety problems." *The Cochrane Library* (2012).

⁴⁵Katon WJ. "Collaborative Depression Care Models: From Development to Dissemination." *American Journal of Preventive Medicine*, 012;42(5):550–552.

Initiative Title	1. Integration of Behavioral Health and Primary Care
	<p>achieved positive outcomes.⁴⁶ Furthermore, the Center for Integrated Health Solutions sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) include evidence-based practices in integrated primary care and behavioral health services to better address the needs of individuals with mental health and substance use concerns and that have demonstrated positive impacts, including on health care costs, for integration in many environments.⁴⁷</p> <p>Substance use and addiction are significant challenges for society and for public payer populations. Unidentified mental health and substance use treatment needs contribute to higher costs and poor health outcomes. Alcohol and substance use disorders are frequently co-occurring with other mental health and physical health conditions. A recent publication released by the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that in Massachusetts, only 53.8 % of adults with any mental illness (approximately 522,000 individuals per year in 2010-2014) actually received mental health treatment within the year prior to being surveyed, and only 7.5% of those with alcohol abuse or dependence received treatment in the prior year.⁴⁸ Furthermore, the national problem of death related to opioid use disorder and overdose is increasing year by year in Massachusetts.⁴⁹</p> <p>Utilization of necessary treatments has been shown to have a return on investment with impacts in health care and other public programs. According to the National Institute on Drug Abuse, for every dollar spent on addiction treatment programs there is an estimated \$4 to \$7 reduction in the criminal-justice-related costs and a \$12 reduction in costs if health-care costs are included.⁵⁰ Evidence-based approaches are available to support population health strategies and address such conditions in primary care. The United States Preventive Services Task Force has given a rating of ‘B’ to alcohol misuse screening for adults, indicating strong recommendation of this service and high certainty of moderate to substantial net benefit.⁵¹</p> <p>Over the past few years, efforts have been initiated to build a system for screening for high risk alcohol use and substance use disorder in primary care, and interventions as appropriate. With this initiative, future work may entail: a) increasing the percentage of the primary care patient population who receives these screenings; b) improving the quality of the interventions provided for those who screen ‘positive’; c) expanding the range of treatment offerings provided in primary care, and d) optimizing primary-care-based pain management offerings including alternatives to chronic opioid therapy, as providers increasingly optimize the use of opioid-based regimens for patient that require this modality of treatment.</p> <p>According to the American Academy of Pediatrics, behavioral and emotional problems during childhood are common, often undetected, and frequently untreated despite primary role in significant morbidity and mortality. According to current estimates, approximately 11% to 20%</p>

⁴⁶Agency for Healthcare Research and Quality website: <http://www.ahrq.gov/research/findings/evidence-based-reports/mhsapctp.html>

Integration of Mental Health/Substance Abuse and Primary Care, Structured Abstract. October 2008. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/mhsapctp.htm>

⁴⁷Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Integrated Health Solutions research: http://www.integration.samhsa.gov/about-us/CIHS_NACHC_BH_Integration_September_19_2013_FINAL.pdf

⁴⁸Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Massachusetts, 2015*. HHS Publication No. SMA-16-BARO-2015-MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

⁴⁹<http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf>

⁵⁰<https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment>

⁵¹<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>

Initiative Title	1. Integration of Behavioral Health and Primary Care
	<p>of children in the United States have a behavioral or emotional disorder at any given time.^{52 53} Estimated prevalence rates are similar in young 2- to 5-year-old children. Developmental and behavioral health disorders are now the top 5 chronic pediatric conditions causing functional impairment.^{54 55 56} The American Academy of Pediatrics (AAP) urges clinicians to screen for developmental and behavioral problems at all health supervision visits using quality tools.⁵⁷ Indeed, population health starts with population screening.</p> <p>Children and adolescents comprise a significant portion of the patient panel or public providers and Medicaid populations. Primary care providers caring for children and adolescents in the Commonwealth are required to use routine screening for developmental, behavioral and mental health disorders and the evidence and practice standards around screening in this population have evolved significantly in recent years. As such, there is an opportunity to update routine, comprehensive screening for behavioral and developmental conditions in the child and adolescent population, using validated screening instruments such as the Survey of Wellbeing of Young Children (SWYC) for developmental screening, the Pediatric Symptom Checklist (PSC) and PHQ-9 for depression, and CRAFFT (mnemonic acronym of first letters of key words in the six screening questions) short clinical assessment tool for substance related risks and problems, and to develop the associated registries and analyze utilization patterns and service gaps. In addition, the identification and deployment of key, evidence-based interventions intended to have a beneficial impact on the behavioral and developmental outcomes in the patient population of children and adolescents. In conjunction with implementation of the CRAFFT instrument for alcohol and substance use among adolescents, primary care providers will optimize follow-up workflows according to the evidence base for SBIRT among adolescents.⁵⁸</p>
Goals/Objectives	<p>Goals include leveraging the foundation for primary care-behavioral health (BH) integration to advance integrated approach for adults and pediatrics to improve key intermediate and outcomes measures for high-prevalence BH conditions (e.g. depression, anxiety, alcohol and substance use disorder (SUD)). Additional goals include optimizing primary care based treatment for pain and opioid addiction. Furthermore, aims include cardiovascular, metabolic, and diabetes monitoring for patients on antipsychotic medications, and cross-disciplinary care coordination improvements for mental illness.</p> <p>Specific objectives include:</p> <ul style="list-style-type: none"> • Increase screening and follow-up for high prevalence behavioral health conditions (depression, anxiety, SUD) among adults, adolescents and pediatric patients.

⁵²Costello EJ, Mustillo S, Erkanli A, Keeler G, Angold A. Prevalence and development of psychiatric disorders in childhood and adolescence. *Arch Gen Psychiatry*. 2003;60(8):837–844

⁵³*Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

⁵⁴Slomski, A. Chronic Mental Health Issues in Children Now Loom Larger Than Physical Problems *JAMA*. 2012;308(3):223-225.

⁵⁵Halfon N, Houtrow A, Larson K, Newacheck PW. The changing landscape of disability in childhood. *Future Child*. 2012;22(1):13–42

⁵⁶Promoting Optimal Development: Screening for Behavioral and Emotional Problems. Carol Weitzman, Lynn Wegner, the Section on Developmental and Behavioral Pediatrics, Committee on Psychosocial Aspects of Child and Family Health, Council on Early Childhood and Society for Developmental and Behavioral Pediatrics. *Pediatrics* Feb 2015, 135 (2) 384-395.

⁵⁷Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, Medical Home Initiatives for Children With Special Needs Project Advisory Committee *Pediatrics* Jul 2006, 118 (1) 405-420.

⁵⁸Massachusetts Department of Public Health Bureau of Substance Abuse Services. Provider Guide: Adolescent Screening, Brief Intervention, and Referral to Treatment Using the CRAFFT Screening Tool. Boston, MA. Massachusetts Department of Public Health, 2009.

Initiative Title	1. Integration of Behavioral Health and Primary Care
<ul style="list-style-type: none"> • Improve depression response and remission. • Improve rates of screening, intervention, engagement for drug and alcohol use disorder • Improve training and competency among relevant providers. • Improve provider satisfaction and confidence in diagnosing and managing key conditions. • Improve management of opioid prescribing, as a means for preventing opioid dependence and promoting alternative treatments for chronic pain management. • Improve management and expand options for treatment of pain. • Improved collaboration related to the care continuum for mental health and substance use, including cardiovascular risk optimization for persons on antipsychotic medications • Improve transitions in care. • Ongoing evaluation of evidence-base supporting the expansion of treatment options for behavioral health and pain management in primary care. 	
Core Components	
<p>This initiative, if undertaken, may include the following components:</p> <ol style="list-style-type: none"> 1. Improve screening, treatment, and outcomes for depression and anxiety <ul style="list-style-type: none"> • Build upon overall adult wellbeing screening using validated instruments including the PHQ-9, GAD-7, NIAAA-1, NIDA-1, AUDIT and DAST • Evaluate local and national protocols for suicide risk assessment and management; design and implement appropriate local practices. • Improve referral management across the care continuum according to the Stepped Model of Care, including ongoing assessment of patient severity and type seen by integrated behavioral health staff and those referred to specialty mental health. Work to formalize tools to manage capacity and prioritization of patients as appropriate. • Promote patient engagement in care by expanding access to initiatives such as mindfulness-based stress reduction groups, self-help mobile technology, and peer-support groups. • Monitor and continuously improve primary care and behavioral health staff confidence in managing appropriate behavioral health conditions, satisfaction and skills with Primary Care Behavioral Health Integration. • Optimize care for moderate and severe mood disorder patients in primary care (i.e. those who require specialty mental health care for conditions like bi-polar and schizoaffective disorders, but do not connect there) • Improve rates of screening/follow-up/improvement /remission in depression/anxiety 2. Optimize primary care screening, diagnosis, and treatment for substance use disorders (SUD) <ul style="list-style-type: none"> • Enhance offerings for patients with substance use disorders in primary care (e.g. medication treatment for severe alcohol use disorder). Medication-assisted treatment (MAT) in combination with counseling and behavioral therapies can provide a whole-person approach to treatment of substance use disorders. <ul style="list-style-type: none"> • Expand offerings in groups in primary care setting (peer support or staff-facilitated) • Enhanced training for primary care providers • Expand use of medication-assisted treatment (MAT) for opioid use disorders in primary care, including buprenorphine and naltrexone, which are medications currently approved by the Food and Drug Administration for the treatment of opioid dependence through medication-assisted treatment. Naltrexone may also be used in the treatment of alcohol use disorders.⁵⁹ 	

⁵⁹ <http://www.samhsa.gov/medication-assisted-treatment>

Initiative Title	1. Integration of Behavioral Health and Primary Care
	<ul style="list-style-type: none"> • Conduct ongoing program evaluation and adaptation of protocols for Screening, Brief Intervention and Referral to Treatment (SBIRT) for treatment of less-severe disorders in primary care • Improve communication and shared decision-making among staff at points of transition in care, including inpatient/outpatient. • Develop peer support programming for SUD. <p>3. Develop programming for chronic pain management in primary care</p> <ul style="list-style-type: none"> • Explore alternatives to chronic opioid therapy for pain management as warranted • Evaluate evidence base, payor coverage, landscape of local services, feasibility, and patient needs for chronic pain management services (including psychotherapy, mindfulness, acupuncture, biofeedback, and tai chi / yoga) • Build and expand group- and individual-based Cognitive Behavioral Therapy and mindfulness treatment strategies, based on above-mentioned evaluation (including through training of integrated mental health staff) • Develop expedited referral pathways to physical therapy to support effective chronic pain management. • Establish a system-wide provider-to-provider peer committee for review of challenging cases • Create a registry for chronic opioid and other high-risk prescriptions and develop a system for reviewing and optimizing care • Ensure screening and monitoring of chronic pain co-morbidities. <p>4. Screen and follow-up for high prevalence BH conditions for children and adolescents</p> <ul style="list-style-type: none"> • Ensure routine behavioral health screening for the child and adolescent population using validated screeners, such as the SWYC, PSC, and CRAFFT, that comply with Massachusetts legal requirements and support the most current clinical practice guidelines. • Standardize screening for developmental and behavioral health conditions, including depression and substance use. • Incorporate routine screening for post-partum depression into pediatric primary care visits. • Develop and deploy registries to facilitate and track appropriate referrals and care. • Introduce SBIRT for adolescents with or at risk for substance use disorders • Assess and analyze gaps in services and care for other childhood behavioral and developmental conditions, and improve care as warranted. • Improve referral management across the care continuum, including ongoing assessment of patient severity and type seen by integrated behavioral health staff and those referred to specialty mental health. Work to formalize tools to manage capacity and prioritization of patients as appropriate.

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).</i>										
Measure Slate 1		1: Behavioral Health and Primary Care Integration			Achieve 2 of 4 Measures	Achieve 4 of 11 Measures	Achieve 5 of 11 Measures	Achieve 6 of 11 Measures	Achieve 7 of 11 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Depression Response at 6 Months - Progress Towards Remission (across all core primary care sites)	NQF 1884	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	This target is based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved ⁶⁰ .
2	Depression Response at 12 Months - Progress Towards Remission (across all core primary care sites)	NQF 1885	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	This target is, based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved ⁶¹ .
3	Primary Care Provider confidence in management of depression, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 90%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on evidence-based depression programming in primary care.
4	Primary Care Provider confidence in management of substance use disorders, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 70%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on newness of initiative introducing universal screening for substance use disorders in primary care and care management initiatives.

⁶⁰Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

⁶¹Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

Required Measure Slate: Improvement and Outcomes Measures (Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).										
Measure Slate 1		1: Behavioral Health and Primary Care Integration			Achieve 2 of 4 Measures	Achieve 4 of 11 Measures	Achieve 5 of 11 Measures	Achieve 6 of 11 Measures	Achieve 7 of 11 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
5	Screening and Brief Intervention for Alcohol Use for adults (across all core primary care sites)	NQF 2152	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target based on literature review of best practice performance levels. ⁶²
6	Screening and Brief Intervention for Drug Use for adults (across all core primary care sites)	NQF 2152, adapted to include substance use	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Same as above.
7	Patients on Chronic Opioid Therapy with a Controlled Substance Agreement (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target aligned to initiative to optimize opioid prescribing practice.
8	Patients on Chronic Opioid Therapy with urine drug screening (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target aligned to initiative to optimize opioid prescribing practice.
9	Patients with chronic pain who had functional assessment (across all core primary care sites)	NQF 0050, adapted to include all chronic pain conditions	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on newness of initiative, and literature indicating the value of functional assessment in patients with chronic pain ⁶³ .

⁶²Bertholet N, Daeppen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of Alcohol Consumption by Brief Alcohol Intervention in Primary Care. Archives of Internal Medicine. 2005;165:986-995; Babor TF, Higgins-Biddle JC, Dauser D, Burleson JA, Zarkin GA, Bray J. Brief Interventions for At-Risk Drinking: Patient Outcomes and Cost-Effectiveness in Managed Care Organizations. Alcohol and Alcoholism. 2006;41(6):624-631.

⁶³Institute for Clinical Systems Improvement, Assessment and Management of Chronic Pain 2013

Required Measure Slate: Improvement and Outcomes Measures (Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).										
Measure Slate 1		1: Behavioral Health and Primary Care Integration			Achieve 2 of 4 Measures	Achieve 4 of 11 Measures	Achieve 5 of 11 Measures	Achieve 6 of 11 Measures	Achieve 7 of 11 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
10	Screening and Brief Intervention for Alcohol and Drug Use for adolescents (across all core primary care sites)	NQF 2152, adapted to expand to new age range for adolescents	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Expansion of measure to the adolescent patient population. Improvement target based on newness of initiative for adolescent patients.
11	Maternal Depression Screening (across all core primary care sites)	NQF 1401	No external benchmark; hospital specific improvement target = 75%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on literature indicating value of maternal depression screening in conjunction pediatric visits to identify developmental risk factors. ⁶⁴

⁶⁴Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions
Description/Rationale	
<p>Poor access to appropriate levels of care is a leading barrier to recovery for individuals with mental health and substance use (MHSU) conditions.⁶⁵ A comprehensive system for MHSU treatment – offering the right care to the right people at the right time – requires a wide range of services and delivery methods to meet the unique needs of individuals and families. Among others, these services include outpatient counseling (including primary care integration), intermediate care (intensive outpatient, partial hospital), residential and inpatient facilities, support for care transitions, and triage and emergency services. A robust continuum of care helps people access services when they need and want them, improving patient experience and the value of care (quality/cost).</p> <p>A comprehensive treatment system allows individuals and their providers to develop an optimal care plan most likely to help them stay connected to their communities and succeed in daily activities, such as work or school. This, in turn, promotes greater engagement of family and community supports, ensuring that more resources are in place to support one’s recovery. Individuals who do receive appropriate treatment early in their onset of illness may require less intensive care, experience fewer relapses,⁶⁶ and have better long-term health outcomes.⁶⁷ New programs offering integrated, person-centered MHSU care show promising results – greater use of community-based outpatient care, fewer hospital and emergency department (ED) admissions, better health outcomes⁶⁸⁻⁶⁹ – and offer hope for developing more effective, sustainable care models.</p> <p>However, left untreated, behavioral health disorders and co-occurring health conditions have harmful economic, interpersonal, and social impacts for the population as a whole.⁷⁰ This troubling impact is most evident in the 20 to 30 year gap in life expectancy among people living with serious mental illnesses (SMI).⁷¹⁻⁷² This disparity is driven largely by higher rates of chronic disease (e.g. diabetes, hypertension, hyperlipidemia, and obesity), delayed diagnosis and treatment of medical conditions,⁷³ fragmented delivery of inadequate care,</p>	

⁶⁵American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>.

⁶⁶Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. *Managing Managed Care: Quality Improvement in Behavioral Health*. Washington (DC): National Academies Press (US); 1997. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK233235/>

⁶⁷Kane JM, Robinson DG, Schooler NR, et al. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry AJP*. 2016;173(4):362-372. doi:10.1176/appi.ajp.2015.15050632.

⁶⁸Krupski A, West II, Scharf DM, et al. Integrating Primary Care Into Community Mental Health Centers: Impact on Utilization and Costs of Health Care. *PS Psychiatric Services*. 2016. doi:10.1176/appi.ps.201500424.

⁶⁹Gilmer TP, Henwood BF, Goode M, Sarkin AJ, Innes-Gomberg D. Implementation of Integrated Health Homes and Health Outcomes for Persons With Serious Mental Illness in Los Angeles County. *PS Psychiatric Services*. 2016. doi:10.1176/appi.ps.201500092.

⁷⁰American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>.

⁷¹Druss BG, Zhao L, Esenwein SV, Morrato EH, Marcus SC. Understanding Excess Mortality in Persons With Mental Illness: 17-year Follow Up of a Nationally Representative US Survey. *Medical Care*. 2011;49(6):599-604. doi:10.1097/mlr.0b013e31820bf86e.

⁷²Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*. 2006;3(2):1-14.

⁷³Nasrallah HA, Meyer JM, Goff DC, et al. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: Data from the CATIE schizophrenia trial sample at baseline. *Schizophrenia Research*. 2006;86(1-3):15-22. doi:10.1016/j.schres.2006.06.026.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions
<p>medication side effects,⁷⁴ and higher rates of modifiable risk factors⁷⁵ – all of which are more common among people with SMI and/or substance use disorders (SUD).</p> <p>Based on data from 2010 to 2014, on average 4.2 percent of Massachusetts residents are living with SMI and 10 percent have a SUD,⁷⁶ and the majority of state residents who need MHSU services do not receive any. Among adult residents with any mental illness, about 46 percent receive no care each year; for SUD, the figure is closer to 90 percent.⁷⁷ Even for those who do access care, not all treatment is appropriate or sufficient. Among adults who access mental health care, 30 percent still report unmet needs, and more than one-third of those treated in the state’s public mental health system say it has not improved their functioning.⁷⁸</p> <p>Massachusetts’ MHSU service gaps are due in part to shortages across the entire care continuum, from outpatient care to emergency services, inpatient beds, partial hospital programs, crisis stabilization units, detoxification, residential programs, and so on. This can result in sub-optimal wait times for outpatient therapy; extended hospitalizations due to lack of community-based services; and “boarding” in emergency departments (ED) as people await transfer to intermediate or acute care. These access issues can be more pronounced for MassHealth enrollees because many providers do not contract with Medicaid to serve its members. Massachusetts now faces an opioid use epidemic that has doubled the rate of overdose deaths from 2012 to 2015.⁷⁹ The problem and need for care is growing exponentially. Improving access to opioid treatment will require expanding capacity for Medication-Assisted Treatment (MAT) and providing more timely access to comprehensive evidence-based outpatient care for SUD.</p> <p>A substantial portion of the public care system for individuals with the most disabling conditions extends beyond health care services to rehabilitative and support services, including housing, job counseling, literacy, and other programs. The coordination of these services requires collaborative and cooperative relationships among many agencies, service providers, and community organizations. Most of these services are not covered by private insurance and have not been developed by most private behavioral health care companies. Poor linkage and fractured funding impedes the ability to provide access to these services in a coordinated and integrated way.⁸⁰ One strategy that may be employed to address this barrier to care is formalization of agreements between healthcare providers and community-based providers who offer complementary services, and providing integrated population case management.</p> <p>Along with improving access to MHSU treatment and reliable coordination among all service providers, a focus on health promotion is essential to impact health outcomes for this population. A national study</p>	

⁷⁴Meyer JM, Davis VG, Goff DC, et al. Change in metabolic syndrome parameters with antipsychotic treatment in the CATIE Schizophrenia Trial: Prospective data from phase 1. *Schizophrenia Research*. 2008;101(1-3):273-286. doi:10.1016/j.schres.2007.12.487.

⁷⁵SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008-2010.

⁷⁶Substance Abuse and Mental Health Services Administration (SAMHSA). Behavioral Health Barometer: Massachusetts, 2015. HHS Publication No. SMA-16-Baro-2015-MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

⁷⁷Massachusetts Department of Public Health. State Health Plan: Behavioral Health, Dec 2014. Available at: <http://www.mass.gov/eohhs/docs/dph/health-planning/hpc/deliverable/behavioral-health-state-health-plan.pdf>.

⁷⁸Colton CW, Manderscheid, RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease*. 2006;3(2):1-14.

⁷⁹Massachusetts Department of Public Health. Data Brief: Opioid-related Overdose Deaths Among Massachusetts Residents. May 2016. Available at: <http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/county-level-pmp/data-brief-overdose-deaths-may-2016.pdf>.

⁸⁰Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. *Managing Managed Care: Quality Improvement in Behavioral Health*. Washington (DC): National Academies Press (US); 1997. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK233235/>

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions
<p>estimated 85 percent of the life expectancy gap for people living with schizophrenia was attributable to “natural” causes, such as cardiovascular disease, cancers, pneumonia, diabetes, and so on.⁸¹ Early screening and intervention for these medical conditions is essential to improving health outcomes. This is particularly true for patients taking antipsychotic medications that increase the risk for certain medical conditions, most notably metabolic syndrome. While these diseases can develop for numerous reasons, modifiable factors such as smoking, diet, physical activity, substance use, and social needs are key drivers. Promoting healthy living through education, skills training, and behavioral therapy will be necessary to improve population health. Certain interventions have improved health outcomes among people with psychotic disorders.⁸²⁻⁸³</p> <p>Improving access to MHSU care overall requires attention to all aspects of the care continuum, from the professional care provided by trained clinicians to self care and social support. Expansion of services in those areas of the continuum that are most lacking, particularly in the intermediate levels of care that provide step-down and diversionary services, will assist with shifting care away from more intensive levels and providing patients with care at the appropriate level of service. Providers must also consider adopting treatment modalities that can improve efficiency and create capacity within existing services, such as shorter term evidence-based treatments and technology-based services, such as telemedicine consultations. Patient care teams may be redefined to include all who work with the patient, including clinicians, paraprofessionals, peer specialists/coaches, community-based providers, social support providers, etc., with the patient at the center of the team.</p>	
Goals/Objectives	
<p>The ultimate goal of this project is to achieve Triple Aim results – improved population health, better experience of care, and lower costs – and deliver higher-value care for people with serious mental illness and/or substance use disorders. To pursue the Triple Aim for this vulnerable population, the initiative aims to:</p> <ul style="list-style-type: none"> • Improve access (proximity and timeliness) to specialty MHSU care; • Provide access to outpatient appointments within 7 days for patients discharged from inpatient psychiatry units and within 14 days for non-urgent MHSU referrals; • Expand capacity for Medication-Assisted Treatment (MAT) for patients with SUD; • Increase utilization of routine primary care and outpatient behavioral health services; • Increase utilization of alternatives to traditional care, including tele-medicine consultations; • Implement population health management initiatives that support integrated specialty behavioral health and physical health and improved patient outcomes; • Improve the population’s metabolic and cardiovascular health, both modifiable causes of premature death; • Provide key screening and intervention activities for hospitalized patients; • Improve the experience of care among people using specialty MHSU treatment services; • Improve reliable communication and coordination among entire care teams across different levels of care, including primary care/medicine, behavioral health, medical specialty, and community-based service providers; • Increase utilization of patient-informed plans of care; 	

⁸¹Kane JM, Robinson DG, Schooler NR, et al. Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry AJP*. 2016;173(4):362-372. doi:10.1176/appi.ajp.2015.15050632.

⁸²Bartels S, Desilets R. Health Promotion Programs for People with Serious Mental Illness (Prepared by the Dartmouth Health Promotion Research Team). Washington, DC. SAMHSA-HRSA Center for Integrated Health Solutions. Jan 2012.

⁸³Bruins J, Jörg F, Bruggeman R, Slooff C, Corpeleijn E, Pijnenborg M. The Effects of Lifestyle Interventions on (Long-Term) Weight Management, Cardiometabolic Risk and Depressive Symptoms in People with Psychotic Disorders: A Meta-Analysis. *PLoS ONE*. 2014;9(12). doi:10.1371/journal.pone.0112276.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions
<ul style="list-style-type: none"> • Reduce utilization of avoidable emergency department visits for adults with serious mental illness (target population of high acute care and/or emergency services utilization); • Provide alternatives to higher cost services for this particularly high-cost Medicaid sub-population.⁸⁴ 	
Core Components	
<p><i>This initiative, if undertaken, may include the following components:</i></p> <p>Health promotion and chronic disease management for populations with mental health and substance use (MHSU) disorders</p> <ul style="list-style-type: none"> • Identify evidence-based practices for development and implementation of metabolic and cardiovascular screening protocols for people prescribed antipsychotic medications. • Reliably screen for frequent co-morbid diseases that are key drivers of premature mortality: diabetes, hyperlipidemia, hypertension, obesity, etc. • Offer health promotion activities, such as behavioral activation strategies for healthy eating, exercise, weight management. • Develop processes to screen for social service needs and develop follow-up plan. • Perform screening, brief intervention, and referral to treatment for tobacco cessation. • Reliable medication management and reconciliation across multiple providers. • Evaluation and screening for use of long-acting antipsychotics for people for serious mental illness. • Screen patients hospitalized on inpatient psychiatry units for unhealthy alcohol use, and initiate treatment if indicated by providing brief intervention during the patient’s hospitalization. • Improve screening for medical conditions for patients on inpatient psychiatry units, with special attention to metabolic disorders and other medical conditions that may result from use of psychiatric medications. <p>Promote timely access to ambulatory MHSU treatment through greater variety and efficiency of services</p> <ul style="list-style-type: none"> • Distribute ambulatory MHSU services across service area based on panel size and local needs. • Expand capacity for more evidence-based group treatment modalities, such as Problem Solving Therapy, Cognitive Behavioral Therapy, Internal Family Systems Therapy, neurobiofeedback, etc. • Increase capacity for Medication-Assisted Treatment (MAT) for opioid use disorder among primary care and specialty BH providers, and improve access to MAT for patients with opioid use disorder. • Partner (informally or contractually) with community-based providers of social and health services to reliably link patients to local supports. • Greater adoption of tele-medicine technology for specialty mental health and addiction care in order to provide ready access to psychiatric consultation for medical service providers, other community-based providers, and/or direct consultation with patients. • Enhance administrative systems to increase provider productivity by reducing unused appointments. • Expand resources for case management and service coordination so all providers can work to the top of their license. • Integrate paraprofessional service providers and peer specialists/recovery coaches into existing clinical teams. <p>Fill service gaps with greater variety and volume of intermediate and ambulatory MHSU care options</p> <ul style="list-style-type: none"> • Increase access and decrease wait times for patients in need of ambulatory services through development of assessment service. • Improve access to Partial Hospital Programs (PHP) and Intensive Outpatient Programs (IOP) as part of the continuum to provide appropriate treatment and decrease utilization of high intensity inpatient care. 	

⁸⁴Buck JA, Teich JL, Miller K. Use of mental health and substance abuse services among high-cost Medicaid enrollees. *Administration and Policy in Mental Health*. Sep 2003;31(1):3-14. PMID: 14650645.

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions
<ul style="list-style-type: none"> • Provide greater access to more immediate outpatient care through a transition or bridge service that serves as a holding place for patients transitioning through different levels of care, and/or patients who have a longer wait for an appointment with an outpatient provider. • Explore ways to expand the continuum of care for substance use, which may include adding new capacity for inpatient detoxification and residential services through partnerships. • Expand MHSU services in geographic areas with limited capacity. • Improve access to timely post-discharge follow-up appointments for patients discharged from inpatient psychiatry via direct access to transition service, PHP and IOP. <p>Comprehensive coordination and management of care for populations</p> <ul style="list-style-type: none"> • Use risk stratification approaches to identify high-risk cases and/or frequent service users. • Provide access to intensive case management for individuals identified as having greater risk/cost, such as patients with SMI who are high utilizers of acute care and ED services. • Develop centralized preventative management capabilities for patients with opioid use disorder, which may include electronic registry functionality to facilitate management and coordination of care. • Enhance patient outreach, either through the use of paraprofessionals or through partnership with community-based providers. • Promote use of a central, integrated care plan in EMR shared by primary care and specialty providers. • Implement an integrated approach to coordinate both the primary care and behavioral health needs for patient populations with SMI and SUD. • Develop systems for providing comprehensive transitional care. • Proactively monitor the quality of care and outcomes experienced by MHSU patients. • Develop systems to facilitate transitions of care for patients discharged from inpatient psychiatry units through the development of a transition record with clinically important information that is given to the patient upon discharge. <p>Develop new EMR functionality and IT tools that enable coordinated management of population health</p> <ul style="list-style-type: none"> • Create patient registries in the electronic medical record (EMR) for discrete MHSU subpopulations to support delivery of best practice. • Implement real-time electronic alerts for acute care admissions, discharges, or transfers. • Build discharge follow-up reports (for ED and inpatient discharges) within EMR for target subpopulations. • Educate and train providers to improve adoption of EMR functionality and other IT tools that support efficient documentation, care coordination, care transitions, and population management. <p>Promote greater patient engagement and self-management of their health needs</p> <ul style="list-style-type: none"> • Support patients in developing skills to effectively collaborate in care planning with their providers. • Foster integrated approaches to chronic illness care. • Address self-management challenges posed by behavioral health conditions. • Educate patients about wellness recovery, maintenance, and crisis prevention/recovery planning using evidence-based practices. • Integrate peer specialists/recovery coaches into discharge planning process and overall care delivery system. • Support development of a robust peer recovery community and facilitate the process of connecting patients with MHSU conditions to these services. • Develop and implement mechanisms to obtain ongoing patient and/or family satisfaction and feedback. 	

Initiative Title	2. Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions
<ul style="list-style-type: none"> • Continue to assess patient, family, community, and provider needs to address ongoing gaps in the MHSU continuum of care. • Evaluate ED and readmission utilization to identify candidates for specialized consultation in integrated care planning. • Establish relationships with home health and/or other community-based providers to provide home-based education, monitoring, and self-care support for patients with significant barriers to care. <p>Reliably connect patients and families to necessary health resources and services in community</p> <ul style="list-style-type: none"> • Screen for social determinants of health conditions. • Promote strategies for addressing social determinants of health in care planning. • Develop collaborative referral relationships with appropriate community-based services. • Evaluate progress in addressing social determinants of health in the population served. • Collaborate with community-based partners to reduce the impact of social factors on health outcomes. • Integrate community-based providers into care team meetings and discharge planning for hospitalized patients. <p>Develop a clinical workforce that successfully integrates medical and behavioral health care</p> <ul style="list-style-type: none"> • Provide training and education in strategies that address the unique self-management challenges posed by co-morbid physical and behavioral health conditions. • Provide team-based consultation designed to improve clinical skills and treatment plans for individuals with such co-morbid conditions. • Provide education in behavioral medicine for providers across the care delivery system. • Align competency assessment with goals for improving clinical outcomes for population served. • Provide training for the next generation of clinicians and providers that incorporates strategies for integrating medical and behavioral health care. 	

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 2		2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions			Achieve 2 of 5 Measures	Achieve 5 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Controlling high blood pressure for people with serious mental illness (for BH Home population)	NQF 2602	MA Medicaid (HEDIS) 2015 75 th percentile: 65.09% (proxy benchmark from NQF 0018 for overall population)	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Using related benchmark for NQF 0018 for overall population.
2	Proportion of patients with identified opioid use disorder accessing medication-assisted treatment (MAT)	N/A	No external benchmark; Hospital target = 50.00%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target of 50% informed by experience with patient engagement in opioid treatment
3	Hospitalized patients screened within 72 hours of admission using a validated screening tool for unhealthy alcohol use (all public hospital system inpatient psychiatric discharges, age 18 and above)	NQF 1661 SUB-1	Joint Commission (2014) 75 th percentile = 94.20%	Gap to Goal (10%) or attainment at target	O (CY2017)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	Using Joint Commission benchmark for SUB-1
4	Alcohol use brief intervention provided or offered (during public hospital system psychiatric hospitalization, age 18 and above)	NQF 1663 SUB-2	Joint Commission (2014) average = 48.20%	Gap to Goal (10%) or attainment at target	B (CY2017)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	New measure as of 1/1/16; using related benchmark for NQF 1663, which is a similar measure for all inpatient admissions
5	Follow-up after hospitalization for mental illness (for BH Home population) – 7 days for public hospital system hospitalizations	NQF 0576 (7-day)	National (HEDIS) Medicaid 2015 90 th percentile = 63.85%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 2		2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions			Achieve 2 of 5 Measures	Achieve 5 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
6	Transition record with specified elements received by discharged patients (for public hospital system psychiatric hospitalizations)	NQF 0647	MA IPFQR-HBIPS 2014 average = 83.27%	Gap to Goal (10%) or attainment at target	B (CY2017)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	New IPFQR measure to be implemented 1/1/17; using related measure for NQF 0557, which is HBIPS-6 for creation of the transition continuing care plan
7	Access to public hospital system ambulatory mental health care: Scheduled intakes within 14 days of referral (for in-network referrals)	N/A	National Medicaid (HEDIS) 2015 90th percentile = 48.10%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Using proxy benchmark derived from National Medicaid (HEDIS) Initiation and Engagement of AOD treatment (initiation component only), NQF 0004.
8	Increase number of synchronous and asynchronous tele-consultations with psychiatrists	N/A	No external benchmark; Hospital target = 400 per year	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target informed by roll-out and expansion of tele-psychiatry
9	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications (for active primary care patients and BH home patients)	NQF 1932	MA Medicaid (HEDIS) 2015 90th percentile = 86.96%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	
10	Cardiovascular health screening for people with Schizophrenia or Bipolar Disorder who are prescribed antipsychotic medications (for active primary care patients and BH home patients)	NQF 1927	No external benchmark; hospital-specific target = 75.00%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target informed by experience with screening measures for other populations

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 2		2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions			Achieve 2 of 5 Measures	Achieve 5 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
11	Diabetes Monitoring for People with Diabetes and Schizophrenia (for active primary care patients and BH home patients)	NQF 1934	National (HEDIS) Medicaid 2014 90th percentile = 76.67%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	
12	Screening for metabolic disorders (psychiatric inpatient discharges on routinely-scheduled antipsychotic screened during/before stay)	CMS IPFQR	No external benchmark	Improvement over CY 2017 baseline	B (CY2017)	O (CY2018) 2% increase over CY2017	O (CY2019) 5% increase over CY2017	O (CY2020) 8% increase over CY2017	O (CY2021) 10% increase over CY2017	No existing benchmark; CMSIPFQR measure to be implemented 1/1/17
13	Increase the percentage of BH Home target population patients who have a care plan (care plans may include CHA coordinated care plan and/or ACO behavioral health community partner care plan)	NCQA Medical Home	NCQA 2014 Medical Home Standard = 75.00%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 75% is 2014 NCQA Medical Home standard.

Initiative Title	3. Referral Management and Integrated Care Management
Description/Rationale	
<p>Toward the goals of better health and optimal, more coordinated and cost-effective care, this suite of initiatives is aimed at increasing patient access to high-quality care, promote appropriate referrals and access (i.e. the right provider in the right setting) based on the complexity of the patient’s needs. Providing integrated care across the continuum of care through effective referral management and care coordination is foundational to the accountable care model and alternative payment arrangements with quality, cost and health care utilization accountability. This is particularly important for Medicaid and other vulnerable patient populations that often face barriers to care and care fragmentation.</p> <p>This initiative builds and supports systems to maintain a preferred, high value network and simultaneously provide highly coordinated and quality care. This initiative aims to accomplish this in four ways: focus on public hospital system access and effective operational improvements in primary care and specialties, encourage public hospital referrals and the use of care within the public hospital system and with clearly defined high value preferred provider networks enabled to coordinate care, build relationships with key community-based partners such as visiting nurse associations (VNAs), skilled nursing facilities (SNFs), and detoxification facilities, and leverage proven technology to improve access and convenience for the patient panel to specialty opinions and care. The Massachusetts Office of the Attorney General’s report published in September, 2015 found wide variation in the prices health insurance companies pay providers for similar services, unexplained by differences in quality, complexity of services, or other common measures of consumer value. The report found that higher priced providers are drawing patient volume from lower priced providers, which increases costs as care is shifted from less costly community settings to higher relative price settings.⁸⁵ To address this, payers and employers in Massachusetts have embraced referral networks comprised of high value providers as an opportunity to address costs. Initial analysis of this strategy based on state experience within a Massachusetts state employees plan has shown up to a 36% reduction in expenditures for patient panels that switch to a narrow network insurance plan.⁸⁶</p> <p>Encouraging a preferred and narrow network requires multidisciplinary leadership, systems and collaboration in primary care, medical and surgical specialties, behavioral health and the emergency department. Providers and patients need to feel confident that the choice in care is patient-centered and high-quality. Integration and clinical teams will work to develop relationships and business arrangements to align the value-based interests of non-traditional caregivers often critical during care transitions such as VNAs and SNFs. This initiative will expand the capacity of the public hospital’s medical, surgical and behavioral health specialists to coordinate and manage referrals internally, including redirected referrals from higher cost, lower-value external referrals. Toward this end, this initiative will focus on monitoring and improving the rate of referrals within the public hospital system and with in-network clinical affiliates, and measures of quality, productivity and access to specialists.</p> <p>In addition, this initiative will refine emergency department (ED) and inpatient case management capabilities to offer alternative treatment modalities and community-based care to patients who do not need admission. This initiative will expand e-consults beyond tele-dermatology based on success and evidence from both the public hospital and other systems in order to increase access to consultations with specialists, reduce cost and enable more capacity for face-to-face visits</p>	

⁸⁵Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12, § 11N Report for Annual Public Hearing Under G.L. c. 6D, § 8

⁸⁶Gruber J, & McKnight R. (2014). Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees.” NBER working paper #20462.

Initiative Title	3. Referral Management and Integrated Care Management
<p>when appropriate.⁸⁷ This initiative may also focus on facilitating transportation to in-network care providers for patients who lack transportation by utilizing a non-medical transportation support service. Convenience and effectiveness also drives efforts to examine and take advantage of text-messaging in care management. Evidence for the potential of text messages providing improvements in disease prevention and management interventions have been observed for weight loss, smoking cessation, and diabetes management. These effects appeared to exist among adolescents and adults, among minority and non-minority populations, and across nationalities.⁸⁸</p>	
Goals/Objectives	
<p>This initiative will use referral and outmigration processes to drive high value, coordinated care for patients and advance Accountable Care Organization (ACO), total cost of care strategies, and increased retention of appropriate care within the public hospital system.</p> <ul style="list-style-type: none"> • Improve patient care coordination, continuity of care, and referral to services within a high value, clinically integrated network with emphasis on the public hospital system, other community-based services, and with clinical affiliates. • Increase access and efficiency of the public hospital system’s clinical services by retaining services when appropriate. • Reduce out-migration of inpatient and ED services for patient panel to non-public hospital facilities, where appropriate. Preliminary analysis of Medicaid inpatient stays and ED utilization outside the public hospital system confirms the opportunity to improve performance through care coordination within integrated community networks. Data reveals that a significant portion of inpatient care (up to 60%) and ED visits (up to 30%) across various payor cohorts occur outside of the system, frequently at higher-cost institutions, which add cost and care fragmentation. • Support the delivery of care by the right provider, in the right care setting and at the right time by reducing care received outside of the public hospital system when clinically indicated and increasing access to specialty health care and other community-based services outside of the acute care setting. • Promote alternate care modalities, as clinically appropriate, as options in lieu of avoidable emergency department and/or inpatient care. • Launch innovations, such as e-consults, patient care communications/messaging, and patient transportation options to overcome barriers to access to ambulatory care and promote patient self-management of their health conditions. • Encourage in-depth clinical collaborations and the use of defined provider partnerships, including VNAs, SNFs, and substance use treatment. • Advance total cost of care strategies. 	

⁸⁷Utilization, Benefits, and Impact of an e-Consultation Service Across Diverse Specialties and Primary care. Liddy et al. Telemedicine and e-Health 2013 Apr; 19(10):733-738

⁸⁸Text Messaging as a Tool for Behavior Change in Disease Prevention and Management. Epidemiology Reviews 2010 Apr; 32(1) 56-59

Core Components

This initiative if undertaken, may include the following components:

1. Build on current on specialty care coordination within the public hospital system and advance up to three specialty access improvement initiatives along measurable dimensions for timeliness of appointments, access, quality, and reduction in out-of-network specialty care referrals.
2. Develop capabilities for referral systems for mental health and substance use disorder services within the public hospital system and a coordinated care network.
3. Encourage patients to receive care at the public hospital system for inpatient, ED, and specialty services or at high-value preferred partners when clinical conditions such as tertiary care are beyond the scope of the public hospital system.
 - Engage case management in the ED to organize home-based services tailored to the needs of the patient such as community-based integrated transition facilitators, visiting nurses, and/or home visits by nurse practitioners to ensure post-ED aftercare is in place. This builds on the ED commitment to providing the highest and most needs-sensitive care possible for patient populations and fosters clinical partnerships with post-ED community-based providers.
 - Patient education by public hospital system primary care teams to reinforce the value and care coordination benefits of “staying within the public hospital system” campaign. This may include patient education materials and after visit summaries that emphasize referrals and follow-up appointments.
 - Use recent and ongoing surveys of public hospital system specialists and primary care teams to develop and communicate standardized specialty-specific key interventions prior to a referral which makes the specialty visit more productive and may prevent avoidable referrals or tests.
 - Review patterns of referrals by primary care region, referring provider, and specialty to determine opportunities to influence decisions to utilize the public hospital system whenever possible.
4. Leverage effective post-acute and community-based providers to address gaps in care or to increase care coordination.
 - a. Define, develop and refine formal agreements with post-acute providers, such as VNAs, SNFs and detoxification facilities, with both programmatic support and skilled clinical personnel.
5. Develop transportation solutions (such as Uber / Lyft / taxi) for patients to ensure that they can make their scheduled medical appointments and to facilitate usage of the appropriate facilities and network of providers.
6. Execute newly designed mobile paramedic program which may deploy highly skilled paramedics to the home to assess and evaluate patients with the goal to match the patient’s needs with the appropriate level of care, thereby allowing patients to remain in the community and avoid potentially preventable emergency and inpatient utilization when appropriate.
7. Develop tools and processes for active referrals to mental health and addictions providers
8. Further expand the electronic platform for consultations (e-consults) to maximize specialty access and minimize patient inconvenience and cost.

9. Establish patient communication tools to enhance care coordination such as enhanced use of the patient portal platform of electronic medical record (EMR) as well as texting programs for care management, care coordination and appointment reminders.
10. Expand preferred provider relationships to include clinical services not provided at the public hospital system and include these in the EMR Referral Guidance directory in order to maximize quality and clinical connectivity.
11. Engage an appropriate leadership team including multidisciplinary stakeholders on referral management work.
12. Refine existing patient attribution and outreach efforts to identify and schedule appointments with new or unengaged patients.
13. Restructure primary care triaging processes to address patients' immediate and urgent care needs.
14. Continue to develop/refine reporting tools to support referral management work.
15. Develop, adopt, and monitor referral management policies and procedures that align with defined ACO strategies (such as escalation for ED transfers, etc).
16. Identify practice region and specialty-specific challenges to adopting referral management policies and tailor support to these issues beyond system-wide infrastructure.
17. Support staff and providers in referral management efforts to achieve quality outcomes when they are linked to access.

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 3		3: Referral Management and Integrated Care Management			Achieve 2 of 5 Measures	Achieve 4 of 10 Measures	Achieve 7 of 13 Measures	Achieve 6 of 10 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Overall Reduce proportion of Emergency Department Outmigration to Non-Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service) ⁸⁹	No external benchmark; hospital specific improvement target = 25%	Gap to Goal (10%) or attainment at target	B (CY2016)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	Target of 25% informed by out-migration improvement opportunity
2	Overall Reduce proportion of Inpatient Outmigration to – Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service) ⁵	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	B (CY2016)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	Target of 50% informed by out-migration improvement opportunity
3	Overall Reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient)	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	O (4/1/20 – 3/31/21)	O (4/1/21 - 3/31/22)	Target of 10% informed by out-of-network referral improvement opportunity
4	Selected Public Hospital Primary Care Practice(s) Initiative: Primary care reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient) referrals	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	B (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20) Initial Practice (s)	O (4/1/20 – 3/31/21)	O (4/1/21 - 3/31/22)	Target of 10% informed by out-of-network referral improvement opportunity
					Initial Practice (s)	Initial Practice (s)	New Practice (s)	New Practice (s)	New Practice (s)	

⁸⁹Baseline and outcome measures are dependent on stable populations and relevant claims data. Should there be material changes in populations, payor contracts and access to claims data these measures will need to be re-based.

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 3		3: Referral Management and Integrated Care Management			Achieve 2 of 5 Measures	Achieve 4 of 10 Measures	Achieve 7 of 13 Measures	Achieve 6 of 10 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
5	Reduce the proportion of out-of-network referrals for selected specialty care areas within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2 nd Specialty Area) (SFYs 2021 – 2022 will be a 3 rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 6%; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	B (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	B (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
6	Completed appointments per FTE or total number of completed appointments for selected specialties within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2 nd Specialty Area) (SFYs 2021 – 2022 will be a 3 rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 1300 appointments per FTE; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	B (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	B (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
7	Time to first appointment: percentage of referrals to scheduled within 60 days for selected specialties within	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology=50%;	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	B (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	B (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 3		3: Referral Management and Integrated Care Management			Achieve 2 of 5 Measures	Achieve 4 of 10 Measures	Achieve 7 of 13 Measures	Achieve 6 of 10 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
	the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2 nd Specialty Area) (SFYs 2021 – 2022 will be a 3 rd Specialty Area)		Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty		Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	reported with baseline data
8	Increase the # of E-Consults referrals made by public hospital primary care providers to defined public hospital specialists	Customized Measure	No external benchmark; hospital specific improvement over SFY 2018 baseline	Defined improvement over SFY 2018 baseline	B (4/1/17 - 3/31/18)	O 10% improvement over SFY18 baseline (4/1/18 - 3/31/19)	O 20% improvement over SFY18 baseline (4/1/19 - 3/31/20)	O 30% improvement over SFY18 baseline (4/1/20 - 3/31/21)	O 40% improvement over SFY18 baseline (4/1/21 - 3/31/22)	Increased access for consultative services to facilitate care and access for patients to critical specialties
9	Demonstrate improvement in colorectal cancer screening rates (for active public hospital primary care patients)	NQF 0034	National (HEDIS) Commercial 2014 90th percentile = 72%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 3		3: Referral Management and Integrated Care Management			Achieve 2 of 5 Measures	Achieve 4 of 10 Measures	Achieve 7 of 13 Measures	Achieve 6 of 10 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
10	Improvement in inpatient discharge referral rate to in-network skilled nursing facilities for Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network SNFs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all SNFs ⁹⁰	No external benchmark; hospital specific improvement target= 75%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Appropriate post acute placement of patients based on clinical need
11	Improvement in inpatient discharge referral rate to in network Visiting Nurse Association (VNAs) Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network VNAs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all VNAs ⁹¹	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Appropriate post acute community-based care for patients based on clinical need

⁹⁰ Any Visiting Nurses Association (VNA) with whom public hospital system has a signed preferred provider agreement. Preferred provider relationships are evaluated annually and are subject to change if VNAs are not in compliance with the terms of the agreement. Changes in preferred VNA relationships may require a rebasing of the measures.

⁹¹ Any Skilled Nursing Facility (SNF) approved by the public hospital network development committee as being "in-network" at any point during the measurement year. The network development committee oversees the collaborative relationships in which the public hospital system participates. The committee abides by specific principles related to access, continuity of care, communication expectations and quality improvement. Changes to in-network SNF relationships may require a rebasing of the measures.

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).</i>										
Measure Slate 3		3: Referral Management and Integrated Care Management			Achieve 2 of 5 Measures	Achieve 4 of 10 Measures	Achieve 7 of 13 Measures	Achieve 6 of 10 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
12	% of patient appointments at which the AVS was printed for the patient at the conclusion of their medical specialty appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	B (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	O (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types
13	% of patient appointments at which the AVS was printed for the patient at the conclusion of their surgical appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	B (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	O (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types

Initiative Title	4. Evidence-Based Practices for Medical Management of Chronic Conditions
Description/Rationale	
<p>Evidence Based Medicine (EBM) is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.⁹² The goal is to improve outcomes, quality, and cost by reducing the variation of care for key conditions and integrate EBM into the health care delivery system across the continuum. The concept of variation of care was outlined in the 2010 Dartmouth Institute’s reflections on geographic variations⁹³; however, a similar deviation from EBM and variations in care may also be observed <i>within</i> health care systems and practices, acknowledging natural differences between patients. Toward safer, higher-quality care, redesigned systems of care, including the use of information technology, can best support clinical and administrative processes to adopt EBM and improve patient outcomes.⁹⁴</p> <p>Efforts to change the culture of medical practice to adopt EBM include education on recommendations from peer-reviewed groups such as Cochrane or the U.S. Preventive Services Task Force (USPTF), integration of EBM into clinical activities via clinical decision support (CDS), and the application of population health data to prioritize and subsequently develop systems to close quality gaps.⁹⁵</p> <p>Building on systematic efforts in medical management such as those sponsored by the Institute for Health Care Improvement learning collaborative known as “Pursuing Perfection”⁹⁶ and foundational transformation work under the current Waiver, planned future initiatives build on capabilities to develop and use population health databases, risk stratify patients, and help connect the most costly and vulnerable patients with complex care management, transitional facilitators, and palliative care services.</p> <p>Evidence-based patient engagement strategies may include those such as motivational interviewing in chronic health conditions and for substance use disorders, electronic medical record clinical decision support for chronic conditions and prevention, expansion of nursing, pharmacist, and other care team member roles in chronic disease management, and mental health team integration within primary care. Initiatives may include refining tools, frameworks, analytics, and clinical workforce development in the use of evidence-based guidelines across the care continuum to care for specific populations of patients. A goal is to “hard wire” enhanced quality by utilizing evidence-based practices to support providers and patients in making informed decisions about treatments, medications, risks, costs, and benefits.⁹⁷</p>	

⁹²Sackett DL, Rosenberg WMC, Gray JAM et al. Evidence-based medicine: what it is and what it isn’t. Br Med J 1996;312:71-72

⁹³Jonathan Skinner and Elliott S. Fisher “Reflections on Geographic Variations in U.S. Health Care,” The Dartmouth Institute for Health Policy & Clinical Practice, updated May 12

⁹⁴Crossing the Quality Chasm: A New Health System for the 21st Century Institute of Medicine 2001

⁹⁵McCarthy, Mueller, Wrenn. Geisinger Health System: Achieving the Potential of System Integration through Innovation, Leadership, Measurement, and Incentives. The Commonwealth Fund, Case Study Organized Health Care Delivery System June 2009

⁹⁶Pursuing Perfection: Raising the Bar for Healthcare Performance Robert Wood Johnson Foundation Results Report Grant ID: CPC Updated January 10, 2014

⁹⁷Remarks by Carolyn Clancy, M.D., Director of the Agency for Healthcare Research and Quality (AHRQ) World Healthcare Innovation and Technology Congress, Washington, DC, November 1, 2006

Initiative Title	4. Evidence-Based Practices for Medical Management of Chronic Conditions
Goals/Objectives	
<p>A medical management program is one of the pillars of health care reorganization to function effectively as an Accountable Care Organization (ACO) to improve population health outcomes. Medical management programs aim to develop and implement evidence-based clinical guidelines for populations of patients with particular conditions to ensure the right care at the right time in the right context and produce optimal outcomes for quality, safety, cost, and experience. Efforts will focus on improving care and reducing cost for populations of patients with five conditions: chronic obstructive pulmonary disease; congestive heart failure; hypertension; diabetes; and pediatric asthma.</p> <p>Specific objectives may include:</p> <ul style="list-style-type: none"> • Improve health indicators for primary care panel patients with selected chronic health conditions (which may include chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, diabetes, and pediatric asthma), including those with co-occurring mental health conditions and substance use disorders; • Improve transitions in care and reduce avoidable hospital readmission for patients with targeted chronic health conditions; • Foster advance care planning and use of palliative care services for patients with advanced stage illness related to the targeted chronic health conditions; • Articulate institutional evidence-based guidelines for selected chronic health conditions for care across the continuum (self care, primary care, specialty care, emergency department and hospital care) that recognize the importance of attention to co-occurring mental health needs and the social determinants of health; • Embed evidence-based guidelines into standard workflows and the electronic medical record; • Train key staff and providers in population health management skills and improving multidisciplinary collaboration and team-based across the care continuum including thoughtful engagement of pharmacists, nurses, and other allied health professionals. • Engage patients and families as design partners and in effective self management of their health condition(s) through multidisciplinary health education and coaching; • Develop a registry that permits risk stratification and monitoring of adherence to care guidelines; • Evaluate medical management programs for chronic conditions to determine successful management for decreases in the rate of hospitalization, re-hospitalization, emergency department (ED utilization), and total medical expense, based on the availability of claims data for payer populations; • Adhere to evidence-based guidelines in selected targeted conditions (COPD, CHF, hypertension, and/or diabetes) that include adherence to nationally validated measures for clinical care processes and treatments; and • Advance team-based care within a patient centered medical home model with a distinctive approach to medical management that recognizes the importance of integrated mental health care and attention to the social determinants of health. 	
Core Components	
<p><i>This initiative, if undertaken, may include the following components:</i></p> <p>We plan to develop and implement medical management programs for targeted conditions in a staggered fashion over a 5-year period.</p> <ol style="list-style-type: none"> 1. Essential elements for evidence-based disease management program (s), based on a review of the literature and from experience may include the following: 	

Initiative Title	4. Evidence-Based Practices for Medical Management of Chronic Conditions
	<ul style="list-style-type: none"> • Engage an appropriate leadership team including multidisciplinary clinical stakeholders as well as patients and families; • Identify key evidence-based practices from review of literature; <ul style="list-style-type: none"> • Build an understanding of the population of patients with the target condition through review of both quantitative and qualitative data; • Design strategies for embedding best practices into clinical workflows across the care continuum and build appropriate decision support strategies within the electronic medical record integrating innovative technology platforms whenever possible; • Develop materials and forums for enhancing patient and family understanding of the condition and capacity for self care, including the use of care planning with patients and families for selected conditions; • Develop and use a registry database for risk stratification, for use in identifying and closing gaps in care, and for use in monitoring adherence to best practices; • Support staff and providers to learn and use new skills in population health management, in multidisciplinary team-based care and collaboration, and in care-giving relationships with patients that enable self care through coaching and goal setting; <ul style="list-style-type: none"> • Build referral pathways to special programs for high risk patients such as complex care management, house calls for frail homebound patients, elder services, palliative care, and emerging partnerships with home care services, skilled nursing facilities, and other community-based partnerships. <ol style="list-style-type: none"> 2. Improve transitions in care for patients with chronic health conditions with a focus on reducing 30 day hospital readmission through timely follow up phone calls, clinic visits, and home visits after inpatient hospitalization and emergency department visits. 3. Continue to cultivate institutional improvement work in chronic disease management in primary care and through patient-centered medical homes in primary care and expand population health management tools and team-based care into medical specialty clinics. 4. Adopt a holistic approach to chronic disease management that includes attention to mental health and substance abuse, with expanded screening and treatment for depression and appropriate referral to special programs such as the behavioral health home, integrated mental health providers within primary care, and multi-level substance abuse treatment supports, to address the high burden of co-morbid mental health and substance abuse with the target population(s). 5. Evaluate medical management programs for chronic conditions to determine successful management for decreases in the rate of hospitalization, re-hospitalization, emergency department (ED utilization), and total medical expense, based on the availability of claims data for payer populations. 6. Improve end of life care for patients with chronic conditions including more frequent use of advanced directives and referral to specialized palliative care services.

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).</i>										
Measure Slate 4		4: Evidence-Based Practices for Medical Management of Chronic Conditions			Achieve 2 of 3 Measures	Achieve 4 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
	Chronic Obstructive Pulmonary Disease (COPD)									
1	The percentage of active primary care patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	NQF 0577	2015 90 th percentile National Medicaid = 47.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid.
2	Percentage of active primary care patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 60% and have symptoms who were prescribed an inhaled bronchodilator.	NQF 102	2015 90 th percentile National Medicaid= 90.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid.
3	Improve the percentage of patients with COPD who received patient education for COPD by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 85% reflects best practice adoption of the required workflows.
	Congestive Heart Failure (CHF)									
4	Improve the percentage of patients with CHF who received patient education for CHF by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 85% reflects best practice adoption of the required workflows.
	Diabetes									

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).</i>										
Measure Slate 4		4: Evidence-Based Practices for Medical Management of Chronic Conditions			Achieve 2 of 3 Measures	Achieve 4 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
5	Diabetes: HbA1c Control- % of active primary care patients ages 18 to 75 with diabetes whose most recent HbA1c control is <8.0%	NQF 0575	2015 90 th percentile National Medicaid: 59.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid
6	Comprehensive Diabetes Care: Eye Exam (retinal) performed (for active primary care patients)	NQF 0055	2015 90 th percentile National Medicaid: 68.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid
7	Improve the proportion of active primary care patients 18-75 years of age with diabetes with poorly controlled Hemoglobin HbA1C (most recent >=8.0%) who have a care plan	NCQA	No external benchmark; hospital specific improvement Target = 75%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 75% is NCQA 2014 Medical Home Standard.
8	Percentage of high risk diabetic primary care patients receiving enhanced diabetes management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure (denominator linked to NQF 0575)	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	B	O	O	O	O	Target reflects roll-out implementation and capacity for new workflows.
Hypertension (HTN)										

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).</i>										
Measure Slate 4		4: Evidence-Based Practices for Medical Management of Chronic Conditions			Achieve 2 of 3 Measures	Achieve 4 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
9	Percentage of high risk hypertensive primary care patients receiving enhanced hypertension management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	B	O	O	O	O	Target reflects roll-out implementation and capacity for new workflows.
Composite Measures										
10	Hospitalization Follow-up: The percentage of discharges for patients 18 years of age and older (with any of the following conditions Diabetes, Hypertension COPD, and/or CHF) who were discharged to home from public hospital's medical/surgical inpatient services and who had an outpatient visit within 7 days or contact within 2 days with a care team member documented in EMR.	Customized Measure	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve follow up after hospitalization for chronic health conditions

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).</i>										
Measure Slate 4		4: Evidence-Based Practices for Medical Management of Chronic Conditions			Achieve 2 of 3 Measures	Achieve 4 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
11	% of active primary care patients 3 years and older with the following conditions: Diabetes, Pediatric Asthma, Hypertension, COPD, and CHF, for whom a public hospital follow-up contact or visit is completed within seven calendar days post ED discharge	Customized Measure	No external benchmark; hospital specific improvement target =50%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve follow up after ED visits for chronic health conditions
12	Screening for Depression in active primary care patients 18 years and older with Diabetes, HTN, CHF, and/or COPD	Approximate Match- NQF 0418 (Adjusted for Chronic Conditions at high risk)	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve depression screening for patients with chronic health conditions at high risk..
13	Co-morbid Conditions: Depression Follow-Up in active primary care patients with Diabetes, HTN, CHF, and/or COPD	Customized Measure	No external benchmark; hospital specific improvement target = 60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve follow up for depression care for patients with chronic health conditions.

Initiative Title	5. Community Empowered Population Health Initiative (Not Selected)
Description/Rationale	
<p>The Community Empowered Population Health Initiative builds and supports systems to address social determinants of health (SDH) and to address health disparities in patients with chronic conditions. This may be accomplished by implementing a screening and referral system for SDH, leveraging close ties with social service agencies, strengthening communities through collaboration with community and governmental agencies, and developing systems to improve chronic disease disparities.</p> <p>The initiative is in recognition that social, behavioral and environmental factors account for 70% of what it takes to stay healthy while only 10% are attributable to direct medical care.⁹⁸ According to the Institute of Medicine, “an aligned system with a strong interface among public health, health care, and the community and non health sectors could produce better prevention and treatment outcomes for populations living with chronic illness.”⁹⁹ Understanding the critical role of SDH, Healthy People 2020 highlights the importance of addressing the social determinants of health by including “Create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.¹⁰⁰ Based on emerging evidence that addressing social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs, CMS has prioritized addressing SDH through the Accountable Health Communities model to address critical gaps between clinical care and community services.¹⁰¹ The initiative also recognizes that health disparities have persisted for families and communities that have systematically experienced social and economic disadvantage and consequently face greater obstacles to optimal health. In appreciation of the importance of addressing health disparities, CMS has laid out work.^{102,103}</p> <p>Improving SDH and health disparities requires supporting communities in addressing their health needs, implementing screening and referral processes to social service agencies and building programs that identify and address health disparities. Community health improvement teams will work with community based organizations and governmental entities to support their efforts to improve community health. Clinical and community health improvement teams will work together to screen for SDH, refer patients with social needs to existing community services, and rescreen patients with social needs. Clinical and community health improvement teams will also work closely to identify populations with disproportionately higher rates of poor control of chronic health conditions, monitor and improve their care through ensuring they receive interventions such as education, outreach, and linkage to primary, specialty and other ambulatory care services.</p>	
Goals/Objectives	
<p>This initiative will build on community relationships and clinical care infrastructure to drive coordinated care across the medical to community continuum for panel patients and to improve the health of the communities we serve. The initiative aims to increase screening for social determinants of health, referral to social service agencies, and improvement in chronic disease care for patients with disproportionately lower rates of chronic disease control. Thus, this project is intended to support high quality patient-centered care by more completely addressing the full spectrum of needs for patients. This will in turn support efforts to improve the health of patients and communities.</p> <p>Specific objectives include:</p>	

⁹⁸McGinnis et al. The Case for More Active Policy Attention to Health Promotion. Health Affairs 2002; 21(2); 78-93

⁹⁹IOM. Living well with chronic illness: a call for public health action. Washington, DC: The National Academies Press; 2012

¹⁰⁰Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

¹⁰¹Alley DE, et al. Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid. N Engl J Med 2016; 374:8-11.

¹⁰²CMS. CMS Equity Plan for Improving Quality in Medicare. Sept 2015. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf

¹⁰³CMS. <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/quality-of-care-health-disparities.html>

Initiative Title	5. Community Empowered Population Health Initiative (Not Selected)
	<ul style="list-style-type: none"> • Address social determinants of health through screening of defined patient panel population in order to refer to responsive community and social services • Increase use of social determinant screening tools and implement follow-up rescreening to assess social determinants of health and progress made through active referrals to community and social supports. • Develop systems for referrals to community and social service organizations. • Explore and initiate the use of innovative technologies for social determinant screening, referrals to community and social service resources, patient education and/or self-management support. • Evaluate patient panel for health disparities as defined by disproportionately higher rates of poor control of chronic health conditions such as hypertension and diabetes control to select target population(s) for improvement initiatives. • As measured by nationally validated measures for hypertension control and diabetes blood glucose control, monitor and improve health outcomes for targeted patient population(s) identified with disproportionately poorer control of their health condition. • Develop and implement patient-centered education, outreach, and/or other interventions to support the effective management of chronic health conditions. • Increase community-based, primary care, specialty care, complex care management and ambulatory care utilization for targeted patient populations with higher rates of poor control of their chronic health condition. • Foster community partnerships that link community and public health with patient panel health promotion initiatives.
Core Components	
<p>This initiative, if undertaken, may include the following components:</p> <ol style="list-style-type: none"> 1. Build systems to screen for social determinants of health across defined patient panel population segment(s), such as vulnerable patients with chronic conditions and/or behavioral health conditions, high risk/ high utilizers, clinical practice sites and/or others. 2. Identify social determinant(s) tools and develop and implement processes for screening and follow-up rescreening to assess social determinants of health and progress made through active referrals to community and social supports. <ul style="list-style-type: none"> • Implementation of innovative technology for initial and reassessment of social determinants of health for selected patient populations. 3. Develop and implement a referral system to community and social services and supports, which may include a range of services such as organizations addressing food insecurity, housing concerns, legal assistance. Establish relationships and referral systems with community services and social services organizations in order to refer patients for services, including those who have been screened for social determinants of health. 4. Based on an assessment of patient populations with disproportionately poorer outcomes on effective control of health conditions such as hypertension and diabetes, develop strategies which may include small tests of change and other population-specific initiatives, to improve how the health care delivery system in partnership with community and social services support patients in managing their health condition(s) and impacts the defined health outcome measure(s). 5. Implement and measure the proportion of patients in the defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control that receive patient education, outreach, or another intervention to support effective chronic health condition management. 6. Devise and implement activities to increase primary care and other ambulatory care utilization for the defined patient population(s) with health disparities as a usual source of care. 7. Build on relationships with communities to: <ul style="list-style-type: none"> • Provide communities with information about the health and well being of their community by providing a health assessment in targeted communities 	

Initiative Title	5. Community Empowered Population Health Initiative (Not Selected)
	<ul style="list-style-type: none">• Provide educational programs in the targeted communities on topics to prevent or address chronic medical conditions, such as hypertension/heart health, diabetes, chronic obstructive pulmonary disease, asthma, and/or mental health and substance use.• Foster community and clinically-linked population efforts through ongoing collaborations with community, public health and social services organizations to discuss common health priorities, the needs of their communities and to work together on responsive efforts.<ul style="list-style-type: none">• Work with community, public health and social services organizations to support efforts to address healthy living, physical activity, nutrition and mental illness/substance abuse• Incorporates social service partners into care planning, coordination and case review efforts to facilitate resolution of identified social determinants for specific regionally-based patient populations.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) <i>(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).</i>										
Measure Slate 5		5: Community Empowered Population Health Initiative			Baseline	Achieve 3 of 9 Measures	Achieve 5 of 9 Measures	Achieve 5 of 9 Measures	Achieve 6 of 9 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Social Determinant Screenings: Utilizing implemented social determinant(s) screening tool, increase percentage of defined patient panel population segment(s) (such as patients with chronic conditions and/or behavioral health conditions, high risk/high utilizers, specific primary or specialty practices) within the ACO/public payor population) screened for selected Social Determinants	Customized Measure	No external benchmark; hospital specific improvement target =70%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is based on population screening measures for this new initiative.
2	Referrals to Community and Social Services: The percentage of defined patient panel screened for social determinant(s) (in measure 1 above) with referrals to community and social services and supports	Customized Measure	No external benchmark; hospital specific improvement target =60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is informed by referrals to community and social services.
3	Expansion of Social Determinant Screening to Additional Patient Cohorts: Expand patient panel subpopulations or practice sites whose patients receive social determinant screening	Customized Measure	No external benchmark; hospital specific target = Add at least 1 additional patient subpopulation or practice site per year	Defined Increase Per Year	B	O	O	O	O	Target based on phased implementation of new social determinants initiative.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) <i>(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).</i>										
Measure Slate 5		5: Community Empowered Population Health Initiative			Baseline	Achieve 3 of 9 Measures	Achieve 5 of 9 Measures	Achieve 5 of 9 Measures	Achieve 6 of 9 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
4	Follow-up Social Determinant Screening: Percentage of identified & active patient panel populations with follow-up social determinant(s) rescreening for appropriate determinants	Customized Measure	No external benchmark; hospital specific improvement Target= 50%	Gap to Goal (10%) or attainment at target		B	O	O	O	Rescreening rates to begin in year two to measure presence or resolution of social determinants
5	Reducing Health Disparities for Hypertension: Controlling High Blood Pressure Measure (2015 HEDIS Definition) for defined patient panel population(s) with disproportionately poorer outcomes for good control of hypertension	NQF 0018 (for hospital-defined patient panel population(s) with health disparities	MA Medicaid (HEDIS) 2014 90 th percentile = 85.67%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.
6	Reducing Health Disparities for Hypertension Control in Patients with Diabetes: Comprehensive Diabetes Care: Blood Pressure Control (<140/90) for defined patient panel population(s) with diabetes and disproportionately poorer outcomes for good control of hypertension	NQF 0061 (for hospital-defined patient panel population(s) with health disparities	MA Medicaid (HEDIS) 2014 90 th percentile = 82.74%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) <i>(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).</i>										
Measure Slate 5		5: Community Empowered Population Health Initiative			Baseline	Achieve 3 of 9 Measures	Achieve 5 of 9 Measures	Achieve 5 of 9 Measures	Achieve 6 of 9 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
7	Comprehensive Diabetes Care: A1c Poor Control or A1c Good Control for defined patient panel population(s) with disproportionately poorer outcomes for diabetes blood glucose control	NQF 0059 or NQF 0575 (one of the two measures above will be selected and confirmed in the baseline year based on hospital evaluation of health disparities. (for hospital-defined patient panel population(s) with health disparities	NQF 0059 MA Medicaid (HEDIS) 2014 90 th percentile = 18.57% or NQF 0575 MA Medicaid (HEDIS) 2014 90 th percentile = 59.37%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.
8	Composite Diabetes & Hypertension Patient Education, outreach or Intervention: Proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above that received patient education, outreach, or another intervention to support chronic health condition management	Customized Measure (for hospital-defined patient panel population(s) with health disparities	No external benchmark; hospital specific improvement target = 60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve patient education, outreach, and/or interventions for patients with disproportionately poorer health outcomes.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected) <i>(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).</i>										
Measure Slate 5		5: Community Empowered Population Health Initiative			Baseline	Achieve 3 of 9 Measures	Achieve 5 of 9 Measures	Achieve 5 of 9 Measures	Achieve 6 of 9 Measures	
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
9	<p>Primary Care and Ambulatory Care Utilization Among Panel Population(s) with Health Disparities: Increase the proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above who had at least one community health, primary care and/or other ambulatory care visit during the measurement period</p>	Customized Measure (for hospital-defined patient panel population(s) with health disparities	No external benchmark; Improvement over SFY 2018 baseline by defined % point(s)	Improvement compared to SFY 2018 baseline.	B	O Improve by at least 1% point above the SFY 2018	O Improve by at least 2% point above the SFY 2018	O Improve by at least 3% points above the SFY 2018	O Improve by at least 4% points above the SFY 2018	Target derived to improve utilization of primary care and ambulatory care for patients with disproportionately poorer health outcomes.

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

Measure Slate 6	Population-Wide Community and Public Health Indicators	Source	Geography	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022
1	Age-adjusted rate* per 100,000 for premature death (below age 75), by race and ethnicity, as available	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
2	Age-adjusted rate* per 100,000 for hospital discharges for primary care manageable conditions: asthma - by age, race and ethnicity as available	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
3	Age-adjusted rate* per 100,000 for suicide mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
4	Age-adjusted rate* per 100,000 for Hepatitis C incidence	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
5	Percentage of children fully immunized at kindergarten entry	Immunization Program, Massachusetts Department of Public Health and Massachusetts Department of Elementary and Secondary Education	Cambridge, Somerville, Everett, Malden, Statewide	R	R	R	R	R
6	Percent of adolescents reporting specific risk behaviors (as available), from the Youth Risk Behavior Survey (YRBS)- high school and middle school surveys	Youth Risk Behavior Survey (YRBS) (Bi-Annual)	Cambridge, Somerville, Everett, Malden, (as available by community) Statewide	R	R	R	R	R
7	Age-adjusted rate* per 100,000 for Opioid poisoning mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
8	Ranking top cause of 1) hospitalizations and 2) Emergency Department visits, by city: Age-adjusted rate* per 100,000 for hospitalizations (by individual cause) Age-adjusted rate* per 100,000 for Emergency Department visits (by individual cause).	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
9	Age-specific rate* per 100,000 for 1) Emergency Department -visits and 2) mortality related to falls among those age 65 years and over by city.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

Measure Slate 6	Population-Wide Community and Public Health Indicators	Source	Geography	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022
10	Age-adjusted rate* per 100,000 for Emergency Department visits related to alcohol or substance use.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
11	Age-adjusted rate* per 100,000 for Emergency Department visits related to Opioid poisoning.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
12	Age-adjusted rate* per 100,000 for hospitalizations related to Hypertension.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
13	Age-adjusted rate* per 100,000 for 1) hospitalizations and 2) Emergency Department visits related to Renal Failure or Renal Disorder.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

*Age-adjusted and age-specific rates are expressed per 100,000 persons.

^ Measures are reported using the most recent available data from public sources.

Appendix: Measure Slates 1-6

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 4 in Year 1, 4 of 11 Outcome Measures in Year 2, 5 out of 11 in Year 3, 6 out of 11 in Year 4, and 7 out of 11 in Year 5).</i>										
Measure Slate 1		1: Behavioral Health and Primary Care Integration			Achieve 2 of 4 Measures	Achieve 4 of 11 Measures	Achieve 5 of 11 Measures	Achieve 6 of 11 Measures	Achieve 7 of 11 Measures	Baseline (B) Outcome (O) Reporting (R)
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Depression Response at 6 Months - Progress Towards Remission (across all core primary care sites)	NQF 1884	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	This target is based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved ¹⁰⁴ .
2	Depression Response at 12 Months - Progress Towards Remission (across all core primary care sites)	NQF 1885	No external benchmark; hospital-specific improvement target = 45%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	This target is, based on literature on collaborative care indicating that a rate of 45% on the depression response measures represents the highest level of statistically meaningful improvement that has currently been achieved ¹⁰⁵ .
3	Primary Care Provider confidence in management of depression, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 90%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on evidence-based depression programming in primary care.

¹⁰⁴Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

¹⁰⁵Thota Et al (2012). Collaborative Care to Improve the Management of Depressive Disorders. Am J Prev Med. 42(5): 525-538.; Unutzer et al (2002). Collaborative Care Mgmt of Late Life Depression in the Primary Care Setting. JAMA 288 (22).

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

4	Primary Care Provider confidence in management of substance use disorders, measured through annual survey	PCMH	No external benchmark; hospital specific improvement target = 70%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on newness of initiative introducing universal screening for substance use disorders in primary care and care management initiatives.
5	Screening and Brief Intervention for Alcohol Use for adults (across all core primary care sites)	NQF 2152	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target based on literature review of best practice performance levels. ¹⁰⁶
6	Screening and Brief Intervention for Drug Use for adults (across all core primary care sites)	NQF 2152, adapted to include substance use	No external benchmark; hospital specific improvement target = 65%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Same as above.
7	Patients on Chronic Opioid Therapy with a Controlled Substance Agreement (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target aligned to initiative to optimize opioid prescribing practice.
8	Patients on Chronic Opioid Therapy with urine drug screening (across all core primary care sites)	N/A	No external benchmark; hospital-specific improvement target = 80%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target aligned to initiative to optimize opioid prescribing practice.
9	Patients with chronic pain who had functional assessment (across all core primary care sites)	NQF 0050, adapted to include all chronic pain conditions	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on newness of initiative, and literature indicating the value of functional assessment in patients with chronic pain ¹⁰⁷ .

¹⁰⁶Bertholet N, Daepfen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of Alcohol Consumption by Brief Alcohol Intervention in Primary Care. Archives of Internal Medicine. 2005;165:986-995; Babor TF, Higgins-Biddle JC, Dauser D, Bureson JA, Zarkin GA, Bray J. Brief Interventions for At-Risk Drinking: Patient Outcomes and Cost-Effectiveness in Managed Care Organizations. Alcohol and Alcoholism. 2006;41(6):624-631.

¹⁰⁷Institute for Clinical Systems Improvement, Assessment and Management of Chronic Pain 2013

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

10	Screening and Brief Intervention for Alcohol and Drug Use for adolescents (across all core primary care sites)	NQF 2152, adapted to expand to new age range for adolescents	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Expansion of measure to the adolescent patient population. Improvement target based on newness of initiative for adolescent patients.
11	Maternal Depression Screening (across all core primary care sites)	NQF 1401	No external benchmark; hospital specific improvement target = 75%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target based on literature indicating value of maternal depression screening in conjunction pediatric visits to identify developmental risk factors. ¹⁰⁸

Required Measure Slate: Improvement and Outcomes Measures
(Achieve 2 out of 5 in Year 1, 5 of 13 Outcome Measures in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, and 8 out of 13 in Year 5).

Measure Slate 2		2: Comprehensive Systems for Treating Mental Health & Substance Use (MHSU) Conditions			Achieve 2 of 5 Measures	Achieve 5 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	Baseline (B) Outcome (O) Reporting (R)
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Controlling high blood pressure for people with serious mental illness (for BH Home population)	NQF 2602	MA Medicaid (HEDIS) 2015 75 th percentile: 65.09% (proxy benchmark from NQF 0018 for overall population)	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Using related benchmark for NQF 0018 for overall population.
2	Proportion of patients with identified opioid use disorder accessing medication-assisted treatment (MAT)	N/A	No external benchmark; Hospital target = 50.00%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target of 50% informed by experience with patient engagement in opioid treatment

¹⁰⁸Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington (DC): US Department of Health and Human Services; US Department of Health and Human Services; US Department of Education; US Department of Justice, 2000.

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

3	Hospitalized patients screened within 72 hours of admission using a validated screening tool for unhealthy alcohol use (all public hospital system inpatient psychiatric discharges, age 18 and above)	NQF 1661 SUB-1	Joint Commission (2014) 75 th percentile = 94.20%	Gap to Goal (10%) or attainment at target	O (CY2017)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	Using Joint Commission benchmark for SUB-1
4	Alcohol use brief intervention provided or offered (during public hospital system psychiatric hospitalization, age 18 and above)	NQF 1663 SUB-2	Joint Commission (2014) average = 48.20%	Gap to Goal (10%) or attainment at target	B (CY2017)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	New measure as of 1/1/16; using related benchmark for NQF 1663, which is a similar measure for all inpatient admissions
5	Follow-up after hospitalization for mental illness (for BH Home population) – 7 days for public hospital system hospitalizations	NQF 0576 (7-day)	National (HEDIS) Medicaid 2015 90 th percentile = 63.85%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	
6	Transition record with specified elements received by discharged patients (for public hospital system psychiatric hospitalizations)	NQF 0647	MA IPFQR-HBIPS 2014 average = 83.27%	Gap to Goal (10%) or attainment at target	B (CY2017)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	New IPFQR measure to be implemented 1/1/17; using related measure for NQF 0557, which is HBIPS-6 for creation of the transition continuing care plan
7	Access to public hospital system ambulatory mental health care: Scheduled intakes within 14 days of referral (for in-network referrals)	N/A	National Medicaid (HEDIS) 2015 90 th percentile = 48.10%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Using proxy benchmark derived from National Medicaid (HEDIS) Initiation and Engagement of AOD treatment (initiation component only), NQF 0004.
8	Increase number of synchronous and asynchronous tele-consultations with psychiatrists	N/A	No external benchmark; Hospital target = 400 per year	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target informed by roll-out and expansion of tele-psychiatry

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

9	Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications (for active primary care patients and BH home patients)	NQF 1932	MA Medicaid (HEDIS) 2015 90th percentile = 86.96%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	
10	Cardiovascular health screening for people with Schizophrenia or Bipolar Disorder who are prescribed antipsychotic medications (for active primary care patients and BH home patients)	NQF 1927	No external benchmark; hospital-specific target = 75.00%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target informed by experience with screening measures for other populations
11	Diabetes Monitoring for People with Diabetes and Schizophrenia (for active primary care patients and BH home patients)	NQF 1934	National (HEDIS) Medicaid 2014 90th percentile = 76.67%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	
12	Screening for metabolic disorders (psychiatric inpatient discharges on routinely-scheduled antipsychotic screened during/before stay)	CMS IPFQR	No external benchmark	Improvement over CY 2017 baseline	B (CY2017)	O (CY2018) 2% increase over CY2017	O (CY2019) 5% increase over CY2017	O (CY2020) 8% increase over CY2017	O (CY2021) 10% increase over CY2017	No existing benchmark; CMSIPFQR measure to be implemented 1/1/17
13	Increase the percentage of BH Home target population patients who have a care plan (care plans may include CHA coordinated care plan and/or ACO behavioral health community partner care plan)	NCQA Medical Home	NCQA 2014 Medical Home Standard = 75.00%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 75% is 2014 NCQA Medical Home standard.

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 out of 5 in Year 1, 4 of 10 Outcome Measures in Year 2, 7 out of 13 in Year 3, 6 out of 10 in Year 4, and 8 out of 13 in Year 5).</i>							
Measure Slate 3	3: Referral Management and Integrated Care Management	Achieve 2 of 5 Measures	Achieve 4 of 10 Measures	Achieve 7 of 13 Measures	Achieve 6 of 10 Measures	Achieve 8 of 13 Measures	Baseline (B) Outcome (O) Reporting (R)

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Overall Reduce proportion of Emergency Department Outmigration to Non-Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service) ¹⁰⁹	No external benchmark; hospital specific improvement target = 25%	Gap to Goal (10%) or attainment at target	B (CY2016)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	Target of 25% informed by out-migration improvement opportunity
2	Overall Reduce proportion of Inpatient Outmigration to – Public Hospital System Facilities within specific payer contracts	Customized Measure: Claims based (units of service) ⁵	No external benchmark; hospital specific improvement target = 50%	Gap to Goal (10%) or attainment at target	B (CY2016)	O (CY2018)	O (CY2019)	O (CY2020)	O (CY2021)	Target of 50% informed by out-migration improvement opportunity
3	Overall Reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient)	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	O (4/1/20 – 3/31/21)	O (4/1/21 - 3/31/22)	Target of 10% informed by out-of-network referral improvement opportunity
4	Selected Public Hospital Primary Care Practice(s) Initiative: Primary care reduce proportion of out-of-network Medical & Surgical specialty referrals (outpatient) referrals	Customized Measure	No external benchmark; hospital specific improvement target = 10%	Gap to Goal (10%) or attainment at target	B (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	O (4/1/20 – 3/31/21)	O (4/1/21 - 3/31/22)	Target of 10% informed by out-of-network referral improvement opportunity
					Initial Practice (s)	Initial Practice (s)	New Practice (s)	New Practice (s)	New Practice (s)	

¹⁰⁹Baseline and outcome measures are dependent on stable populations and relevant claims data. Should there be material changes in populations, payor contracts and access to claims data these measures will need to be re-based.

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

5	Reduce the proportion of out-of-network referrals for selected specialty care areas within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2 nd Specialty Area) (SFYs 2021 – 2022 will be a 3 rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 6%; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	B (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	B (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
6	Completed appointments per FTE or total number of completed appointments for selected specialties within the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2 nd Specialty Area) (SFYs 2021 – 2022 will be a 3 rd Specialty Area)	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology = 1300 appointments per FTE; Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	B (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	B (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and reported with baseline data
					Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	
7	Time to first appointment: percentage of referrals to scheduled within 60 days for selected specialties within	Customized Measure	No external benchmark; hospital specific improvement target (Gastroenterology=50%;	Gap to Goal (10%) or attainment at target	O (4/1/17 - 3/31/18)	B (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	B (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target for new specialties will be specified at the time of the selection of the specialty and

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

	the public hospital system: (SFY 2018 will continue Gastroenterology) (SFYs 2019 – 2020 will be a 2 nd Specialty Area) (SFYs 2021 – 2022 will be a 3 rd Specialty Area)		Applicable to SFY 2018) New Specialty Target will be submitted with baseline data for each new specialty		Gastroenterology	New Specialty 1	New Specialty 1	New Specialty 2	New Specialty 2	reported with baseline data
8	Increase the # of E-Consults referrals made by public hospital primary care providers to defined public hospital specialists	Customized Measure	No external benchmark; hospital specific improvement over SFY 2018 baseline	Defined improvement over SFY 2018 baseline	B (4/1/17 - 3/31/18)	O 10% improvement over SFY18 baseline (4/1/18 - 3/31/19)	O 20% improvement over SFY18 baseline (4/1/19 - 3/31/20)	O 30% improvement over SFY18 baseline (4/1/20 - 3/31/21)	O 40% improvement over SFY18 baseline (4/1/21 - 3/31/22)	Increased access for consultative services to facilitate care and access for patients to critical specialties
9	Demonstrate improvement in colorectal cancer screening rates (for active public hospital primary care patients)	NQF 0034	National (HEDIS) Commercial 2014 90th percentile = 72%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	
10	Improvement in inpatient discharge referral rate to in-network skilled nursing facilities for Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network SNFs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all SNFs ¹¹⁰	No external benchmark; hospital specific improvement target= 75%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Appropriate post acute placement of patients based on clinical need

¹¹⁰ Any Visiting Nurses Association (VNA) with whom public hospital system has a signed preferred provider agreement. Preferred provider relationships are evaluated annually and are subject to change if VNAs are not in compliance with the terms of the agreement. Changes in preferred VNA relationships may require a rebasing of the measures.

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

11	Improvement in inpatient discharge referral rate to in network Visiting Nurse Association (VNAs) Medical/Surgical inpatients discharged from the public hospital system	Numerator: Discharges to In- Network VNAs Denominator: Medical/ Surgical Inpatient Discharges from the Public Hospital System to all VNAs ¹¹¹	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Appropriate post acute community-based care for patients based on clinical need
12	% of patient appointments at which the AVS was printed for the patient at the conclusion of their medical specialty appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	B (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	O (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types
13	% of patient appointments at which the AVS was printed for the patient at the conclusion of their surgical appointment at the public hospital system	MU P220	No external benchmark; hospital specific improvement	Gap to Goal (10%) or attainment at target: Target 90%	B (4/1/17 - 3/31/18)	O (4/1/18 - 3/31/19)	O (4/1/19 - 3/31/20)	O (4/1/20 - 3/31/21)	O (4/1/21 - 3/31/22)	Target of 90% established based on clinical operations standards, taking into account the spectrum of patient routine and urgent visit types

Required Measure Slate: Improvement and Outcomes Measures <i>(Achieve 2 of 3 Outcome Measures in Year 1, 4 out of 13 in Year 2, 7 out of 13 in Year 3, 8 out of 13 in Year 4, 8 out of 13 in Year 5).</i>							
Measure Slate 4	4: Evidence-Based Practices for Medical Management of Chronic Conditions	Achieve 2 of 3 Measures	Achieve 4 of 13 Measures	Achieve 7 of 13 Measures	Achieve 8 of 13 Measures	Achieve 8 of 13 Measures	Baseline (B) Outcome (O) Reporting (R)

¹¹¹ Any Skilled Nursing Facility (SNF) approved by the public hospital network development committee as being "in-network" at any point during the measurement year. The network development committee oversees the collaborative relationships in which the public hospital system participates. The committee abides by specific principles related to access, continuity of care, communication expectations and quality improvement. Changes to in-network SNF relationships may require a rebasing of the measures.

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
	Chronic Obstructive Pulmonary Disease (COPD)									
1	The percentage of active primary care patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	NQF 0577	2015 90 th percentile National Medicaid = 47.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid.
2	Percentage of active primary care patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 60% and have symptoms who were prescribed an inhaled bronchodilator.	NQF 102	2015 90 th percentile National Medicaid= 90.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid.
3	Improve the percentage of patients with COPD who received patient education for COPD by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 85% reflects best practice adoption of the required workflows.
	Congestive Heart Failure (CHF)									
4	Improve the percentage of patients with CHF who received patient education for CHF by a member of their inpatient care team prior to discharge (across public hospital's inpatient hospital campuses)	Customized Measure	No external benchmark; hospital specific improvement target = 85%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 85% reflects best practice adoption of the required workflows.
	Diabetes									

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

5	Diabetes: HbA1c Control- % of active primary care patients ages 18 to 75 with diabetes whose most recent HbA1c control is <8.0%	NQF 0575	2015 90 th percentile National Medicaid: 59.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid
6	Comprehensive Diabetes Care: Eye Exam (retinal) performed (for active primary care patients)	NQF 0055	2015 90 th percentile National Medicaid: 68.0%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target reflects the 2015 th 90 th Percentile National Medicaid
7	Improve the proportion of active primary care patients 18-75 years of age with diabetes with poorly controlled Hemoglobin HbA1C (most recent >=8.0%) who have a care plan	NCQA	No external benchmark; hospital specific improvement Target = 75%	Gap to Goal (10%) or attainment at target	O	O	O	O	O	Target of 75% is NCQA 2014 Medical Home Standard.
8	Percentage of high risk diabetic primary care patients receiving enhanced diabetes management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure (denominator linked to NQF 0575)	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	B	O	O	O	O	Target reflects roll-out implementation and capacity for new workflows.
Hypertension (HTN)										

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

9	Percentage of high risk hypertensive primary care patients receiving enhanced hypertension management services, including nursing-led patient education and self-management coaching, pharmacist-led medication management services, or other care team member support.	Customized Measure	No external benchmark; hospital specific improvement target	Improvement over SFY 2018 baseline SFY 19: Improve 2% over SFY 2018 baseline SFY 20: Improve 4% over SFY 2018 baseline SFY 21: Improve 6% over SFY 2018 baseline SFY 22: Improve 8% over SFY 2018 baseline	B	O	O	O	O	Target reflects roll-out implementation and capacity for new workflows.
Composite Measures										
10	Hospitalization Follow-up: The percentage of discharges for patients 18 years of age and older (with any of the following conditions Diabetes, Hypertension COPD, and/or CHF) who were discharged to home from public hospital's medical/surgical inpatient services and who had an outpatient visit within 7 days or contact within 2 days with a care team member documented in EMR.	Customized Measure	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve follow up after hospitalization for chronic health conditions
11	% of active primary care patients 3 years and older with the following conditions: Diabetes, Pediatric Asthma, Hypertension, COPD, and CHF, for whom a public hospital follow-up contact or visit is completed within seven calendar days post ED discharge	Customized Measure	No external benchmark; hospital specific improvement target =50%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve follow up after ED visits for chronic health conditions

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

12	Screening for Depression in active primary care patients 18 years and older with Diabetes, HTN, CHF, and/or COPD	Approximate Match- NQF 0418 (Adjusted for Chronic Conditions at high risk)	No external benchmark; hospital specific improvement target = 80%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve depression screening for patients with chronic health conditions at high risk..
13	Co-morbid Conditions: Depression Follow-Up in active primary care patients with Diabetes, HTN, CHF, and/or COPD	Customized Measure	No external benchmark; hospital specific improvement target = 60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target derived to improve follow up for depression care for patients with chronic health conditions.

Required Measure Slate: Improvement and Outcomes Measures – (Not Selected)
(Achieve 3 of 9 Outcome Measures in Year 2, 5 of 9 in Year 3, 5 of 9 in Year 4, and 6 of 9 in Year 5).

Measure Slate 5		5: Community Empowered Population Health Initiative			Baseline	Achieve 3 of 9 Measures	Achieve 5 of 9 Measures	Achieve 5 of 9 Measures	Achieve 6 of 9 Measures	Baseline (B) Outcome (O) Reporting (R)
#	Measure Description	Measure Steward NQF#	Benchmark	Improvement Methodology	Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022	Rationale for Improvement Target
1	Social Determinant Screenings: Utilizing implemented social determinant(s) screening tool, increase percentage of defined patient panel population segment(s) (such as patients with chronic conditions and/or behavioral health conditions, high risk/high utilizers, specific primary or specialty practices) within the ACO/public payor population) screened for selected Social Determinants	Customized Measure	No external benchmark; hospital specific improvement target =70%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is based on population screening measures for this new initiative.

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

2	Referrals to Community and Social Services: The percentage of defined patient panel screened for social determinant(s) (in measure 1 above) with referrals to community and social services and supports	Customized Measure	No external benchmark; hospital specific improvement target =60%	Gap to Goal (10%) or attainment at target	B	O	O	O	O	Target is informed by referrals to community and social services.
3	Expansion of Social Determinant Screening to Additional Patient Cohorts: Expand patient panel subpopulations or practice sites whose patients receive social determinant screening	Customized Measure	No external benchmark; hospital specific target = Add at least 1 additional patient subpopulation or practice site per year	Defined Increase Per Year	B	O	O	O	O	Target based on phased implementation of new social determinants initiative.
4	Follow-up Social Determinant Screening: Percentage of identified & active patient panel populations with follow-up social determinant(s) rescreening for appropriate determinants	Customized Measure	No external benchmark; hospital specific improvement Target= 50%	Gap to Goal (10%) or attainment at target		B	O	O	O	Rescreening rates to begin in year two to measure presence or resolution of social determinants
5	Reducing Health Disparities for Hypertension: Controlling High Blood Pressure Measure (2015 HEDIS Definition) for defined patient panel population(s) with disproportionately poorer outcomes for good control of hypertension	NQF 0018 (for hospital-defined patient panel population(s) with health disparities	MA Medicaid (HEDIS) 2014 90 th percentile = 85.67%	Gap to Goal (5%) or attainment at target	B	O	O	O	O	Gap to Goal adjusted to reflect populations with health disparities.

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

6	<p>Reducing Health Disparities for Hypertension Control in Patients with Diabetes: Comprehensive Diabetes Care: Blood Pressure Control (<140/90) for defined patient panel population(s) with diabetes and disproportionately poorer outcomes for good control of hypertension</p>	<p>NQF 0061 (for hospital-defined patient panel population(s) with health disparities)</p>	<p>MA Medicaid (HEDIS) 2014 90th percentile = 82.74%</p>	<p>Gap to Goal (5%) or attainment at target</p>	B	O	O	O	O	<p>Gap to Goal adjusted to reflect populations with health disparities.</p>
7	<p>Comprehensive Diabetes Care: A1c Poor Control or A1c Good Control for defined patient panel population(s) with disproportionately poorer outcomes for diabetes blood glucose control</p>	<p>NQF 0059 or NQF 0575 (one of the two measures above will be selected and confirmed in the baseline year based on hospital evaluation of health disparities. (for hospital-defined patient panel population(s) with health disparities)</p>	<p>NQF 0059 MA Medicaid (HEDIS) 2014 90th percentile = 18.57% or NQF 0575 MA Medicaid (HEDIS) 2014 90th percentile = 59.37%</p>	<p>Gap to Goal (5%) or attainment at target</p>	B	O	O	O	O	<p>Gap to Goal adjusted to reflect populations with health disparities.</p>
8	<p>Composite Diabetes & Hypertension Patient Education, outreach or Intervention: Proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above that received patient education, outreach, or another intervention to support chronic health condition management</p>	<p>Customized Measure (for hospital-defined patient panel population(s) with health disparities)</p>	<p>No external benchmark; hospital specific improvement target = 60%</p>	<p>Gap to Goal (10%) or attainment at target</p>	B	O	O	O	O	<p>Target derived to improve patient education, outreach, and/or interventions for patients with disproportionately poorer health outcomes.</p>

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

9	<p>Primary Care and Ambulatory Care Utilization Among Panel Population(s) with Health Disparities: Increase the proportion of patients in defined patient panel population(s) with disproportionately poorer health outcomes for hypertension and diabetes control in measures 5, 6, and 7 above who had at least one community health, primary care and/or other ambulatory care visit during the measurement period</p>	<p>Customized Measure (for hospital-defined patient panel population(s) with health disparities</p>	<p>No external benchmark; Improvement over SFY 2018 baseline by defined % point(s)</p>	<p>Improvement compared to SFY 2018 baseline.</p>	<p>B</p>	<p>O Improve by at least 1% point above the SFY 2018</p>	<p>O Improve by at least 2% point above the SFY 2018</p>	<p>O Improve by at least 3% points above the SFY 2018</p>	<p>O Improve by at least 4% points above the SFY 2018</p>	<p>Target derived to improve utilization of primary care and ambulatory care for patients with disproportionately poorer health outcomes.</p>
---	---	---	--	---	----------	---	---	--	--	---

Measure Slate 6	Population-Wide Community and Public Health Indicators	Source	Geography	Baseline (B), Outcome (O), Reporting (R)				
				Year 1 SFY 2018	Year 2 SFY 2019	Year 3 SFY 2020	Year 4 SFY 2021	Year 5 SFY 2022
1	Age-adjusted rate* per 100,000 for premature death (below age 75), <i>by race and ethnicity, as available</i>	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
2	Age-adjusted rate* per 100,000 for hospital discharges for primary care manageable conditions: asthma - <i>by age, race and ethnicity as available</i>	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
3	Age-adjusted rate* per 100,000 for suicide mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
4	Age-adjusted rate* per 100,000 for Hepatitis C incidence	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

Public Hospital Transformation and Incentive Initiative Protocol – February 16, 2017

5	Percentage of children fully immunized at kindergarten entry	Immunization Program, Massachusetts Department of Public Health and Massachusetts Department of Elementary and Secondary Education	Cambridge, Somerville, Everett, Malden, Statewide	R	R	R	R	R
6	Percent of adolescents reporting specific risk behaviors (as available), from the Youth Risk Behavior Survey (YRBS)- high school and middle school surveys	Youth Risk Behavior Survey (YRBS) (Bi-Annual)	Cambridge, Somerville, Everett, Malden, (as available by community) Statewide	R	R	R	R	R
7	Age-adjusted rate* per 100,000 for Opioid poisoning mortality	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
8	Ranking top cause of 1) hospitalizations and 2) Emergency Department visits, by city: Age-adjusted rate* per 100,000 for hospitalizations (by individual cause) Age-adjusted rate* per 100,000 for Emergency Department visits (by individual cause).	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
9	Age-specific rate* per 100,000 for 1) Emergency Department -visits and 2) mortality related to falls among those age 65 years and over by city.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
10	Age-adjusted rate* per 100,000 for Emergency Department visits related to alcohol or substance use.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
11	Age-adjusted rate* per 100,000 for Emergency Department visits related to Opioid poisoning.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
12	Age-adjusted rate* per 100,000 for hospitalizations related to Hypertension.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R
13	Age-adjusted rate* per 100,000 for 1) hospitalizations and 2) Emergency Department visits related to Renal Failure or Renal Disorder.	MA Department of Public Health (Annual)	Cambridge, Somerville, Everett, Malden, Revere, Statewide	R	R	R	R	R

**MassHealth 1115 Demonstration
Attachment L: Pilot Accountable Care Organization (ACO) Payment
Methodology**

Contents

Pilot Accountable Care Organization (ACO) Payment Methodology..... 1

Section 1. Eligible and Enrolled Population 2

 1.1. Performance Period 2

 1.2. Member eligibility 2

 1.3. Member attribution to ACO 3

Section 2. Services included in Total Cost of Care (TCOC) 3

 2.1. List of covered services 3

 2.2. Excluded services 4

Section 3. Calculation of TCOC target 4

 3.1. Base data..... 4

 3.2. Risk/acuity adjustment 5

 3.3. Stop-loss adjustment..... 5

 3.4. Trend..... 5

 Other sources of information are reviewed, as needed, such as regional and national economic indicators that can provide broad perspectives of industry trends in the United States and in the Northeast.**Error! Bookmark not defined.**

 3.5. Program changes..... 5

 MassHealth will account for program changes occurring between the base and performance periods that are expected to affect the TCOC. Data will be adjusted for any known programmatic, benefit, fee, population changes occurring between the base period and the performance period. 3.6. Seasonality 5

Section 4. Calculation of shared savings and losses 6

 4.1. Retrospective calculation of TCOC performance and savings / losses 6

 4.2. Determination of shared portion of savings / losses..... 6

 4.3. Impact of quality reporting on shared savings / losses..... 7

Note: The methodology described in this attachment is wholly distinct from the methodology

used for the full implementation of MassHealth's ACO program rolling out late 2017.

Overview: MassHealth providers will be paid on a fee-for-service basis for care provided to members attributed to Pilot AOCs. For each ACO, MassHealth will track the total costs of care (TCOC) for the ACO's attributed members during the performance period, and will retrospectively compare these costs against an ACO-specific target. Based on the difference between an ACO's TCOC performance and its TCOC target, EOHHS may share savings with the ACO or require the ACO to pay a share of losses. This attachment describes the methodology MassHealth will use to calculate these payments.

The Commonwealth may modify this Attachment with the approval of CMS without amending the STCs.

Section 1.1 Section 1. Eligible and Enrolled Population

1.1. Performance Period

The ACO Pilot performance period will begin December 1, 2016 and end November 30, 2017.

1.2. Member eligibility

MassHealth members must be enrolled in the MassHealth PCC Plan during the performance period in order to be attributed to a Pilot ACO. The eligible population is therefore the same population eligible for the PCC Plan, which includes disabled and non-disabled children and adults under age 65 (i.e., RC I, II, IX, and X). Similarly, MassHealth members who are not eligible for the PCC Plan will not be eligible for the Pilot ACO program, including members who are Medicare dually eligible, limited standard eligible, family planning waiver, women eligible due to pregnancy, Health Safety Net members, and third party liability members. In developing the Pilot ACO TCOC targets, MassHealth is using data for PCC Plan members during the base period.

Rating Category	Description
RC I Child	Temporary Assistance to Needy Families (TANF) less than 21 years of age.
RC I Adult	Temporary Assistance to Needy Families (TANF), ages 21 through 64.
RC II Child	Disabled members, including Supplemental Security Income (SSI) and SSI-related less than 21 years of age.
RC II Adult	Disabled members, including Supplemental Security Income (SSI) and SSI-related, ages 21 through 64.
RC IX	Individuals ages 21 through 64 with incomes up to 133% federal poverty level (FPL), who are not pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage.
RC X	Individuals ages 21 through 64 with incomes up to 133% FPL, who are not pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage, who are also receiving EAEDC through the Massachusetts Department of Transitional Assistance

1.3. Member attribution to ACO

Members in the PCC Plan are each enrolled with a PCC. Each Pilot ACO has a unique, exclusive group of PCCs who have contracted to participate with that ACO; PCC Plan members enrolled with a Pilot ACO's PCCs are considered attributed members for that Pilot ACO.

Section 2. Services included in Total Cost of Care (TCOC)

The services included in TCOC will be broadly consistent with services included in the base capitation for MassHealth's managed care organizations, with some differences. In particular, there are select services (e.g., Hepatitis C drugs) that MassHealth will exclude from the TCOC calculation in order to prevent unpredictable, rare, high-cost events from driving substantial losses for an individual ACO. Additionally, Home Health and LTC services are also excluded from the TCOC, but will be tracked and reported to providers.

2.1. List of covered services

Below is a list of covered service categories under the ACO Pilot program:

Category	Definition
Inpatient PH — Non-maternity	Inpatient services that have not been identified as maternity, behavioral health or LTC. Includes services provided in acute and chronic hospital settings; includes both room and board data and ancillary data billed by the facility during the stay.
Inpatient PH — Maternity	Inpatient PH — Maternity Acute hospital inpatient services related to maternity care and deliveries.
Emergency Room	Emergency room services provided in acute hospital settings; does not include ancillary data associated with the visit if not coded "emergency room" on the claim. Emergency room discharges that result in an admission are not included in this category.
Lab and Radiology — Facility	Laboratory and radiology services provided as outpatient services by acute or chronic care hospitals and freestanding facilities.
Other Outpatient Hospital	Outpatient services provided by acute care hospitals, chronic care hospitals, and ambulatory surgical centers, except those meeting categorization criteria for behavioral health, emergency room, and laboratory and radiology.
Clinics (CHC)	Services provided by Community Health Centers.
Professional Services	PH services provided by medical professionals; including physicians, nurse practitioners, podiatrists, chiropractors, and physical therapists. This category includes professional laboratory services, as well as physician inpatient services billed separately.

Category	Definition
DME & Supplies	DME and medical supplies; including hearing aids, orthotics, prosthetics, and oxygen/respiratory care equipment.
Emergency Transportation	Transportation services provided by emergency transportation providers.
Pharmacy	Retail pharmacy.
Other Medical Services	Speech and hearing services, renal dialysis, dental care, hospice care, and other miscellaneous services.
Inpatient Behavioral Health	Inpatient services related to behavioral health care, provided in acute care hospitals, chronic care hospitals, behavioral health hospitals, or other specialty behavioral health residential facilities.
Outpatient Behavioral Health	Outpatient behavioral health services provided by behavioral health hospitals, mental health clinics, acute care hospitals, physicians, and other appropriate behavioral health service providers. Does not include CBHI services.
Diversionary Behavioral Health	Diversionary behavioral health services are home and community-based mental health and substance use disorder services furnished as clinically appropriate alternatives to and diversions from inpatient mental health and substance use disorder services in more community-based, less structured environments. Diversionary services are also provided to support an individual's return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community.

2.2. Excluded services

MassHealth's current MCO capitation rates include certain high-cost services that are relatively new to the MassHealth program, which may result in a large and unpredictable impact on ACOs' TCOC. Some such services, specifically Hepatitis C drugs, Cystic Fibrosis drugs, and Applied Behavioral Analysis, will therefore be excluded from TCOC calculations.

TCOC will also exclude services that are currently excluded from MCO capitation rates. Long Term Supports & Services (LTSS) will be excluded, as will services rendered by state agencies outside of MassHealth or the health safety net.

Section 3. Calculation of TCOC target

Prior to the start of the performance year, MassHealth will establish a preliminary TCOC target for each Pilot ACO. This section describes how that target will be calculated.

3.1. Base data

The TCOC target will be based on a one-year historical base period of October 1, 2014 through September 30, 2015. MassHealth selected this base period after reviewing the most recent three years of available and reliable data for the ACO-eligible population.

All base data for PCC Plan members and included services will be utilized to inform adjustments such as trend. The base data will consist of MassHealth eligibility records, Primary Care Clinician (PCC) Plan claims and Massachusetts Behavioral Health Partnership (BHP) contractor encounter data for PCC and BHP covered services. Each Pilot ACO's TCOC target will be based on the data for members attributed to that ACO's participating PCCs, specifically, during the base period.

3.2. Risk/acuity adjustment

For each ACO, MassHealth will adjust for any observed changes in acuity between the members attributed during the base period (October 1, 2014 - September 30, 2015) and the ACO performance period (December 1, 2016 to November 30, 2017). Specifically, MassHealth will normalize each ACO's risk score to the overall PCC program during the base period, and again during the performance period.

MassHealth will use a statistically developed risk adjustment tool and standard DxCG grouper to develop individual member-level risk scores; this tool also incorporates independent variables related to social determinants of health.

3.3. Stop-loss adjustment

Consistent with the stop-loss approach described in Section 4.1, MassHealth will adjust the base data in order to mitigate the risk to providers from claims incurred for individual members beyond the stop-loss thresholds (\$50,000 for RC I, \$110,000 for RC II). Expenditures beyond these thresholds will be reduced by 90% in the base data; ACOs are therefore "at risk" for only 10% of these outlier costs.

3.4. Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future time period. As part of the TCOC development process, unit cost and utilization trend factors by RC, region, and service category will be developed.

The primary data sources used in trend development will consist of ACO-eligible members' eligibility records, PCC Plan claims, and BHP encounter data for PCC and BHP covered services. The data reflects a variety of influences, including potential changes in medical management practices, network construction, and population risk. Some of these influences may be accounted for in other aspects of rate setting, such as program changes, and, as such, the data must be considered within the broader context of other assumptions. Any services excluded from TCOC will also be excluded from the trend development.

3.5. Program changes

MassHealth will account for program changes occurring between the base and performance

periods that are expected to affect the TCOC. Data will be adjusted for any known programmatic, benefit, fee, population changes occurring between the base period and the performance period.

Section 4. Calculation of shared savings and losses

4.1. Retrospective calculation of TCOC performance and savings / losses

Within one year from the end of the performance period, MassHealth will calculate each ACO's TCOC performance for the list of covered services described in Section 2.1. Several potential adjustments may be made at that time to account for additional changes between the base and performance periods:

- Shifts in risk: MassHealth will calculate each ACO's benchmark to reflect the actual risk scores of the ACO's covered population, as well as reflect the ACO's final enrollment mix by rating category (i.e., rating category and age group).
- Program changes: To the degree that MassHealth introduces substantial shifts in policy during the performance period that has an effect on TCOC, calculations of performance may be adjusted to reflect the impact of those policy changes
- Stop-loss: In order to appropriately incent ACOs to manage costs, it is important to insulate those ACOs' performance from the impact of unmanageable catastrophic costs incurred by a small number of members. Therefore, MassHealth will count only 10% of claims beyond \$50,000 for individual members in Rating Category I and \$110,000 for individual members in Rating Category II in the calculation of TCOC performance. This approach is consistent with the discounting of those claims from the base data, as described in Section 3. The threshold amounts for each rating category were determined based on Monte Carlo simulations using the distribution in member-level spending and the expected number of attributed lives in the expected Pilot ACOs. By testing the financial impact of different stop-loss thresholds on each ACO's TCOC performance under the assumption that members are randomly assigned to ACOs, MassHealth determined an appropriate threshold that protected ACOs from suffering significant losses due to random variation alone while maintaining a meaningful incentive to manage utilization for high-cost members.

After the adjustments described above, the difference in each ACO's TCOC performance and its target (each expressed as a PMPM) will be calculated on a PMPM basis.

4.2. Determination of shared portion of savings / losses

Once the total savings or losses have been calculated, MassHealth will follow a series of steps that determine the portion of savings or losses retained by the ACO:

- Savings / losses cap: MassHealth will recognize savings or losses for each individual ACO up to a cap of 15% of the ACO's TCOC target. For example, if an ACO's target TCOC is \$500 PMPM, then its cap on recognized savings or losses is $\$500 * 15\% = \75 PMPM. If the ACO achieves TCOC performance of \$400 PMPM, MassHealth would

only recognize \$75 PMPM of the savings. Similarly, if the ACO has a TCOC performance of \$580 PMPM, only \$75 PMPM of losses would be recognized. For the ACO, 100% of savings or losses would be recognized if the ACO performed between \$425 and \$575 PMPM.

- Share of savings: After the determination of savings and losses, MassHealth will pay 50% of recognized savings to ACOs with TCOC performance below target. In the example where an ACO performs at \$400 PMPM on a \$500 PMPM target, MassHealth would therefore pay the ACO $\$75 * 50\% = \37.50 PMPM. Therefore, the maximum financial upside in the ACO Pilot is 7.5% of target.
- Share of losses: MassHealth will recoup 10% of the recognized losses from ACOs with TCOC performance above target. In the example where ACO A performs at \$580 PMPM on a \$500 PMPM target, MassHealth would therefore recoup from ACO A $\$75 * 10\% = \7.50 PMPM. Therefore, the maximum financial upside beyond target TCOC is 1.5% of target.
- Minimum savings / loss ratio: If total savings or losses are less than 2% of the TCOC target, MassHealth will not pay shared savings or recoup shared losses. This approach prevents payments or recoupments from being incurred due to random variation. For example, if an ACO's target TCOC is \$500 PMPM, and its performance is between \$490.01 and \$509.99 PMPM, no savings or losses will be shared. If performance was \$490.00 and below or \$510.00 and above, then the full difference between performance and target would be recognized (per the prior three bullets)

4.3. Impact of quality reporting on shared savings / losses

Pilot ACOs will be required to report on certain clinical quality measures. ACOs that fail to satisfy quality reporting requirements will not be eligible to share in savings.

ATTACHMENT M
DSRIP Protocol

Reserved

**MassHealth 1115 Demonstration
Attachment N
Safety Net Provider Payment Eligibility and Allocation**

Hospitals that meet the eligibility criteria to receive a Safety Net Provider Payment pursuant to STC 51 and their corresponding payments are listed in Table 1 below.

Safety Net Provider Payment allocation methodology:

Hospitals that are eligible to receive Safety Net Provider Payments must demonstrate an uncompensated care shortfall on their 2014 UCCR or 403 cost reports (if UCCR is unavailable) based on their Medicaid and Uninsured payments and costs. Further detail related to hospital eligibility for Safety Net Provider Payments can be found in STC 51.

Eligible hospitals are split into two groups based on these criteria:

Group 1: Group 1 includes any hospital that received Delivery System Transformation Initiative (DSTI) payments in the SFY 2015-2017 demonstration period.

Group 2: Group 2 includes any eligible hospital that did not receive DSTI payments in the SFY 2015-2017 demonstration period.

SFY 2022 payments are determined as follows:

- Group 1 hospitals will receive payments equal to 72% of the payments received in SFY 2017.
- Group 2 hospitals will receive a share of remaining available funding for Safety Net Provider Payments based on each hospital's relative Medicaid Gross Patient Service Revenue (GPSR) reported in the latest available hospital cost report as of August 2016.

Note that the initial allocation of DSTI payments among the eligible hospitals for the SFY 2012-2014 and SFY 2015-2017 demonstration periods was similarly determined based on relative Medicaid and Low Income Public Payer GPSR.

An increasing portion of these payments are at risk for each individual hospital in each year of the demonstration extension period, subject to accountability and performance requirements as specified in STC 51. As such, provider payment amounts are classified as "potential payments" as reflected in Table 1 below

Table 1. Safety Net Provider Potential Payments by Eligible Hospital Provider

Hospital Provider	SFY18 (\$M)	SFY19 (\$M)	SFY20 (\$M)	SFY21 (\$M)	SFY22 (\$M)
Group 1					
Boston Medical Center*	\$107.70	\$106.30	\$106.30	\$106.30	\$105.21
Holyoke Medical Center	\$6.49	\$6.49	\$6.49	\$6.49	\$6.49
Lawrence General Hospital	\$13.20	\$12.90	\$12.50	\$12.20	\$11.47
Mercy Medical Center	\$13.00	\$12.60	\$12.20	\$12.12	\$12.04
Signature Healthcare Brockton Hospital	\$14.70	\$14.00	\$13.50	\$13.30	\$13.27
Steward Carney Hospital	\$5.12	\$5.12	\$5.12	\$5.12	\$5.12
Group 2					
Baystate Medical Center	\$5.61	\$5.61	\$5.61	\$5.61	\$5.61
North Shore Medical Center	\$3.37	\$3.37	\$3.37	\$3.37	\$3.37
Southcoast Hospital Group	\$4.07	\$4.07	\$4.07	\$4.07	\$4.07
Tufts Medical Center	\$3.40	\$3.40	\$3.40	\$3.40	\$3.40
Morton Hospital	\$0.50	\$0.50	\$0.50	\$0.50	\$0.50
Franklin Medical Center	\$0.47	\$0.47	\$0.47	\$0.47	\$0.47
Berkshire Medical Center	\$1.63	\$1.63	\$1.63	\$1.63	\$1.63
Good Samaritan Hospital	\$0.95	\$0.95	\$0.95	\$0.95	\$0.95

In addition, note that for Boston Medical Center, the 72 percent Group 1 target payment amount for SFY 2022 takes into account SFY 2017 DSTI payment authority, plus \$32 million in Public Service Hospital Safety Net Care payment authority that does not continue in the new demonstration extension period.

MassHealth 1115 Demonstration
Attachment O
-Pricing methodology for ACOs and MCOs

The Commonwealth may modify this Attachment with the approval of CMS without amending the STCs.

1. Unified approach to setting TCOC Benchmarks for Primary Care ACOs and MCO-Administered ACOs, and setting prospective Capitation Rates for MCOs and Partnership Plans

Massachusetts will set total cost of care (TCOC) Benchmarks using a uniform methodology that aligns with the methodology for setting prospective Capitation Rates for MCOs and Accountable Care Partnership Plans. As described in STC 41, Accountable Care Partnership Plans will be paid prospectively rated capitation payments, which are subject to annual rate certification. Primary Care ACOs will share savings and losses with the Commonwealth based on comparison between their TCOC Performance and TCOC Benchmark (i.e., their performance on managing the costs of their attributed or enrolled population). Primary Care ACOs may also be paid under a prospective pre-payment methodology as described in STC 41. Similarly, MCO-administered ACOs will share savings and losses with their contracting MCOs based on the same comparison. EOHHS intends to establish an aligned methodology for setting TCOC benchmarks for Primary Care ACOs and MCO-Administered ACOs, as further described below; EOHHS will require MCOs to share savings and losses with their contracted MCO-Administered ACOs using this methodology and based on the risk-tracks and schedule set by the state. Such requirement is broadly consistent with 42 CFR 438.6.

The TCOC benchmark (for Primary Care ACOs or MCO-Administered ACOs) or prospective Capitation Rate (for MCOs or Accountable Care Partnership Plans) will be developed as follows:

1. A benchmark or rate will be developed for each individual rate cell, where a rate cell is defined as a specific region and rating category (e.g., Rating Category I – Adults in Greater Boston Region).
2. All such benchmarks and rates will be based on a unified base dataset, which will be constructed as follows:
 - a) Claims and encounter experience for all Managed Care-eligible lives, including members enrolled in the MCO, PCC, and ACO programs, will be aggregated for a baseline period established annually by the Commonwealth (e.g., one to three years of the most recent available history).
 - b) Only services covered under the list of MCO Covered Services, the list of ACO Covered Services, or the list of TCOC Included Services will be included in the base data. These three lists of services will align, as ACOs will be financially accountable for the same services as MCOs. EOHHS will finalize and publish these lists in advance of finalizing the benchmarks/rates.
 - c) Actual prices paid for covered services during the baseline period will be re-priced to reflect average market prices paid for those services. The methodology used to

re-price services delivered during the base period will be developed by the Commonwealth and shared with CMS for approval before the Operational Start Date of the ACO and MCO programs.

3. For each rate cell, actuarial methods will be applied to the base dataset to estimate the average per-member per-month total cost of care (“market-rate TCOC”). Actuarial adjustments could account for factors such as, but not limited to, the following:
 - a) Changes in member risk and enrollment
 - b) Completion for incurred but not reported encounters in the base data
 - c) Anticipated program changes between the base period and the performance period
 - d) Cost and utilization trends from the base period to the performance period
 - e) Other adjustments as appropriate
4. This market-rate TCOC will be consistent across all ACOs and MCOs within each rate cell, and will be incorporated into the final benchmarks and rates, along with the Network Efficiency factor as described in the following section.

2. Development and incorporation of the Network Efficiency Factor in TCOC Benchmarks and prospective Capitation Rates

The Commonwealth will incorporate an ACO-specific Network Efficiency Factor into the TCOC Benchmarks for Primary Care ACOs and MCO-Administered ACOs, and into the prospective Capitation Rates for Partnership Plans.

The Commonwealth will calculate and apply the Network Efficiency Factor for each ACO, for each Performance Year, as follows:

1. The Network Efficiency Factor will equal the ACO’s Historic TCOC divided by the ACO’s market-rate TCOC, after applying adjustments for each ACO’s member mix across rate cells and member acuity.
 - a) For each ACO, using a similar methodology and adjustments to those used to calculate the market-rate TCOC, the Commonwealth will develop for each rate cell an ACO’s Historic TCOC based on the cost experience in the base period for the Managed Care eligible members attributed to primary care providers participating in the ACO.
 - b) The Network Efficiency Factor represents the variance between an ACO’s Historic TCOC and the ACO’s market-rate TCOC that cannot be explained by variation in price or member risk
2. The Commonwealth will multiply each ACO’s market-rate TCOC (after applying adjustments for each ACO’s member mix across rate cells and member acuity) by the ACO’s Network Efficiency Factor. The Commonwealth will calculate and apply the Network Efficiency Factor each year, but intends to place a decreasing weight on the Network Efficiency Factor over time. For example, in the first rating period under the demonstration, a 90 percent weight may be placed on the Network Efficiency Factor; that is, an ACO with a Network Efficiency Factor of 1.10 would have a TCOC benchmark that is 9.0% higher than its market-rate TCOC, while an ACO with a Network Efficiency Factor of 0.95 would have a TCOC benchmark that is 4.5% below its market-rate TCOC.

3. Additional detail on TCOC reconciliation

The Commonwealth may incorporate a number of further policies into the TCOC benchmark-setting methodology described above, subject to CMS approval. Such decisions may include, but are not limited to:

1. Excluding certain high-cost services (e.g., therapies for treating Hepatitis C) from the list of covered services, and therefore the base dataset
2. Applying stop-loss thresholds in the base period and performance period TCOC benchmark
3. Setting TCOC Benchmarks on a preliminary basis, and refining them during reconciliation to produce final TCOC Benchmarks that incorporate certain retrospective adjustments for unforeseen effects, to ensure ACOs are appropriately held accountable for their performance rather than exogenous factors

The Commonwealth may decide to apply such policies for some types of ACOs but not others, subject to CMS approval. For instance, the Commonwealth may decide to exclude certain high-cost drugs from the benchmark for Primary Care ACOs and MCO-administered ACOs, but not Accountable Care Partnership Plans. Should such a policy be applied differently between ACO model types, the benchmark-setting methodology for each model type would fully reflect the difference.

For each Primary Care ACO and MCO-Administered ACO, total savings or losses will be calculated as the difference between actual TCOC performance during the performance period and the ACO's TCOC benchmark, in aggregate across all rate cells in which the ACO participates. The portion of savings and losses shared, as well as the mechanism by which savings and losses are shared, will differ by ACO model type. The share of savings and losses may be symmetric or asymmetric, and may include shares of savings and losses up to 100%. ACO risk sharing arrangements will include requirements for financial stability (e.g., including reinsurance requirements) and in some cases will include maximum caps on gains and losses. The Commonwealth intends to generally increase the share of savings and losses over time in ACO risk tracks, and to move towards symmetric rather than asymmetric arrangements; however, the Commonwealth will continue to evaluate ACOs' performance and ability to bear risk in setting risk track policy. The Commonwealth will submit details of these risk arrangements to CMS for approval prior to the Operational Start Date of the ACO and MCO programs.

For each ACO model type, the final calculation of shared savings and losses is subject to the ACO's quality performance. In the event that an ACO is determined to have earned savings, poor quality performance can reduce the share of savings retained by Accountable Care Partnership Plans or paid to Primary Care ACOs and MCO-administered ACOs. In the event that an ACO is determined to have incurred losses, strong quality performance can reduce the share of losses retained by Accountable Care Partnership Plans or the share of losses owed by Primary Care ACOs and MCO-administered ACOs.

ATTACHMENT P ADDITIONAL HISTORICAL INFORMATION

The MassHealth demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types and benefit levels. The demonstration was initially implemented in July 1997, and expanded Medicaid income eligibility categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility was also expanded to certain non-categorically eligible populations, including unemployed adults and non-disabled persons living with Human Immunodeficiency Virus (HIV). Finally, the demonstration also authorized the Insurance Partnership program, which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings. However, the Commonwealth's preferred mechanism for achieving coverage has consistently been employer-sponsored insurance, whenever available and cost-effective.

The implementation of mandatory managed care enrollment under MassHealth changed the way health care was delivered resulting in a new focus on primary care, rather than institutional care. In order to aid this transition to managed care, the demonstration authorized financial support in the form of supplemental payments for two managed care organizations (MCOs) operated by safety net hospital providers in the Commonwealth to ensure continued access to care for Medicaid enrollees. These payments ended in 2006.

In the 2005 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars to further expand coverage directly to the uninsured, funded in part by redirecting certain public funds that were dedicated to institutional reimbursement for uncompensated care to coverage programs under an insurance-based model. This agreement led to the creation of the Safety Net Care Pool (SNCP). This restructuring laid the groundwork for health care reform in Massachusetts, because the SNCP allowed the Commonwealth to develop innovative Medicaid reform efforts by supporting a new insurance program.

Massachusetts' health care reform legislation passed in April 2006. On July 26, 2006, CMS approved an amendment to the MassHealth demonstration to incorporate those health reform changes, which expanded coverage to childless adults, and used an insurance connector (Marketplace) and virtual gateway system to facilitate enrollment into the appropriate program. This amendment included:

- a) The authority to establish the Commonwealth Care program under the SNCP to provide sliding scale premium subsidies for the purchase of commercial health plan coverage for uninsured persons at or below 300 percent of the FPL;
- b) The development of payment methodologies for approved expenditures from the SNCP;
- c) An expansion of employee income eligibility to 300 percent of the FPL under the Insurance Partnership; and
- d) Increased enrollment caps for MassHealth Essential and the HIV/Family Assistance Program.

At this time, there was also an eligibility expansion in the Commonwealth's separate title XXI

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

program for optional targeted low-income children between 200 percent and 300 percent of the FPL, which enabled parallel coverage for children in households where adults are covered by Commonwealth Care. This expansion ensured that coverage is equally available to all members of low-income families.

In the 2008 extension of the demonstration, CMS and the Commonwealth agreed to reclassify three eligibility groups (those aged 19 and 20 under the Essential and Commonwealth Care programs and custodial parents and caretakers in the Commonwealth Care program) with a categorical link to the title XIX program as “hypotheticals” for budget neutrality purposes as the populations could be covered under the state plan. As part of the renewal, the SNCP was also restructured to allow expenditure flexibility through a 3-year aggregate spending limit rather than annual limits; a gradual phase out of federal support for the Designated State Health Programs; and a prioritization in the SNCP to support the Commonwealth Care Program.

Three amendments were approved in 2010 and 2011 to allow for additional flexibility in the Demonstration. On September 30, 2010, CMS approved an amendment to allow Massachusetts to (1) increase the MassHealth pharmacy co-payment from \$2 to \$3 for generic prescription drugs; (2) provide relief payments to Cambridge Health Alliance totaling approximately \$216 million; and (3) provide relief payments to private acute hospitals in the Commonwealth totaling approximately \$270 million.

On January 19, 2011, CMS approved an amendment to: (1) increase authorization for Designated State Health Programs for state fiscal year 2011 to \$385 million; (2) reclassify Commonwealth Care adults without dependent children with income up to and including 133 percent of the federal poverty level (FPL) as a “hypothetical” population for purposes of budget neutrality as the population could be covered under the state plan; and (3) allow the following populations to be enrolled into managed care: (a) participants in a Home and Community-Based Services Waiver; (b) Katie Beckett/ Kaileigh Mulligan children; and (c) children receiving title IV-E adoption assistance.

Additionally, on August 17, 2011, CMS approved an amendment to authorize expenditure authority for a maximum of \$125.5 million for state fiscal year (SFY) 2012 for Cambridge Health Alliance through the SNCP for uncompensated care costs. This funding was approved with the condition that it be counted toward a budget neutrality limit eventually approved for SFY 2012 as part of the 2011 extension.

In the 2011 extension of the demonstration, CMS and the Commonwealth agreed to use federal and state Medicaid dollars for the following purposes:

- e) Support a Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children with high-risk asthma;
- f) Offer early intervention services for children with autism who are not otherwise eligible through the Commonwealth’s currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
- g) Utilize Express Lane eligibility methodologies to conduct renewals for parents and caretakers to coincide with the Commonwealth’s intent to utilize Express Lane

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

eligibility for children; and

- h) Further, expand the SNCP to provide incentive payments to participating hospitals for Delivery System Transformation Initiatives focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

In the extension granted on December 20, 2011 the Commonwealth's goals under the demonstration were:

- i) Maintain near-universal health care coverage for all eligible residents of the Commonwealth and reduce barriers to coverage;
- j) Continue the redirection of spending from uncompensated care to insurance coverage;
- k) Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and
- l) Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

Under the September 2013 amendment, the Commonwealth revised the demonstration and waiver authorities to comply with the provisions of the Affordable Care Act. Additionally, the amendment supported the Commonwealth's ability to sustain and improve its ability to provide coverage, affordability and access to health care under the demonstration. The amendment allowed Massachusetts to continue certain programs and realign other programs to comply with the Affordable Care Act provisions that became effective January 1, 2014. For example, the amendment allowed Massachusetts to sunset certain demonstration programs such as MassHealth Basic, MassHealth Essential and the Medical Security Program December 31, 2013. These changes were made to reflect the fact that effective January 1, 2014, the individuals eligible under certain demonstration programs with income up to 133 percent of the federal poverty level (FPL) became eligible under the Medicaid state plan and those with income above 133 percent of the FPL became eligible to purchase insurance through Massachusetts' health insurance Marketplace, the Health Connector. With the combination of previous expansions and the recent health reform efforts, the MassHealth Medicaid section 1115 demonstration now covers approximately 1.8 million individuals.

In the 2014 extension of the demonstration, the Commonwealth continued its commitment to the same goals articulated for the 2011-2014 extension period. In accordance with these goals, CMS and the Commonwealth agreed to:

- i. Extend the demonstration for a five-year period based upon the authority under Section 1915(h)(2) of the Social Security Act which authorizes five-year renewal terms for states that provide medical services for dual eligible individuals through their demonstration. The five-year renewal period supported the Commonwealth's dual eligibles demonstration as some of the authorities for the duals demonstration are contained in the in the section 1115(a) demonstration.
- ii. Continue authority for the Pediatric Asthma Pilot Program focused on

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

- improving health outcomes and reducing associated Medicaid costs for children ages 2-18 with high-risk asthma;
- iii. Continue authority to offer intensive early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
 - iv. Continue Health Connector Subsidies to provide premium assistance to individuals receiving Qualified Health Plan (QHP) coverage through the Marketplace with incomes at or below 300 percent of the FPL;
 - v. Continue and expand the authority for the Commonwealth to conduct streamlined eligibility redeterminations using Supplemental Nutrition Assistance Program (SNAP) verified income data;
 - vi. Provide for payment of the cost of the monthly Medicare Part A and Part B premiums and the cost of deductibles and coinsurance under Part A and Part B for Medicare-eligible individuals who have incomes up to 133 percent of the FPL, and pay the costs of the Medicare Part B premium only for CommonHealth members with incomes between 133 and 135 percent FPL; and
 - vii. Through June 30, 2017, provide incentive payments to participating hospitals for Delivery System Transformation Initiatives and the Public Hospital Transformation and Incentive Initiatives, and provide support for Infrastructure and Capacity Building investments focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

During the extension period granted in 2014, the goals of the demonstration were:

- viii. Maintain near universal coverage for all residents of the Commonwealth and reduce barriers to coverage;
- ix. Continue the redirection of spending from uncompensated care to insurance coverage;
- x. Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and
- xi. Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

In the 2016 amendment to the demonstration, the Commonwealth and CMS agreed to implement new demonstration components to support a value-based restructuring of MassHealth's health care delivery and payment system, including a new Pilot Accountable Care Organization program, building toward a transition to fuller accountable care models in the future. In addition, behavioral health services authorized under the demonstration have been expanded to strengthen

ATTACHMENT P
ADDITIONAL HISTORICAL INFORMATION

Massachusetts' system of recovery-oriented Substance Use Disorder treatments and supports, in large part with the goal of addressing the opioid addiction epidemic.

The amendment also made other changes, including expanding CommonHealth eligibility for working adults over age 65; authorizing MassHealth to require enrollment in Student Health Insurance Plans (SHIP) when deemed cost effective and to provide for continuous eligibility for the duration of the SHIP year; and expanding the availability of Health Connector subsidies to include cost sharing subsidies for Health Connector enrollees with incomes at or below 300 percent of the FPL, in addition to premium subsidies for this population that were previously authorized.

MassHealth 1115 Demonstration
Attachment Q:
Medicaid Managed Care Entity/ACO Performance-Based
Incentive Payment Mechanisms

1. Overview

As delivery system reforms are implemented, the Commonwealth and CMS seek to shift payments to risk-based alternative payment models focused on accountability for quality, integration and total cost of care. Consistent with this goal, within the five-year demonstration term, the Commonwealth will direct Medicaid Managed Care Entities/Accountable Care organizations (MMCE/ACO), to administer performance-based quality incentive programs for hospitals as described below (“MMCE/ACO payment mechanism”). In addition to being critical to the delivery system reform goals shared by the Commonwealth and CMS, these performance-based quality incentive programs are integral to the Commonwealth’s overall financing of activities authorized under the demonstration, and are considered payments that are broadly compliant with requirements for payments made under 42 CFR 438.6(c)(1)(ii).

2. General Requirements

The four MMCE/ACO payment mechanisms described below, which the Commonwealth agrees to establish, shall be implemented through MMCE/ACO contracts consistent with this Attachment in order to meet the requirements of 42 CFR 438.6.

3. Description of the Payment Mechanisms

The Commonwealth intends to direct MMCE/ACOs to administer the following four MMCE/ACO performance-based quality incentive programs:

- a. **Disability Access Incentive (DY21/SFY2018 – DY25/SFY2022):** The Commonwealth will direct MMCE/ACOs to make payments to all contracted acute hospitals based on reporting and performance related to disabled members’ access to medical and diagnostic equipment.
- b. **Hospital Quality Incentive (DY21/SFY2018 – DY25/SFY2022):** The Commonwealth will direct MMCE/ACOs to make payments to Essential MassHealth hospitals (Cambridge Health Alliance and UMass Memorial Health Care, Inc. Hospitals) based on hospital quality performance.
- c. **Integrated Care Incentive (DY22/SFY 2019 – DY25/SFY 2022):** In the event that primary care providers employed by or affiliated with Cambridge Health Alliance participate in the Commonwealth’s Accountable Care Partnership Plan model, the Commonwealth will direct that MMCE/ACO to make payments to non-federal, non-state, public hospitals based on the accountable care performance of such hospitals’ owned or affiliated primary care providers.
- d. **Behavioral Health Quality Incentive (DY23/SFY 2020 – DY25/SFY 2022):** The Commonwealth will direct the Commonwealth’s single Prepaid Inpatient Health Plan (PIHP) to make payments to non-federal, non-state, public hospitals in its network based on behavioral health quality performance.

4. General Methodology Linking Payment Mechanisms to Utilization/Delivery of Services

The Commonwealth shall include in its MMCE/ACO contracts payment mechanisms consistent with the following approach:

- a. The Commonwealth will specify the maximum allowable payment amount that it will direct each MMCE/ACO to pay to one or more designated classes of hospitals during the MMCE/ACO contract year.
- b. The maximum payment amount earned by a specific hospital (i.e., the amount earned if a hospital attains a quality score of 100 percent) will be equal to the total amount directed to the designated class multiplied by the proportion of the class's total managed and non-managed Medicaid Gross Patient Service Revenue ("Medicaid GPSR") or other measure of utilization and delivered of services, for which the specific hospital's Medicaid GPSR, or other measure of delivered services, accounts during the MMCE/ACO contract year.
- c. The Commonwealth will calculate periodic lump sum payments that MMCE/ACOs will be directed to pay to specific hospitals. The periodic lump sum payments will be calculated based on:
 - i. The Commonwealth's projection of each hospital's Medicaid GPSR, or other measure of utilization and delivered services, during the MMCE/ACO contract year;
 - ii. Each hospital's expected performance (based on prior year or other data);
 - iii. A target for the MMCE/ACO to pay 90% of each hospital's expected earned payments in advance of a final reconciliation after the MMCE/ACO contract year.
- d. Within seven days prior to each scheduled lump sum payment described above, the Commonwealth shall make a payment to each MMCE/ACO that is directed to make an incentive payment to hospitals. The Commonwealth's payment to each MMCE/ACO shall be equal to the sum of all payments that the MMCE/ACO is directed to make. The Commonwealth may use any permissible source, including intergovernmental transfers, as the source of the non-federal share for MMCE/ACO payments.
- e. Following the MMCE/ACO contract year, actual Medicaid GPSR, or other measure of utilization and delivered services, for each hospital and performance under each contract will be determined and the actual payment amount earned by hospitals will be calculated.
- f. Final reconciliation: Based on the difference between the periodic lump sum amounts paid to hospitals during the MMCE/ACO contract year and the actual amount earned, MMCE/ACOs will be directed to make a final reconciliation payment to hospitals. In the event that the lump sum payments made by the MMCE/ACO to a hospital during the MMCE/ACO contract year exceeded the total actual amount earned, the hospital will remit the excess payment to the MMCE/ACO as part of the final reconciliation. Any amount remitted by a hospital to a MMCE/ACO as part of the reconciliation shall in turn be remitted by the MMCE/ACO to the Commonwealth.

5. Performance Measures and Evaluation Plan

As required under 42 CFR 438.6(c)(2)(i)(D), the Commonwealth shall have a plan to evaluate the extent to which the payment mechanisms and performance measure incentives achieve the goals and objectives identified in the managed care quality strategy. The Commonwealth may use performance measures based upon the following domains, or other domains not listed below, for the incentive programs. The Commonwealth may include process, improvement, outcomes, system transformation, and innovative measures and indicators that are consistent with the Commonwealth's delivery system reforms and quality strategy. For the Hospital Quality, Integrated Care, and Behavioral Health Quality Incentives, the Commonwealth will designate two types of performance measure domains. Type I domains will have 80% or more of the measures drawn from nationally vetted and endorsed measure sets (e.g. National Quality Forum, National Committee for Quality Assurance, the Joint Commission, etc.) or measures in wide use across Medicare and Medicaid quality initiatives (e.g. the Medicaid Child and Adult Core Set Measures, CMS Core Quality Measures Collaborative measure sets, Health Home measure sets, Behavioral Health Clinic measure sets, and Merit-based Incentive Payment System and Alternative Payment Model measures, etc.). Type II domains will not have a lower limit on the percentage of measures drawn from nationally validated measure sets. As a matter of general principle, where practicable, specific performance measures for each incentive payment mechanism will be drawn from the nationally recognized measure sets.

The Commonwealth will submit the evaluation plan and performance measures to CMS for approval, consistent with the process set forth at 438.6.

Any changes made to the specific domains listed below would not require an amendment to the Demonstration:

- a. **Disability Access Incentive Payment** - Hospital performance expectations shall increase every year from the beginning of the incentive program, beginning with two years of reporting and three years of performance as measured by disability access to MDE:
 - i. Year 1 of incentive program (October 1, 2016 to September 30, 2017): Hospitals required to report:
 - A. The Provider's capacity to provide accessible MDE to individuals with disabilities
 - B. A detailed list of the Provider's accessible MDE
 - C. The Provider's plan to improve its provision of accessible medical and diagnostic equipment
 - D. The name and contact information for the Provider's single point of contact for those seeking or having questions about access for individuals with disabilities (i.e. a Disability Access Key Contact)
 - ii. Year 2: Hospitals shall be required to report:
 - A. Year 1 metrics
 - B. Measures related to patient experience. The measures may include, and are not limited to:
 - Average wait times for disabled patients for specified MDE
 - Ratio of accessible MDE to the number of local disabled individuals
 - Results of disabled patient experience surveys regarding access to MDE

6. Years 3-5

- A. Continued reporting requirements as in Years 1 and 2
 - B. Hospital performance will be measured on the basis of how a disabled member's experience of accessing MDE compares to the experience of a non-disabled member. The metrics upon which the two populations' experience would be compared may include, and are not limited to:
 - Average wait times for disabled patients for specified MDE
 - Ratio of accessible MDE to the number of local disabled individuals
 - Results of disabled patient experience surveys regarding access to MDE
- b. Hospital Quality Incentive Payment** - Performance for this payment mechanism will be based on the following:
- i. Type I domains include measures related to:
 - A. Inpatient care and other hospital system quality (e.g., appropriate care for key conditions)
 - B. Transitions of care (e.g., follow-up after discharge, reconciled medication list at discharge)
 - C. Avoidable utilization and patient safety (e.g., rates of hospital-acquired infections)
 - ii. Type II domains include measures related to:
 - A. System transformation
 - iii. EOHHS may include other domains beyond those listed here
- c. Integrated Care Incentive Payment** - Performance for this payment mechanism will be based on the following:
- i. Type I domains include measures related to:
 - A. Care coordination – transitions of care
 - B. Avoidable / appropriate utilization (e.g., admission from emergency department to inpatient setting and readmissions rates)
 - C. Patient quality scores
 - ii. Type II domains include measures related to:
 - D. Care coordination measures aside from transitions of care
 - E. Member engagement
 - F. Care integration, system transformation, multi-disciplinary team-based care
 - iii. EOHHS may include other domains beyond those listed here
- d. Behavioral Health Quality Incentive Payment** - Performance for this payment will be based on the following:
- i. Type I domains include measures related to:
 - A. Behavioral health-specific quality of care
 - ii. Type II domains include measures related to:
 - A. Behavioral health-specific care coordination
 - B. System transformation
 - iii. EOHHS may include other domains beyond those listed here

- iv. Many of the proposed measures will be the same measures for which non-federal, non-state, public hospitals are accountable in the PHTII program under this demonstration.

Each participating hospital’s performance, under each performance-based incentive payment mechanism, shall be measured against approved benchmarks and a score for each measure or group of measures will be calculated according to a methodology to be defined by EOHHS and approved by CMS. Benchmarks for any individual performance measure may be set either on the basis of absolute performance standards or improvement targets for individual hospitals. Scores will be summed, with or without weighting, across all measures or groups of measures in order to calculate an overall performance score between 0 and 100 percent. Under the MMCE/ACO payment mechanism, each hospital’s performance score shall be multiplied by that hospital’s maximum incentive payment amount in order to calculate the actual payment earned by the hospital.

To the extent practicable and feasible, the specific performance measures for each incentive payment mechanisms should be aligned with comparable national standards and other process, improvement, outcomes, system transformation, and innovative metrics that are consistent with the Commonwealth’s delivery system reforms and quality strategy.

7. Funding Sources and Anticipated Incentive Program Amounts

The scheduled maximum dollar amounts directed to designated classes of providers under each of the four MMCE/ACO incentive payments mechanisms are:

#	Incentive Title	MMCE/ACO vehicle	Hospital class	Maximum MCO incentive payment to designated hospital class, by SFY (\$ millions)				
				SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
1	Disability access incentive	MMCOs	All in-network acute hospitals	265	265	265	265	265
2	Hospital Quality incentive	MMCOs	Essential MassHealth hospitals in network	157	315	316	315	315
3	Integrated care incentive	Accountable care partnership plans affiliated with Cambridge Health Alliance	Non-federal, non-state, public hospitals in network	0	28	39	39	39
4	Behavioral health quality incentive	Commonwealth’s single Prepaid Inpatient Health Plan (PIHP)	Non-federal, non-state, public hospitals in network	0	0	141	138	135

The Commonwealth may propose an increase or decrease of 20 percent of the maximum payment amounts listed in the Table. The incentive payments will be incorporated as a component of the MMCE/ACO capitation amounts, and are therefore subject to CMS approval under the review and approval process described in the next section.

Because of the expectation that these payments will transition out of the demonstration, these amounts are not reflected in Attachment E for the respective years noted above.

8. CMS Review and Approval

No later than November 15, 2016, as part of the template described below, the Commonwealth shall submit to CMS a detailed framework for measuring and scoring performance under the Hospital Quality, Integrated Care, and Behavioral Health Quality incentive payments described in this attachment. The Commonwealth and CMS shall work toward applicable approvals by January 15, 2017.

The Commonwealth shall submit to CMS for approval any payment mechanisms that direct payments as described in 42 CFR 438.6(c) at least 120 days prior to implementation, in a format and template to be specified by CMS. Such submission shall include the incentive payment amounts and the performance measures and scoring benchmarks. In addition, the Commonwealth shall clearly identify the specific goals and objectives described in the Commonwealth's managed care quality strategy that the incentive payment mechanism is designed to achieve. Materials submitted for approval shall be consistent with this Attachment in order to meet the requirements of 42 CFR 438.6 and may be submitted for approval prior to the contract and rate certification submission under 42 CFR 438.3 and 42 CFR 438.7. CMS will provide initial written feedback within 45 calendar days of the Commonwealth's submission, and shall render a final decision on the proposal no more than 90 days after the Commonwealth's initial submission. Pursuant to 42 CFR 438.6(c)(2)(1), the Commonwealth must obtain annual prior written approval from CMS for each performance-based quality incentive program.

This Attachment is intended to describe a common understanding between the Commonwealth and CMS on a framework for implementing incentive payments. The attachment does not prohibit the Commonwealth from modifying the payment amounts or the performance measures to best meet its needs and submitting such revisions through the CMS review and approval process; such changes shall not require an amendment to the demonstration.

CMS and the State recognize that this performance framework is a new, significant shift toward a performance-based structure for hospital supplemental payments. Therefore, at the end of the second year of this demonstration, CMS and the State shall jointly evaluate and review the performance measures described in Section 5 of this Attachment.

**ATTACHMENT R
FLEXIBLE SERVICES PROTOCOL**

Reserved